Abstract

SELF-ESTEEM, EMOTIONAL MATURITY AND BEHAVIORAL PROBLEMS AMONG ORPHANS: A STUDY IN MANIPUR

NINGTHOUJAM DEBALA CHANU

DEPARTMENT OF PSYCHOLOGY
MIZORAM UNIVERSITY

An Orphanage is often examined through problematic psycho-social functioning of children. There is general agreement among researchers that children placed in orphanage settings at a very young age and for long periods of time are at greatly increased risks for development of serious psychopathology later in life. Orphans exist in every age and in all civilizations. According to the joint report of UNICEF, HIV/AIDS and Development (2002), about 1.7 billion children are orphans worldwide. Out of this number, Asia contributes 6.5% orphans and Africa leads with 11.9% orphans.

According to another report of United Nations Children's Fund (UNICEF) and the joint UN program (2005), 7.6% children of the total population of the world are orphan. 132 million orphan children are live in Africa, Asia and America continent. A new study by an international charity for orphaned and abandoned children called Raj in the year 2011 found that India is home to 20-million orphans, a figure projected to increase by 2021. The study found that 4 % of India's child population of 20 million are orphans. Most of these children have been abandoned by their parents. In fact the charity estimates that only 0.3 % of these orphans are children whose parents have actually died. The study found that states such as Uttar Pradesh, Bihar and West Bengal had more orphans than Indian's richer states. The state of Madhya Pradesh, Uttar Pradesh and Chhattisgarh are home to 6-million orphaned children under the age of 18. The eastern region, encompassing Bihar, Orissa, Jharkhand and West Bengal, now houses 5.2-million orphans (India's Family Health Survey-3; 2005-2006). There are different ways of defining an orphan. 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 his/her mother and paternal orphan is referred to a child who has lost his/her father. 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).).

Self-esteem is defined as a stable sense of personal worth or worthiness (Morris Rosenberg,1965). It is understood as an attitude, either positive or negative, a person has about him- or herself. Emotional maturity can be understood in terms of ability of self-control which in turn is a result of thinking and learning. An emotionally matured person is one whose emotional life is well under control (Chamberlain,1960). According to Singh and Bharagava (1990) emotionally mature is not one who necessarily has resolved all conditions that aroused anxiety and hostile. But it is continually involved in a struggle to gain healthy integration of feeling, thinking and action.

Behavioural problems can occur in children with all ages and very often they start in early life. Many risk factors have been proposed for the occurrence of mental disorders, among which social factors are clearly implicated in the genesis and maintenance of these and their extension into adulthood. Internalizing behaviour comes with anxiety, depression, and withdrawal from others. Developmental research proposes children with internalizing symptoms may, in certain cases, perform externalizing behaviour (Perle et al., 2013).

According to a report by National Institute for Health Care Management (2005), globally one in every five children and adolescent suffer from a mental disorder and two out of five who require mental health services do not receive them. It is expected that by 2020, childhood neuropsychiatric disorder will rise to over 50% and will become one of five most common reasons of morbidity, mortality and disability among children. Children living in orphanages are one of the most vulnerable groups of children in a society; many of them have to live with repeated neglect, abuse or fear. For many of them, a new safe home they can trust alone is not enough to repair the damage imposed by abnormal early stress on the developing nervous system (Hughes, 1999).

The present study entitled, 'Self-Esteem, Emotional Maturity and Behavioural Problems among Orphans: A Study in Manipur' was conducted by following the scientific methodology which could be replicated in future to cross checking or to get more information in the selected population for framing prevention and developing intervention strategies for psychological problems. The operation areas of the present study was Manipur State of India.

Objectives:

Given the theoretical and methodological foundations, the objectives of the present study were formed viz,

I) To establish the psychometric adequacy of the psychological tests used, in order to find applicability in the selected population.

II) To explore any significant differences between the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems of the selected samples.

III) To explore any significant relationship between the sub-scales/scales of Self-Esteem, Emotional Maturity and Behavioural problems (externalizing and internalizing) in the selected population.

IV) To explore whether there is any significant independent effect of 'gender' and 'orphanage' on the sub-scales/scales of Self Esteem Emotional Maturity and Behavioural problems (externalizing and internalizing) in the selected population.

V) To explore whether there is any significant interaction effect of 'gender and orphanage' on the sub-scales/scales of Self Esteem, Emotional Maturity and Behavioural problems (externalizing and internalizing) in the selected population.

Hypotheses:

To meet the objectives of the study the following hypotheses are set forth for the study:

I) It is expected that the selected Psychological measures would find applicability in the selected population as it is going to be one of the few endeavours in the selected population.

II) It is expected that there will be a significant mean difference between the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems of the selected samples.

III) It is expected there will be a significant relationship between the sub-scales/scales of Self-Esteem, Emotional Maturity and Behavioural problems (externalizing and internalizing) in the selected population.

IV) It is expected that there will be an independent effect of 'gender' and 'orphanage' on the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems (externalizing and internalizing) among the sample.

V) It is expected that there will be an interaction effect of 'gender and orphanage' on the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems (externalizing and internalizing) among the sample.

For the final inclusion, 200 Children {(2 groups of Children (100 Orphans and 100 Controls) and 2 Genders (Boys and Girls)} was selected through multistage random sampling method. Of which, 100 was children living in an Orphanage in Manipur and whose age range falls between 11 years to 16 years and another100 children who are currently staying with their biological parents at home for control group/comparison group.

To meet the objectives and the hypotheses set forth for the present study, the psychological tests: (1) Rosenberg's Self-esteem Questionnaire (SES; Rosenberg, 1965); (2) Emotional Maturity Scale (EMS; Yasvir Singh and Mahesh Bharagava, 1984); (3) Child

Depression Inventory (CDI Kovacs,1985); (4) Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds, C.R., & Richmond, B.O, 1985); and (5) Strengths and Difficulties Questionnaire (SDQ; Goodman, 2001) were employed to tap the selected dependent variables.

The data collected were analysed in stepwise as follow:

Firstly, the Psychometric adequacy of the Psychological test was done to confirm the trustworthiness of the selected scales for the target population by employing Brown-Forsythe test and the reliability of the psychological tests were calculated.

Secondly, the descriptive statistics were computed including the mean, standard deviation, Standard Error of Mean, Kurtosis and Skewness on the behavioural measures of (i) Self-Esteem Scale, (ii) Emotional Maturity Scale, (iii) Child Depression Inventory (iv) Revised Children's Manifest Anxiety Scale and (v) Strengths & Difficulties Questionnaire.

Thirdly, mean difference was computed for the whole sample.

Fourthly, Pearson Correlation showing the relation of the whole sample on the behavioural measures of Self Esteem, Depression and subscales of Manifest Anxiety, Emotional Maturity and Strengths and difficulties questionnaire. Lastly, 2 X 2 ANOVA with Post-hoc multiple mean comparisons were employed to illustrate the independent and interaction effect of the independent variables on selected dependent variables for the whole samples.

Psychometric Adequacy:

The psychological tests used for the present study were originally made for other culture, and therefore to rule out the difference on cultural norms, the psychometric adequacy of the psychological test was checked before going further analysis by employing Levenes' Test of Homogeneity of Variance (Levene 1960) to test the assumption that variances are equal across groups or samples, Robust Tests of Equality of Means (Brown & Forsythe, 1974) and Reliability measure (Cronbach Alpha; Cronbach, 1951).

The preliminary analyses of the psychometric properties of the behavioural measures were computed was felt necessary that scale constructed and validated for measurement of the theoretical construct in a given population when taken to another cultural milieu may not be treated as reliable and valid unless specific checks are made (Witkin & Berry, 1975). The reliability and predictive validity of the scales and sub-scales were ascertained to ensure the

psychometric adequacy of the scales used for the study. Internal consistency reliability was estimated for each of the scales used in the study using Cronbach's coefficient alpha (Cronbach, 1951) was employed to cross check the Cronbach's coefficient alpha for methodological confinement of the internal consistency i.e.; how well the test components contribute to the construct that's being measured.

The results in Table- 1 revealed that the reliability of Self-Esteem (α=.79), Depression (α=.58) and subscales of Emotional Maturity Scale (Emotional Instability, α=.71; Emotional Regression,α=.65; Social Maladjustment, α= .72; Personality Disintegration, α=.64 and Lack of Independence, α= .78). Similarly, the results in Table- 2 revealed that the reliability of subscales of Revised Children Manifest Anxiety Scale (Physiological Anxiety- α=.51;Oversensitivity/Worry- α=.73; Social Concerns/Concentration -α=.63) and subscales of Strengths and Difficulties Questionnaire(Emotional Problems - α=.74; Conduct Problems,α=.79; Hyperactivity, α= .78; Peer Problem, α=.77, Prosocial, α= .57; Externalizing,α= .78 and Internalizing, α= .67). The total coefficient of correlation of the subjects emerged to be satisfactory over the levels of analysis for the whole sample, which indicating the trustworthiness of the scales such as Self Esteem, Children Depression and emotional Maturity. The Reliability test of Cronbach Alpha shows reliability scores all falling above .50 showing the reliability and the validly proved the trustworthiness of the selected psychological scale for the present population under study. Brown-Forsythe Test of Homogeneity of Variances was used, and Levene's Test from the test it was indicative of homogeneity of the variance within the whole sample.

Descriptive Statistics:

The results (Table-3) highlight the Mean and SD of the scales/subscales of (i) Self-Esteem Scale, (ii) Emotional Maturity Scale, (iii) Child Depression Inventory (iv) Revised Children's Manifest Anxiety Scale and (v) Strengths & Difficulties Questionnaire. The results revealed the mean and standard deviation as well as Skewness and Kurtosis as indices for normality of the scores on the measured variables. All the skewness statistics falls between 1.0 to 2.0 which showing none of the skew and kurtosis were greater than twice the standard error within an acceptable range, and that revealed the applicability of parametric statistics for further analysis (Miles & Shevlin, 2001).

Results presented in Table-3 highlights the Mean comparison among the four comparision groups: Orphan Girls, Orphan Boys, Non-orphan Girls & Non-orphan Boys. It

indicated that for the measure of Self Esteem, the Non-orphan Boys had highest score (M=22.56) followed by Non-orphan Girls (M=20.98), then by Orphan Boys (M=17.80) and lowest score was observed among Orphan Girls (M=15.30). Results also highlighted that the Non-orphans have higher score in Self-esteem than the Orphans (M=21.19,18.14; $p<.01$) and the boys are higher than girls (M=20.18, 18.14) on Self-esteem for the whole sample as showed in Table. This findings are supported by studies by Guthman et al (2002); and also by Wanjiru and Gathogo (2014). The gender difference may be explained by different socializations. Boys feel they are more valued by the society (Guthman et al, 2002).

On the measure of Depression using the Child Depression Inventory, the Orphans had more depressive symptoms (M= 29.01) than the Non-Orphans (M=25.22). Orphan Girls had the highest score (M=29.96) followed by Orphan Boys (M=28.06), Non-Orphan Girls (M=26.54) and lowest by Non-Orphan Boys (M=23.90). The findings of the current study supports the previous separate studies by Atwine, Cantor and others(2005), Manuel (2002) where orphans were more likely than controls to be depressed and bullied. The cross sectional descriptive study by Ramagopal and others (2016) involving 180 children in the age group of 12-18 years living in orphanage also indicted, 35% had depression, most of them who had depression were in the age group of 15-17 years and majority were females. A study by Abdel Thabet and others (2017) on orphan children also highlighted that 67.9% showed depression. Nasir Mohammad Bhatt (2014) also revealed significant difference in emotional stability and depression levels between two groups. Orphans were found at the lower side of emotional stability and higher levels of depression as compared to the non-orphan secondary school students.

Similarly, on all the subscales of Emotional Maturity the mean values calculated for the orphans are: Emotional Instability (M=21.33), Emotional Regression (M= 18.64), Social Maladjustment (21.33), Personality Disintegration (M=18.96) and Lack of Independence (M=19.89). Orphans scored higher mean value than Non-Orphans, from which it can be ascertained that Emotional Maturity was higher in Non-Orphans than the Orphans, since higher score in emotional maturity scale means lower level of Emotional Maturity. This findings supported previous studies by Chaudhary and Bajaj (1993), Upreti and Sharma, S(2018) where they found that adolescents staying at home have higher level of emotional maturity as compared to their counterparts staying at the orphanage. Nasir Mohammad Bhatt (2014) revealed significant difference in emotional stability s between two groups. Orphans were

found at the lower side of emotional stability as compared to the non-orphans secondary school students.

As indicated in Table - 3, the Orphans girls obtained higher mean values than the other comparison groups in all the subscales of Emotional Maturity viz; Emotional Instability, Emotional Regression, Social Maladjustment, Personality Disintegration and Lack of Independence. Similar findings were observed in study done by Kumar,S and his colleagues (2015) where significant gender difference was also observed wherein orphan girls were significantly lower than the orphan boys on social adjustment. Jan Nuzhat (2013) also found female University distance learners have more emotional instability than Male University distance learners. The results of the current study conform to the study done by Krishna Duhan and his associates (2017) where they did a comparison of Male and Female Adolescents on Emotional Maturity and in that female adolescents were on higher side on emotional instability, social maladjustment and lack of independence as compared to their counterparts. Aleem and Sheema (2005) also observed significant difference between the mean scores of male and female students on emotional stability. Reviews of a different line of research also indicated that male university distance learners have more emotional regression than female university distance learners (Jan Nuzhat, 2013). Similar results were observed by Krishna Duhan and others (2017) where Emotional regression and personality disintegration was higher in males as compared to female adolescents as they obtained higher mean scores than their counterparts.

Table -4 indicated the results of the mean values calculated for the Revised Children Manifest Anxiety Scale. The orphans scored higher mean values than the non-orphans on the Oversensitivity/ Worry Factor (M=29.01; 25.22) and Social concerns/ Concentration factor (M=16.70). Among all the groups, orphan boys group showed higher mean values than the orphan girls on the Oversensitivity/ Worry Factor(M=29.96; 28.06) and on the Social concerns/ Concentration factor (M=22.76; 19.90). Whereas, orphan girls scored lower than the non-orphans on the Physiological factor (M=21.77; 16.55). The results of the study are in line with studies of Thabet and colleagues (2007); Nagy Fawzy and Amira Fourad (2010); Thabet and others (2017); and Atwine, Cantor and colleagues (2005).

Table -5 highlights the results of the mean values calculated for the subscales of Strengths and Difficulties subscales for the whole sample. The mean values on emotional problem subscale were higher among the orphans (M=18.64) than the non-orphans (M=16.02). Similarly, the Orphans group was observed to have higher mean value than the non-orphans

group on the subscales of conduct problems (M=21.33; 16.70), hyperactivity (M=18.96; 15.78), prosocial behaviour (M=19.89; 16.30), externalizing (M=20.14; 16.24) and internalizing (M=19.26; 16.14) problems. However, peer problem was observed to be more among non-orphans than the orphans (M=16.27; 13.64). Among all the groups, orphan boys group showed higher mean values than the orphan girls on the emotional problem (M=20.22; 17.06), conduct problem (M=20.22; 17.06), hyperactivity (M=20.22; 17.06), peer problem (M=14.80; 12.48), prosocial (M=20.58; 19.20), externalizing (M=21.49; 18.80) and internalizing (M=17.51; 14.74) problems. Overall, boys were found to have higher mean values than the girls on emotional problem (M=18.10; 16.56), conduct problems (M=20.29; 17.74), hyperactivity (M=18.18; 16.56), prosocial behaviour (M=19.02; 17.17) peer problem (M=15.74; 14.17), externalizing (M=19.23; 17.15) and internalizing (M=16.92; 16.56) problems.

Correlation Statistics:

The results (Table - 6) revealed that Self-esteem had significant negative correlation with Depression (r= -.46; p<.01) which means that as Self Esteem increased, Depressive symptoms decreases. This finding is well supported by Sowislo (2012) analysed 77 studies on depression and self-esteem and it was found that decreases in self-esteem were predictive of increases in depression. It was also revealed that Self-esteem had significant negative correlation with Emotional Instability (r= -.43; p<.01), Emotional Regression (r=-.27; p<.01), Social Maladjustment(r=-.43; p<.01), Personality Disintegration (r= -.35; p<.01), Lack of Independence (r= -.38; p<.01). Similarly, increase in Self Esteem will decrease the scores in the subscales of Emotional Maturity Overall it means that Increase in Self Esteem will increase Emotional Maturity among the children. Leung and friends (1981) also found that students high in self-esteem were found to be more emotionally mature than students low in self-esteem. These findings are in agreement with the findings of Zervas, and Sherman (1994) that self-esteem score correlated with personality factors indicating positive relationship with emotional maturity, psychological adjustment and intellectual behaviour.

Self Esteem is also found to have significant negative correlation with Anxiety subscales viz; Physiological Anxiety (r= -.34; p<.01), Oversensitivity / Worry (r= -.35; p<.01) and Social Concerns / Concentration(r= -.37; p<.01). As Self Esteem increased, anxiety will decrease .According to the results, Depression was positively corelated with Emotional

Instability (r= .31; p<.01), Emotional Regression (r= 00.23; p<.01), Social Maladjustment (r=.31; p<.01), Personality Disintegration (r= .25; p<.01), Lack of Independence (r= .31; p<.01). Depression is also found to have significant positive correlation with Anxiety subscales viz; Physiological Anxiety (r=-.34;p<.01), Oversensitivity / Worry (r=-.35;p<.01) and Social Concerns / Concentration (r= -.37; p<.01).

Emotional maturity subscale: emotional instability is found to have significant positive correlation with Anxiety subscales viz; Physiological Anxiety (r= .19; p<.01), Oversensitivity/Worry (r= .31; p<.01) and Social Concerns/ Concentration (r= .32; p<.01). Emotional regression has significant positive correlation with Physiological Anxiety (r= .26; p<.01), Oversensitivity/Worry (r= .33; p<.01) and Social Concerns/ Concentration (r= .21; p<.01). Social Maladjustment have significant positive correlation with Physiological Anxiety (r= .19; p<.01), Oversensitivity/Worry (r= .31; p<.01) and Social Concerns/ Concentration (r= .32; p<.01). The results also revealed that Personality Disintegration have significant positive correlation with Physiological Anxiety (r= .25; p<.01), Oversensitivity/Worry (r= .36; p<.01) and Social Concerns/ Concentration (r= .21; p<.01). the subscale of lack pf independence was also seen to have positive correlation with Physiological Anxiety (r=.30; p<.01), Oversensitivity/Worry (r= .17; p<.01) and Social Concerns/ Concentration (r= .22 p<.01). Higher scores on the subscales of emotional maturity means lower Emotional Maturity. Hence, from these results it can be ascertained that as the level of Emotional Maturity increases anxiety level will decrease.

Results in Table no:7 indicates the correlation between the measures of Self-Esteem, Depression and subscales of Revised Children Manifest Anxiety and Strengths and Difficulties Questionnaire. Self-Esteem has been found to have negative correlation with emotional problem (r=-.42, p<.01), conduct problem (r=-.47; p<.01), hyperactivity(r=-.45;p<.01),peer problem(r= -.47; p<.01) and internalizing problems (r=-.40,p<.01). Interestingly, Self-Esteem was found to have positive correlation with the Externalizing problems (r= .39, p<.01), this finding needs to be further explored. From the table Depression was observed to have significant positive correlation with emotional problem(r= .32; p<.01), conduct problem(r= .38; p<.01), hyperactivity (r= .38; p<.01),peer problem (r= .28; p<.01), prosocial behaviour (r= .14; p<.05) and internalizing behaviour ((r= .32; p<.01).Depression was found to have negative correlation with externalizing behaviour (r=-.34,p<.01).

The analysis revealed that the subscales of Anxiety: Physiological anxiety, Oversensitivity/worry and Social concerns/Concentration are positively correlated with each other (r= .35, .43, .38; p<.01). The externalizing subscale is found to have significant negative correlation with the Internalizing subscale (r= -.28; p<.01) of the Strengths and Difficulties Questionnaire. From the results table it is also seen that only the Externalizing subscale of the Strengths and Difficulties Questionnaire have a significant negative relationship with all the Anxiety subscales; Physiological anxiety(r=-.31;p<.01), Oversensitivity/worry(r=-.41;p<.01) and Social concerns/Concentration(r= -.35; p<.01). Similarly, Externalizing subscale has significant negative correlation (r values as indicated in the table) with other subscales of Strengths and Difficulties Questionnaire viz emotional problem, conduct problem, prosocial, peer problem, hyperactivity and internalizing problem at p<.01.

Results from Table - 8 depicted the correlation between the subscales of emotional maturity and the strengths and difficulties questionnaire. Here it is revealed that, Emotional Instability have positive correlation with emotional problem (r=.30, p<.01), conduct problem (r=.30; p<.01), hyperactivity(r=.27; p<.01),peer problem(r= .31; p<.01) and internalizing problems (r=.42,p<.01), which implies that as emotional instability increases, emotional problem, per problem, conduct problem, hyperactivity and internalizing problems will also increase. But it was seen to have negative correlation with externalizing behaviour (r=-.39;p<.01). On the subscale of emotional regression positive correlation with emotional problem (r=.28, p<.01), conduct problem (r=.28; p<.01), hyperactivity (r=.27; p<.01),peer problem(r= .28; p<.01) and internalizing problems (r=.22,p<.01) was found. But a negative correlation was found with externalizing behaviour(r=-.20; p<.01). Social maladjustment had significant positive correlation with emotional problem (r=.30, p<.01), conduct problem (r=.32; p<.01), hyperactivity (r=.27;p<.01),peer problem(r= .31; p<.01) and internalizing problems (r=.43,p<.01).). Similarly, Personality Disintegration have significant positive correlation with emotional problem (r=.31, p<.01), conduct problem (r=.31; p<.01), hyperactivity (r=.33;p<.01),peer problem(r= 34.; p<.01) and internalizing problems (r=.28,p<.01). Lack of independence also have positive correlation with emotional problem (r=.26, p<.01), conduct problem (r=.31; p<.01), hyperactivity (r=.31; p<.01), peer problem (r= 32; p<.01) and internalizing problems (r=.26, p<.01). From the results externalizing problem is found to have negative correlation with all other subscales of emotional maturity. Prosocial subscale did not have any significant relationship with any other subscales of Emotional Maturity.

Prediction of the effect of independent variables:

Analysis of Variance (ANOVA) to illustrate the independent effect of two independent variables (Orphanage & Gender) on dependent variables (Self-Esteem, Depression, Anxiety, subscales of Emotional Maturity and subscales of the Strengths & Difficulties Questionnaire) and also interaction effects (Orphanage X Gender) on dependent variables under study. Two-way ANOVA was computed, and the findings are presented under Table-9.

The ANOVA results in Table-9 showed significant independent effect of Orphanage on Self-Esteem with 43% effect ($F=149.50$; $p< .01$, $\eta^2=.43$). Similarly, significant independent effect of Orphanage was found on Depression with 27% ($F=75.47$; $p<.01$, $\eta^2=.27$).

Significant independent effect of Orphanage was also found on subscales of Emotional Maturity viz; Emotional Instability with 28% ($F=77.14$; $p<.01$, $\eta^2=.27$) , Emotional Regression with11% ($F=25.46$; $p<.01$, $\eta^2=.11$), Social Maladjustment with 28% ($F=77.14$; $p<.01$, $\eta^2=.27$), Personality Disintegration with 14% ($F=40.29$; $p<.01$, $\eta^2=.14$), and Lack of Independence with 18% ($F=44.85$; $p<.01$, $\eta^2=.18$). Here independent effect of Orphanage was also found with the subscales of Anxiety: Physiological Anxiety with 17% ($F=41.95$; $p<.01$, $\eta^2=.17$), Oversensitivity/Worry with 20% (49.48; $p<.01$, $\eta^2=.20$) and Social Concerns/ Concentration with 18%($F=43.21$; $p<.01$,$\eta^2=.18$).

Results also depicted the significant independent effect of Gender on Self-Esteem with 6% effect ($F=13.92$; $p< .01$, $\eta^2=.06$). Significant independent effect of Gender on Depression with 9% ($F=21.76$; $p<.01$, $\eta^2=.09$). Gender also had significant independent effect on subscales of Emotional Maturity viz; Emotional Instability with 8% ($F=18.40$; $p<.01$, $\eta^2=.8$) , Emotional Regression with 4% ($F=8.11$; $p<.01$, $\eta^2=.11$), Social Maladjustment with 8% ($F=18.40$; $p<.01$, $\eta^2=.08$) , Personality Disintegration with 4% ($F=9.09$; $p<.01$, $\eta^2=.04$), Lack of Independence with 5% ($F=10.65$; $p<.01$, $\eta^2=.05$). In support to these findings are few studies done by Kumar and his colleagues (2015), Jan Nuzhat (2013), Aleem and Sheema (2005), and Rajakumar and Soundararajan (2012). But other findings such such as Kaur (2006), Krishna Duhan and his associates (2017) contradicts the current findings, and revealed that there were no significant differences in emotional maturity of adolescents as per their gender.

Here independent effect of gender was also found with the subscales of Anxiety: Physiological Anxiety with 5% ($F=10.65$; $p<.01$, $\eta^2=.5$), Oversensitivity/Worry with 6% ($F=13.20$; $p<.01$, $\eta^2=.06$) and Social Concerns/ Concentration with 7% ($F=15.90$; $p<.01$,

η^2=.7). The significant Interaction effect of 'Orphanage and Gender' was also found on Self-Esteem with 49% (F=65.14; p<.01, η^2=.49), Depression with 37% (F=39.64; p<.01, η^2=.37) and subscales of Emotional Maturity viz; Emotional Instability with 36% (F=37.83; p<.01, η^2=.36) , Emotional Regression with 19% (F=16.02; p<.01, η^2=.19), Social Maladjustment with 36% (F=37.83; p<.01, η^2=.36) , Personality Disintegration with 23% (F=19.13; p<.01, η^2=.23), Lack of Independence with 24% (F=20.28; p<.01, η^2=.24). Here interaction effect of 'Orphanage and Gender' was also found with the subscales of Anxiety: Physiological Anxiety with 22% (F=19.07; p<.01, η^2=.22), Oversensitivity/Worry with 27% (F=24.14; p<.01, η^2=.27) and Social Concerns/ Concentration with 28% (F=25.88; p<.01, η^2=.28).

The ANOVA results in Table-10 highlighted significant independent effect of Orphanage on subscales of Strengths and Difficulties Questionnaire viz; Emotional Problems with 27% (F=73.62; p<.01, η^2=.27) , Conduct Problems with 33% (F=96.15; p<.01, η^2=.33), Hyperactivity with 28% (F=78.11; p<.01, η^2=.28), Peer Problems with 26% (F=71.13; p<.01, η^2=.26),Externalizing with 19% (F=47.58; p<.01, η^2=.19) and Internalizing with 35% (F=106.42; p<.01, η^2=.35). Orphanage did not have any significant effect on prosocial behaviour; the same finding conformed the findings of McGregor (2002), and also Makame and his colleagues (2007) which found similar trend of results in their studies.

Significant independent effect of Gender on subscales of Strengths and Difficulties Questionnaire viz; Emotional Problems with 6% (F=14.52; p<.01, η^2=.6) , Conduct Problems with 4% (F=9.21; p<.01, η^2=.4), Hyperactivity with 7% (F=14.26; p<.01, η^2=.7), Peer Problems with 13% (F=28.66; p<.01, η^2=.13) except for Internalizing behaviours was found in the current study. Past studies by Kaur and colleagues (2018), also by Makame and colleagues (2007) supported the current study findings.

The significant Interaction effect of 'Orphanage and Gender' was also found on subscales of Strengths and Difficulties Questionnaire viz; Emotional Problems with 34% (F=33.91; p<.01, η^2=.34) , Conduct Problems with 37% (F=39.41; p<.01, η^2=.37), Hyperactivity with 36% (F=37.36; p<.01, η^2=.07), Peer Problems with 38% (F=40.04 p<.01, η^2=.38),Prosocial with 19% (F=11.01; p<.01, η^2=.19), Externalizing with 49% (F=63.48; p<.01, η^2=.49) and Internalizing with 36% (F=38.13; p<.01, η^2=.36).

As indicated in Table:11, the post-hoc comparisons showed the significant difference between groups on self-esteem that orphan girls had a significant difference with non-orphan girls(-4.76; p< .01), and non-orphan boys at (-7.26; p< .01) on self-esteem. In the current study

orphan boys had a significant difference with non-orphan girls at (-3.18; p<.01) and non-orphan boys at (-5.60; p<.01) on self-esteem. Similar difference among non-orphans and orphans was revealed in study by Asif (2017). Non-orphan girls group had significant difference with non-orphan boys group at (-2.50; p<.01) on Self Esteem.

Similarly, for Depression significant difference between groups was found wherein orphan girls had a significant difference with orphan boys (2.64; p< .01), non-orphan girls (4.16; p< .01), and non-orphan boys at (6.06; p< .01). Safdar, S (2018) study also showed that there is significant difference in childhood depression among orphan boys and girls. Orphan boys had a significant difference with non-orphan girls at (1.52; p<.01) and non-orphan boys at (3.42; p<.01) on Depression. Non-orphan girls group had significant difference with non-orphan boys group at (1.90; p<.01) on Depression. Contradictory results were seen in study done by Thabet and colleagues (2007) found no significant gender differences on any of the mental health measures like depression, anxiety, PTSD.

From Table -11, on the subscale of Emotional Instability, Orphan girls had a significant difference with orphan boys (2.24; p<.01), non-orphan girls at (4.32; p<.01) and non-orphan boys at (-7.18; p<.01). Orphan boys had a significant difference with non-orphan girls at (2.08; p<.01) and non-orphan boys at (-4.94; p<.01) on Emotional Instability. Non-orphan girls group had significant difference with non-orphan boys' group at (-2.86; p<.01) on Emotional Instability as well. On Emotional Regression, Orphan girls had a significant difference with non-orphan boys at (4.16; p<.01). Orphan boys had a significant difference with non-orphan boys at (4.24; p<.01). Non-orphan girls group also had significant difference with non-orphan boys' group at (-3.16; p<.01). Orphan boys did not have any significant difference from orphan girls and non-orphan girls in emotional regression.

Orphan girls on Social Maladjustment had a significant difference with orphan boys (2.24; p<.01), non-orphan girls at (4.32; p<.01) and non-orphan boys at(7.18; p<.01). Orphan boys had a significant difference with non-orphan girls at (2.08; p<.01) and non-orphan boys at (4.94; p<.01). Non-orphan girls group had significant difference with non-orphan boys' group at (2.86; p<.01) as well. On the subscale Personality Disintegration orphan girls had a significant difference with orphan boys (7.20; p<.01), non-orphan girls at (4.06; p<.01) and non-orphan boys at(5.44; p<.01). Orphan boys had a significant difference with non-orphan boys at (3.12; p<.01). Non-orphan girls didn't have any significant difference with non-orphan boys on Personality Disintegration.

Table-12 highlights the post-hoc comparisons between the four groups. The results showed the significant difference between groups on Physiological Anxiety and in that orphan girls had a significant difference with non-orphan boys at (-1.70; p< .01). No significant difference was found between orphan girls and boys and also between non-orphan girls and boys in the experience of physiological anxiety. But Orphan boys had a significant difference with non-orphan boys at (-1.78; p<.01).

Similarly, on Oversensitivity /worry significant difference between groups was found wherein orphan girls had a significant difference with non-orphan girls (1.98; p< .01), and non-orphan boys at (3.82; p< .01). Orphan boys had a significant difference with non-orphan boys at (2.92; p<.01). Non-orphan girls group had significant difference with non-orphan boys group at (-1.84; p<.01).

On Social concerns/concentration anxiety, significant difference between groups was found wherein orphan girls had a significant difference with non-orphan girls (0.96; p< .01), and non-orphan boys at (2.68; p< .01). Orphan boys had a significant difference with non-orphan boys at (2.30; p<.01). Non-orphan girls group had significant difference with non-orphan boys group at (-1.72; p<.01). Atwine and colleagues (2005) also found similar significant difference among the orphans and the non-orphans on the level of anxiety. Hosseini and Khazali (2013) also found significant difference among the boys and girls on the level of anxiety.

Similarly results from Strengths and Difficulties Questionnaire showed that on Emotional Problems subscale, Orphan girls had a significant difference with orphan boys (-1.48; p<.01), non-orphan girls at (2.72; p<.01) and non-orphan boys at (3.74; p<.01). Orphan boys had a significant difference with non-orphan girls at (1.24; p<.01) and non-orphan boys at (2.26; p<.01). Non-orphan girls group did not have any significant difference with non-orphan boys group. On Conduct problems, Orphan girls had a significant difference with orphan boys(-1.48; p<.01)non-orphan girls at (3.38; p<.01) and non-orphan boys at (4.12; p<.01). Orphan boys had a significant difference with non-orphan girls at (1.90; p<.01) and non-orphan boys at (2.64; p<.01). Non-orphan girls group also had significant difference with non-orphan boys group at (3.16; p<.01). In Conduct problem non-orphan girls group did not have any significant difference with non-orphan boys group.

On Hyperactivity, orphan girls had a significant difference with orphan boys (-1.96; p<.01) non-orphan girls at (3.38; p<.01) and non-orphan boys at (4.12;p<.01) . Orphan boys

had a significant difference with non-orphan girls at (1.42 p<.01) and non-orphan boys at (2.16; p<.01). Likewise, on Peer Problem orphan girls had a significant difference with orphan boys (-2.32; p<.01) non-orphan girls at (3.38; p<.01) and non-orphan boys at (4.20 ;p<.01) . Orphan boys had a significant difference with non-orphan girls at (1.88 p<.01).

Orphan girls had a significant difference with orphan boys (-0.62; p<.01) on Prosocial subscale. Similar difference was observed with non-orphan boys group at non-orphan girls at (0.62; p<.01). Difference was found to be insignificant between other groups.

In Externalizing score which was computed, it was found that, orphan girls had a significant difference with orphan boys (-3.30; p<.01), non-orphan girls at (2.56 p<.01) and non-orphan boys at (7.54; p<.01) . Orphan boys had a significant difference with non-orphan boys at (4.24; p<.01) on the Externalizing behaviours. Significant difference was found between non- orphan girls and non-orphan boys at -4.98; p<.01) on this subscale.

Lastly on the internalizing behaviours, Orphan girls had a significant difference with, non-orphan girls at (4.28; p<.01) and non-orphan boys at (4.84; p<.01). Orphan boys had a significant difference with non-orphan girls at (3.10; p<.01) and non-orphan boys at (3.66; p<.01). Supporting findings were seen in study by Makame and colleagues (2007) wherein orphans had markedly increased internalizing problems compared with non-orphans ($p < 0.01$) and 34% reported they had contemplated suicide in the past year and multiple regression analysis indicated that the independent predictors of internalizing problem scores were sex (females higher than males). Makama and friends (2002) found similar trend of findings.

Based on the objectives of the study, the following hypotheses were set forth for the study. Results of the study confirmed those hypotheses and can be summarized as follow:

Hypothesis -1*: It is expected that the selected Psychological measures would find applicability in the selected population as it is going to be one of the few endeavors in the selected population.*

The psychological test used in the present study were standardized but constructed for other culture. The preliminary analyses of the psychometric properties of the behavioural measures were computed as it was felt necessary that scale constructed and validated for measurement of the theoretical construct in a given population when taken to another cultural milieu may not be treated as reliable and valid unless specific checks are made (Witkin & Berry, 1975). The reliability and predictive validity of the scales and sub-scales were

ascertained to ensure the psychometric adequacy of the scales used for the study. Internal consistency reliability was estimated for each of the scales used in the study using Cronbach's coefficient alpha (Cronbach, 1951). As per the results in Table- 1, it revealed the reliability of Self-Esteem (α=.79), Depression (α=.58) and subscales of Emotional Maturity Scale that Emotional Instability (α=.71); Emotional Regression (α=.65); Social Maladjustment (α= .72); Personality Disintegration (α=.64) and Lack of Independence (α= .78). Similarly, the results in Table- 2 revealed that the reliability of subscales of Revised Children Manifest Anxiety Scale (Physiological Anxiety - α=.51; Oversensitivity/Worry- α=.73; Social Concerns/Concentration - α=.63) and subscales of Strengths and Difficulties Questionnaire (Emotional Problems- α=.74; Conduct Problems-α=.79; Hyperactivity - α= .78; Peer Problem - α=.77, Prosocial - α= .57; Externalizing - α= .78 and Internalizing - α= .67). The total coefficient of correlation of the subjects emerged to be satisfactory over the levels of analysis for the whole sample, which indicating the trustworthiness of the scales such as Self Esteem, Children Depression and emotional Maturity. The Reliability test of Cronbach Alpha shows reliability scores all falling above .50 showing the reliability and the validly proved the trustworthiness of the selected psychological scale for the present population under study. Brown-Forsythe Test of Homogeneity of Variances and Levene's Test were used. From the test it was ascertained that there is homogeneity of the variance within the whole sample. Thus, we accept hypthesis1of the current study.

Hypothesis -2*: It is expected that there will be significant differences between the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems of the selected sample.*

Descriptive statistics post hoc means comparisions were computed to excavate any significant difference present in dependent variables in relation to the groups. Results confirmed the hypothesis-2 by showing the significant mean difference between the groups: orphan girls, orphan boys, non-orphan girls and non-orphan boys in almost on all dependent variables as provided by the mean tables, Tables- 3, 4 & 5 and the post hoc comparision table.

Hypothesis-3: *It is expected there will be significant relationship between the sub-scales/scales of Self-Esteem, Emotional Maturity and Behavioural problems in the selected population.*

The correlation matrix of the psychological variables of Self Esteem, Depression and subscales of Revised Children Manifest Anxiety Scale and Emotional Maturity Scale and the strengths and difficulties questionnaire are presented in Table-6, 7 & 8. The results. Results confirmed the hypothesis-3 by showing the significant correlation between almost all the variables. The results in Table - 6 revealed that Self-esteem had significant negative correlation with Depression. It was also revealed that Self-esteem had significant negative correlation with Emotional Instability, Emotional Regression, and Social Maladjustment. Personality Disintegration, Lack of Independence. Overall it means that Increase in Self Esteem will increase Emotional Maturity among the children. Self Esteem is also found to have significant negative correlation with Anxiety subscales viz; Physiological Anxiety, Oversensitivity/Worry and Social Concerns/ Concentration. Depression was found to have positive correlation with Emotional Maturity subscales. It also had significant correlation with the anxiety factors/subscales. Results in Table -7 indicates the correlation between the measures of Self-Esteem, Depression and subscales of Revised Children Manifest Anxiety and Strengths and Difficulties Questionnaire. And it was revealed that all the variables had significant correlation with each other except for the prosocial subscale with self-esteem and physiological anxiety. Results from Table - 8 depicted significant correlation between almost all the subscales of emotional maturity and the strengths and difficulties questionnaire except for the Prosocial subscale of the strengths and difficulties questionnaire which did not have any significant relationship with any other subscales of Emotional Maturity among orphans and non-orphans.

Hypothesis-4: *It is expected that there will be independent effect of 'gender' and 'orphanage' on the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems among sample.*

The ANOVA results in Table-9 showed significant independent effect of Orphanage on Self-Esteem, Depression, and subscales of Emotional Maturity viz; Emotional Instability, Emotional Regression, Social Maladjustment, Personality Disintegration and Lack of Independence. Independent effect of Orphanage was also found with the subscales of Anxiety: Physiological Anxiety, Oversensitivity/Worry Social Concerns/ Concentration and with the subscales of strengths and difficulties questionnaire: emotional problem, conduct problem, hyperactivity, peer problem, externalizing and internalizing behaviours. Results also depicted the significant independent effect of Gender on Self-Esteem with, Depression, Emotional Maturity and Anxiety and with subscales of strengths and difficulties questionnaire except

internalizing behaviour. Results confirmed the Hypothesis-4 that significant independent effect of Gender and orphanage will be observed on the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems among orphans and non-orphans.

Hypothesis-5: *It is expected that there will be interaction effect of 'gender' and 'orphanage' on the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems among sample.*

The ANOVA results in Table-9 showed significant interaction effect of Orphanage on Self-Esteem, Depression, and subscales of Emotional Maturity viz; Emotional Instability, Emotional Regression, Social Maladjustment, Personality Disintegration and Lack of Independence, with the subscales of Anxiety: Physiological Anxiety, Oversensitivity/Worry Social Concerns/ Concentration and with the subscales of strengths and difficulties questionnaire: emotional problem, conduct problem, hyperactivity, peer problem, externalizing and internalizing behaviours. Thus, the results confirmed the Hypothesis-5 that significant interaction effect of Gender and orphanage will be observed on the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems among orphans and non-orphans.

Limitations of the Study:

The study although has most of the variables that will capture behavioural problems using self-report questionnaires it is not free of limitations. First, the sample size of the study can be increased for better representation. Inclusion of children from orphanages from all the districts of Manipur would have been a better representation.

Another limitation of this study is the lack of sufficient data from the caregivers. It would have been informative if the study had included questionnaires which can be administered to the caregivers so that they can respond about the behaviours about the orphan children based on their observations. The researcher felt that qualitative method such as open interview with the children from orphanages and from the caregivers would strengthen the finding of the results. Because the caregivers would have yielded more information about the children based on their observations.

And all the questionnaire was self -report questionnaire, inclusion of at least a caregiver version of a checklist/questionnaire which can be given to the caregiver so that the responses can be crossed checked, would have improved the findings of the study considerably.

Suggestions:

Based on the limitations of the present study, it was suggested that further studies are needed to have a bigger sample size which will include orphanages from other districts as well which will be better representation of the cultural diversities within the state. Including qualitative method such as open interview with the children from orphanages and from the caregivers would strengthen the finding of the results. Inclusion of at least a caregiver version of a checklist/questionnaire which can be given to the caregiver so that the responses can be crossed checked, would have improved the findings of the study considerably. The data collected from the caregivers and the Orphan children can be corelated and analyzed.

Conducting cross-sectional study and longitudinal study is very much needed for better understanding for the onset and progression of behavioural problems over the years of stay in the orphanage, its consequences and antecedents.

Implications:

From the findings of the study, awareness programs be organized in orphanages for psychoeducation about the behavioural problems which will help the caregivers identifying and consulting mental health professional if needed. And this study recommends employing a mental health professional who can cater to the psychological issues of the children in orphanages on a regular basis. It also suggests importance of routine check up to ensure psychological well-being of the children.

Planning intervention programs in orphanages based on the findings of the study to boost their self-esteem and for overall personality development.

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CHAPTER –I
INTRODUCTION

An Orphanage is often examined through problematic psycho-social functioning of children. There is general agreement among researchers that children placed in orphanage settings at avery young age and for long periods of time are at greatly increased risks for the development ofserious psychopathology later in life.Orphans exist in every age and in all civilizations. According to the joint report of UNICEF, HIV/AIDS and Development (2002), about 1.7 billion children are orphans worldwide. Out of this number, Asia contributes 6.5% orphans and Africa leads with 11.9% orphans. According to another report of the United Nations Children's Fund (UNICEF) and the joint UN program (2005), 7.6% of children of the total population of the world are orphans. 132 million orphan children are live in Africa, Asia and America continent. According to this report, out of 132 million orphan children, there are 13 million children who have no mother and father. On the other hand, "The Report on the Situation of World Children" published by UNICEF in 2014 states the world's orphan population at 150 million.

A new study by an international charity for orphaned and abandoned children called SOS Children's Village India in the year 2011 found that India is home to 20-million orphans, a figure projected to increase by 2021. The study found that 4 % of India's child population of 20 million are orphans. Most of these children have been abandoned by their parents. In fact, the charity estimates that only 0.3 % of these orphans are children whose parents have actually died. The study found that states such as Uttar Pradesh, Bihar and West Bengal had more orphans than Indian's richer states. The state of Madhya Pradesh, Uttar Pradesh and Chhattisgarh are home to 6-million orphaned children under the age of 18. The eastern region, encompassing Bihar, Orissa, Jharkhand and West Bengal, now houses 5.2-million orphans (India's Family Health Survey-3; 2005-2006).

There are different ways of defining an orphan. A child who is below 18 years of age and who have lost one or both parents may be defined as an orphan (George, 2011). Maternal orphan is referred to a child who has lost his/her mother and the paternal orphan is referred to a child who has lost his/her father. 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 Convention of the Rights of the Child (CRC, 1998), Article 1 defines Child as, 'every human being below the age of 18 years unless, under the law applicable to the child, the majority is attained earlier.' The Convention clearly specifies the upper age limit for childhood as 18 years but recognizes that the majority may be obtained at an earlier age under laws applicable to the child.

India is the world's largest democracy with a population of over a billion people, of which 400 million are children. Approximately 18 million of this number of children live or work on the streets of India, and the 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). According to a report by National Institute for Health Care Management (2005), globally one in every five children and adolescent suffer from a mental disorder and two out of five who require mental health services do not receive them. It is expected that by 2020, childhood neuropsychiatric disorder will rise to over 50% and will become one of the five most common reasons for morbidity, mortality and disability among children. Children living in orphanages are one of the most vulnerable groups of children in society; many of themmost c have to live with repeated neglect, abuse or fear. For many of them, a new safe home they can trust alone is not enough to repair the damage imposed by abnormal early stress on the developing nervous system (Hughes, 1999).

Self-esteem

Self-esteem is a sense of self, the value one puts on self and the worth one attaches to self. In fact, self-esteem is a basic belief about self. Self-esteem refers to the extent to which we like, accept or approve of ourselves or how much we value ourselves. Self-esteem always involves a degree of evaluation and we may either have a positive or negative view of ourselves. Thus, it may be argued that, if one has a positive belief system about one's self, one will have positive self-esteem. On the other hand, if one views oneself as worthless, one will have negative self-esteem (Mazhar, 2004).

Self-esteem is a personal judgment of worthiness that's expressed in the attitudes the individual holds towards himself (Cooper Smith, 1967 cited in Asif, 2017). It expresses

an attitude of approval or disapproval and indicates the extent to which the individual believes himself to be capable, significant, successful and worthy.

The most frequently referred definition of self-esteem is that of Morris Rosenberg(1965), where he defines self-esteem in terms of a stable sense of personal worth or worthiness. Rosenberg (1965, as cited in Emler, 2001: 11) offers a definition of self-esteem in which it is understood as an attitude, either positive or negative, a person has about him- or herself. Rosenberg (1979, as cited in Bednar& Peterson, 1996: 40) identified three distinct selves: "the extant self (as one privately views oneself), the desired self (as one would like to be), and the presenting self (the self, one attempt to disclose to others)". Problems in self-esteem arise when there is marked disparity between these selves.

For example, an individual may privately view himself as being inadequate, yet having a desire to be confident, and therefore projecting an impression of confidence to others in an attempt to gain verification for the desired self. However, the disparity between the presenting self and the extant self-results instead in feelings of apprehension and insecurity. Therefore, what influences self-esteem is not just the behaviour, but rather the individual's interpretation of their behaviour? The advantage to this definition of self-esteem is that it is easy to measure an individual's global feeling about him- or herself (Mruk, 2006: 11).

Nathaniel Branden(1969) has also briefly defined Self-esteem as "the experience of being competent to cope with the basic challenges of life and being worthy of happiness". This two-factor approach, as some have also called it, provides a balanced definition that seems to be capable of dealing with limits of defining self-esteem primarily in terms of competence or worth alone. Self-esteem has two interrelated aspects: it entails a sense of personal efficacy and a sense of personal worth. It is the integrated sum of self-confidence and self-respect. It is the conviction that one is competent to live and worthy of living.

From the literature, available Self-Esteem had been discussed as having three meanings: Global Self-Esteem, Self-Evaluations and feelings of Self-worth.

Three Meanings of Self-Esteem

1. *Global Self-Esteem*: Most often, the term "self-esteem" is used to refer to a personality variable that captures the way people generally feel about themselves. Researchers call this form of self-esteem global self-esteem or trait self-esteem, as it is relatively enduring, both across time and situations. Attempts to define self-esteem have ranged from an emphasis on primitive libidinal impulses (Kernberg, 1975), to the perception that one is a valuable member of a meaningful universe (Solomon, Greenberg, &Pyszczynski, 1991). Within normal populations, high self-esteem is characterized by a general fondness or love for oneself; low self-esteem is characterized by mildly positive or ambivalent feelings toward oneself. In extreme cases, low self-esteem people hate themselves, but this kind of self-loathing occurs in clinical populations, not in normal populations (Baumeister, Tice, & Hutton, 1989).

2. *Self-Evaluations*: The term self-esteem is also used to refer to the way people evaluate their various abilities and attributes. For example, a person who doubts his ability in school is sometimes said to have low academic self-esteem, and a person who thinks she is popular and well liked is said to have high social self- esteem. In a similar vein, people speak of having high self-esteem at work or low self-esteem in sports. The terms self-confidence and self-efficacy have also been used to refer to these beliefs, and many people equate self-confidence with self-esteem. Self-esteem and self-evaluations are related—people with high self-esteem think they have many more positive qualities than do people with low self- esteem—but they are not the same thing. A person who lacks confidence in school might still like himself a lot. Conversely, a person who thinks she is attractive and popular might not feel good about herself at all. Unfortunately, psychologists don't always make this distinction, often using the terms self- esteem and self-evaluations interchangeably.

The causal association between self-esteem and self-evaluations is also unclear. Cognitive models of self-esteem assume a bottom-up process (e.g., Harter, 1986; Marsh, 1990; Pelham & Swann, 1989). They assume that positive evaluations of self in particular domains give rise to high self-esteem which is referred to as a bottom-up process because it assumes that global self-esteem is built up from these more specific evaluations. Affective models of self-esteem assume a top-down process (Brown, Dutton, & Cook, 2001). These models assume that the causal arrow goes from global

self-esteem to specific self- evaluations: Liking oneself in a general way leads people to believe they have many positive qualities.

3. *Feelings of Self-Worth:*Finally, the term self-esteem is used to refer to rather momentary emotional states, particularly those that arise from a positive or negative outcome. This is what people mean when they speak of experiences that bolster their self-steem or threaten their self-esteem. For example, a person might say her self-esteem was sky-high after getting a big promotion, or a person might say his self-esteem was really low after a divorce. Following William James (1890), these emotions are referred to as self-feelings or as feelings of self-worth. Feeling proud or pleased with ourselves (on the positive side), or humiliated and ashamed of ourselves (on the negative side) are examples of what we mean by feelings of self-worth. Because they involve feelings toward oneself, some researchers (Butler, Hokanson, & Flynn, 1994; Leary, Tambor, Terdal, & Downs, 1995) use the term state self-esteem to refer to the emotions or feelings of self-worth, and trait self-esteem to refer to the way people generally feel about themselves. These terms connote an equivalency between the two phenomena, implying that the essential difference is simply that global self-esteem is persistent, while feelings of self-worth are temporary.

The trait-state assumption has important consequences. First, it suggests that feeling proud of oneself is akin to having high self-esteem and that feeling ashamed of oneself is akin to having low self-esteem. This, in turn, leads investigators to assume that an analogue of high self-esteem or low self-esteem can be created by temporarily leading people to feel good or bad about themselves (Greenberg et al., 1992; Heatherton &Polivy, 1991; Leary et al., 1995). This is typically accomplished by giving people positive or negative self-relevant feedback (e.g., telling people they are high or low in some ability). Other researchers disagree with this approach, arguing that these manipulations do not provide a suitable analogue of high self-esteem or low self-esteem (Brown & Dutton, 1995b; Wells &Marwell, 1976).

William James is repeatedly referred to as the creator of the self-esteem movement (Kling et al., 1999; Leary et al., 1995; Seligman, 1996) and given his "elementary endowment of human nature," (Leary et al.,1995,) one might hypothesize that it has existed since the birth of mankind. James's (1890 as cited in Seligman, 1996) original formula of self-esteem appears to be well respected**.**

According to the formula, Self-Esteem is defined as equal to success divided by the pretension. Pretension is understood as a feeling good about ourselves and success is defined as how well we actually do. The two elements are inextricably linked; we can feel better about ourselves by succeeding in the world but also by varying the levels of our hopes and expectations.

The definition proposed by psychologist Cohen (1968) is the degree of correspondence between an individual ideal and actual concept of himself. Derlga and Janda (1986) it is how we think of ourselves, whether in a positive or negative fashion. Jacobson in Campall (1984) defined it as an expression of the harmony or discrepancy between the self-representations and the wishful concept of the self.

According to Stanley Coopersmith (1967), a pioneer researcher in this area, self-esteem has at least four dimensions: significance, competence, power, and virtue. Other researchers use similar ideas but employ different words.

Significance: Significance has to do with a feeling of being loved and cared about, the feeling that you matter to someone. You can't instill this feeling in a child. You can try to influence it with words and deeds, with nurturing and protection, with caring, and with meeting needs, but you can't ensure that the messages you send are the ones the child will receive. A feeling of significance, the feeling that you are important because you are cared about, is a choice the individual makes.

It is vital to understand that children are active participants in the development of their sense of self. No matter what hand fate deals, it's not the events themselves that determine self-esteem—it's how the child reacts to those events. Some children are born into more fortunate circumstances than others, yet there are children who have everything going for them who don't feel good about themselves. Other children are just the opposite. They manage to emerge from a series of traumas with self-esteem intact and, indeed, growing. These children seem to be able to use adverse circumstances to their own advantage. They grow and learn from their experiences and come out stronger than ever. They seem to take the negative and twist it around to have a positive effect.

Competence: You can influence competence in a child by helping him become increasingly skilled in a number of areas. But whether the child feels competent

depends on whether he compares himself with someone who is more competent than he is. It's a decision the child makes, not one that you make, though you can influence his decision by making comparisons yourself or demanding perfection. If competence is particularly important to him, he may experience lower self-esteem, even though he is highly competent, simply because he doesn't see himself as competent enough. There's a discrepancy between where he thinks he should be (or wants to be) and where he is. He doesn't meet his own standards (which may or may not have come from his family or his culture).

Power: Feeling that you have some control over being who you are, making things happen in the world, having an effect on the people and events in your life, and living your life satisfactorily give a sense of power. If power is of major importance to you, having a feeling of it can raise your self-esteem. Notice that power is not defined here as having control over other people—it's not a matter of overpowering, but power in the pure sense of the word: personal power, which reflects the root meaning of the word "to be able." Power has to do with effectiveness.

*Virtue:*Virtue is the fourth dimension of self-esteem. Being good is important to some people. Their self-esteem relates to how much of a gap there is between how good they perceive themselves to be and how good they want or need to be. Virtue is not a supreme value to everyone. (Gonzalez-Mena, 2009)

Simon and Schuster (1997) define self-esteem as the disposition to experience oneself as being competent to cope with the basic challenges of life and of being worthy of happiness. It may be argued that self-esteem is in fact confidence in the efficacy of our mind and in our ability to think. Simon and Schuster (1997) further suggested that by extension, it is confidence in our ability to learn, make appropriate choices and decisions, and respond effectively to change. It is also the experience that success, achievement, fulfilment, happiness, are right and natural for us. According to Rogers (1959), high self-esteem refers to a positive view of ourselves which tends to lead to confidence in our own abilities; self-acceptance; optimism and not worrying about what others think. On the other hand, lower self-esteem refers to a negative view of ourselves which tends to lead to lack of confidence; the desire to be or look like someone else; always worrying what others might think about us. Damon (1989) observes that self-esteem is an effective evaluation of one's self in terms of positive or negative traits. As such, self-esteem is widely recognized as a control aspect of psychological functioning

and well-being. It has been shown to be related to many psychological as well as behavioural variables.

Another definition of self-esteem was given by Friedman (1995) who defines self-esteem as a psychological construct which refers to how the self (body and mind) is viewed and valued, that is basically how one feels about himself, how he judges himself in terms of skills, talents, abilities and attributes and how much he values and respects himself. In addition, Krider (2002) contends that self-esteem steps beyond the initial descriptive phase of self-concept and becomes a feeling of internal worth that is after evaluating themselves based on the personal values and ideals they have developed.

According to Gecas (1982) and Cast and Burke (2002), self-esteem can be conceptualized as consisting of two dimensions. The first is competence. *Competence* refers to how someone perceives his or her overall capability and effectiveness. This is sometimes referred to as efficacy-based self-esteem. The second dimension is *worth-based self-esteem*. Worth is defined as the degree to which a person believes that they are an individual of value. When viewed together, self-efficacy and worth combine to shape a person's self-evaluation.

The theories on the function of self-esteem converge on the theme that self-esteem is not pursued its own sake but instead serves a more significant function.

Self-Determination Theory*:*

Self-Determination Theory (SDT) states that man is born with an intrinsic motivation to explore, absorb and master his surroundings and that true high self-esteem (Deci& Ryan, 1995 as cited in Ryan &Deci, 2004) is reported when the basic psychological nutrients, or needs, of life (relatedness, competency and autonomy) are in balance (Ryan &Deci, 2004; Reis, Sheldon, Gable, Roscoe, & Ryan, 2000 as cited in Ryan &Deci, 2004).

When social conditions provide support and opportunity to fulfil these basic needs, personal growth, vitality and well-being are enhanced (Chirkou, Ryan, Kim, & Kaplan, 2003; La Guardia, Ryan, Couchman, &Deci, 2000 as cited in Ryan &Deci, 2004). Relatedness was an addition to the original theory to account for people's inherent ability to make meaning and connect with others through the internalization of cultural practices and values (Ryan &Deci, 2004).

Terror Management Theory(TMT; Pyszczynski et al., 2004; Solomon, Greenberg, &Pyszczynski, 2004):

One of the most well-known and inspiring theories of the origins of self-esteem, predicts that self-esteem protects an individual against death anxiety. Self-esteem reflects the degree to which one meets culturally accepted standards, which in turn provides the person with a feeling of immortality. Cultural standards may describe not only personal achievements but also moral principles, basic to order and harmony within the in-group. An individual achieves high self-esteem and a feeling of immortality when he or she fulfill cultural demands. This, in turn, creates the feeling ofbelonging to something greater than oneself. Two possible aspects of self-image that influence self-esteem are implied by this theory. Cultural standards may require achievements as well as morality – hence, knowledge about one's agency and morality should influence self-esteem.

Theories referring to interpersonal sources of self-esteem suggest the significance of beliefs about one's own social functioning. In classic theories by Cooley (1902) and Mead (1934), social functioning and self-concept are directly connected. Interactions between individuals and the environment, and with significant others, in particular, constitute a source of self-concept and self-esteem. Thus, an individual's self-concept and self-esteem reflect how they are perceived and evaluated by others. The key role played by other people in self-esteem has been further supported by Mark Leary's studies (Leary, et al., 1995; cf. Leary, 2005), although the focus here is less on the important others and more on the role of group belonging which is being discussed in their Sociometer Theory.

Sociometer Theory*:*

According to the Sociometer Theory, proposed by Leary and his colleagues, self-esteem reflects the degree of acceptance by a group. When the individual regularly experiences inclusion in a group, this leads to high self-esteem, whereas regular experiences of rejection lead to low self-esteem. Although Leary does not refer to self-concept, it can be assumed that the most important thing for self-esteem would be knowledge of how much one is accepted as a member of various groups.

Tests of self-esteem have generally conceptualized the construct as being (a) an outcome of behavioural processes, (b) a buffer that provides protection from harmful behaviour, or (c) a self-motive in directing current and future behaviour. According to

Cast and Burke (2002) however, “little has been done to synthesize the three research streams into an overall integrated model”. In an attempt to unify these three areas of research, Cast and Burke developed a formal theory of self-esteem (TSE) that integrates the motivational, buffering, and protection aspects of self-esteem. Their theory was established with the framework of Stryker’s (1980) identity theory.

According to Stryker (1980), the self is a multidimensional conglomeration of many identities. Each identity reflects how a person fits into the larger society. In the broadest of terms, this framework of the self is captured in identity theory. A key element of identity theory is that individuals seek out self-verifications of their identity. This self-verification process both produces and reproduces social meanings for individuals and society. Cast and Burke (2002) formulated TSE upon the concept of self-verification. They noted that “verification of identity produces feelings of competency and worth, increasing self-esteem”. As such, self-verification can be either positive or negative. Self-verification plays an important role in shaping the three ways that self-esteem has been conceptualized in the literature (i.e., an outcome of behavioural processes, a buffer that provides protection from harmfulbehaviour, and a self-motive in directing current and future behaviour).

Self-Esteem as a Worth-Based Outcome*:* In some respects, self-esteem as an outcome is the easiest of the three concepts to conceptualize. First, individuals will tend to seek out situations that enhance positive self-verification. In these situations, self-esteem ought to increase. For example, people often make social comparisons and appraise situations as being either positive or negative based on their perception of the value others place in behaviour or action. Sometimes the comparison is to a personal reference point. Consider the role education plays in shaping self-esteem. Education, in the United States, provides a mechanism to increase social status. Education is considered valuable by society. Individuals who seek out opportunities to increase their level of formal education may do so, in part, as a way to self-verify their worth. Within the framework of TSE, self-esteem, as an outcome of this self-verification process, can be enhanced.

Self-Esteem as an Efficacy-Based Outcome:Pursuing additional education throughout the lifespan (as self-verification leading to a self-esteem outcome) can best be seen as a factor affiliated with self-worth, one of two dimensions of self-esteem. Efficacy based

self-esteem, the second dimension of self-esteem, is "more likely to result from self-attributions" (Cast & Burke, 2002). Bandura (1977), Gecas and Schwalbe (1983), and others have noted that when people assess their behaviour as successful, they tend to conclude that they have played an important role in shaping personal outcomes. That is, successful behaviour leads to positive self-verification and the maintenance or enhancement of self-esteem.

Self-Esteem as Identity Verification:Role identity also shapes self-esteem. Cast and Burke (2002) pointed out that identity is relevant to the roles people play in their everyday life. Self-verification is not only a function of personal activity but also an outcome associated with the behaviour of others. The behaviour or actions of others in the household (and broader environment) can affect perceptions and self-evaluations. Consider interactions within a family. At any given time, some individuals are facing challenges and opportunities associated with changes in the make-up of a household. Some families are growing. Others are shrinking. Some individuals are moving into marriage, while others are divorcing. An important assumption with TSE is that "when disturbances occur in the identity-verification process (that is when identities are not verified), distress results in the form of negative emotional responses" (Cast & Burke, 2002).

Self-Esteem as a Buffer*:* Another important element in TSE is the concept that self-esteem acts as a reservoir of energy. This definitional framework fits well with the thoughts of those who view self-esteem as a buffer between behaviour and distress that might occur when self-verification processes fail. As a key proposition of TSE, self-esteem can be seen as a flexible personal resource. Each person's "reservoir" can increase when self-verification is successful, but it can also decrease (i.e., be used up) when self-esteem is used as a buffer. Cast and Burke (2002) noted that negative emotional consequences can occur whenever there is a disruption in the self-verification process. Depression, anxiety, and stress can result especially when disturbances in self-verification are persistent. As a fixture of TSE, self-esteem appears to act as a buffer that reduces the likelihood of distress. When viewed this way, self-esteem can be seen as a mediator between behaviour in one period and subsequent behaviour in another time period. As someone exhibits behaviour that is self-assessed as successful, the reservoir of self-esteem is increased. This should, theoretically, improve the chances of

engaging in other successful behaviour in the future. Continuing the analogy of debt management, as a consumer behaviour issue, imagine that someone has managed their debt level well and that they have few negative financial behaviours. In other words, they deem their debt management behaviour as successful. According to TSE, this series of actions should lead to the maintenance and possible increase in self-esteem. That is, the person's reservoir of self-esteem should remain stable or increase.

***Self-Esteem as Self-Motive**:* The third element of TSE is the role self-esteem plays as a self-motive. Swann (1983) argued that people seek out opportunities for self-verification. This means that people tend to engage in behaviours, either individually or jointly, that confirm their identitie while shunning situations that might limit self-verification. By seeking out self-verification opportunities individuals tend to maintain or increase their reservoir of self-esteem. According to Cast & Burke (2002), "In this way self-esteem can be viewed as a self-motive, organizing and providing direction for behaviour".

Self-esteem can be examined from either a unidimensional or multidimensional theoretical perspective. The unidimensional perspective of self-esteem conceptualizes this concept in a singular, globalterm, whereas the multidimensional perspective puts forward that self-esteem is both hierarchical and based on multiple, distinct qualities. Self-esteem can be examined from either a unidimensional or multidimensional theoretical perspective (Marsh, Craven & Martin, 2006).

The multidimensional perspective of self-esteem has received increasing recognition as to its value, in that it remains with the idea that there are different types of self-esteem within each person (Marsh et al,2006). Self-esteem has received contributions from almost every leading theoretical perspective. The psychodynamic approach constructed self-esteem as being a developmental process; the social psychologists concentrate on the formation of attitudes. The cognitive-behavioural perspective conceptualized self-esteem in terms of coping strategies and problem-solving skills, while the humanistic approach highlights the experimental elements of self-esteem (Mruk,1999)

Personality correlates of Self-esteem:

Self-esteem researchers have conducted thousands of studies examining the correlates, causes, and consequences of high and low self-esteem (Baumeister, 1993; Harter, 1998). Surprisingly, these two important lines of individual-difference research have rarely been connected. We know little about the personality characteristics that distinguish high versus low self-esteem individuals. Understanding the relation between self-esteem and personality is important for several reasons. First, embedding self-esteem within the Big Five framework will link it to all other psychological constructs and outcomes that have been linked to the Big Five.

The Big Five dimensions of Extraversion, Agreeableness, Conscientiousness, Emotional Stability (vs. Neuroticism), and Openness to Experience (hereafter Openness) account for the interrelations among most trait terms (Goldberg, 1993b), and they are conceptualized at the broadest level that retains descriptive utility (John, Hampson, & Goldberg, 1991). Possibly because of this breadth, the Big Five are relatively consistent over the life course (Roberts &DelVecchio, 2000), generalize across many different cultures (McCrae & Costa, 1997), and predict a wide range of outcomes including job performance (Barrick& Mount, 1991), academic achievement (Robins, John, &Caspi, 1998), delinquency (John, Caspi, Robins, Moffitt, &Stouthamer-Loeber, 1994), personality disorders (Widiger&Costa, 1994), adjustment (Graziano& Ward, 1992), and divorce (Cramer, 1993). The Big Five include the factors of openness, extraversion, agreeableness, conscientiousness, and emotional stability (neuroticism reversed). Neuroticism (N) refers to the degree to which a person responds to stress; Extraversion (E) refers to the degree to which a person can tolerate sensory stimulation from people and situations; Openness (O) refers to the degree to which we are open to new experiences; Agreeableness (A) refers to the degree which we relate to others with tolerance and acceptance; and finally, Conscientiousness (C) refers to the degree to which one works towards goals in an industrious, disciplined, and dependable fashion.

Connecting self-esteem to the Big Five will provide a basis for making predictions about how self-esteem might relate to the same set of outcomes and perhaps even offer clues to the mechanisms linking the Big Five to these outcomes. Second, self-esteem and personality are likely to share common developmental roots, and examining the personality correlates of self-esteem across the life span might provide

insights into the nature of self-esteem and its development. Like personality, self-esteem is moderately heritable, with about 30% of the variance due to genetic differences (Kendler, Gardner, & Prescott, 1998).

Basic temperamental characteristics, rooted largely in genetic differences, influence people's behavioural tendencies as well as their effective feelings about what kind of persons they are. For example, individuals with a temperamentally low threshold for the experience of negative affect tend to feel negative about themselves (Watson & Clark, 1984). Similarly, positive emotionality might lie at the core of both Extraversion and self-esteem (DeNeve& Cooper, 1998). It seems likely, then, that self-esteem will be most strongly related to the two Big Five traits that have a clear effective component, namely Extraversion (positive affect) and Neuroticism (negative effect). Third, in addition to sharing a common underlying aetiology, self-esteem and personality may directly influence each other. For example, people's consistent patterns of behaviour (i.e., personality) influence how they perceive and evaluate themselves.

Conversely, self-esteem may play a critical role in shaping personality processes. Individuals' beliefs about themselves influence how they act in particular situations, the goals they pursue in life, how they feel about life events and relationship partners, and the ways in which they cope with and adapt to new environments. For example, a low self-esteem individual might lack the self-confidence to engage in a wide range of social behaviours and, consequently, become more introverted. Many prominent areas of personality research assume a central role for self-esteem and self-evaluations, including research on self-conscious emotions such as shame and embarrassment (Tangney& Fischer, 1995), narcissism (Robins & John, 1997), attachment (Shaver, Collins, & Clark, 1996), goals and motivation (Carver &Scheier, 1998), and depression (Seligman, Abramson, Semmel, & Von Baeyer, 1979) (as cited in. Potter & Gosling,2001).

The other researches have convincingly demonstrated that self-esteem is strongly rooted in basic dimensions of personality, such as the ‘‘Big Five" (Watson, Suls, & Haig, 2002; Erdle, Gosling, and Potter, 2009). Self-esteem has been found to be positively correlated with each of the Big Five factors (Robins et al., 2001). Empirical associations between neuroticism, extraversion and explicit self-esteem are quite robust: self-esteem correlates negatively with neuroticism and positively with extraversion, agreeableness, conscientiousness, and openness (Watson et al., 2002).

A recent study by Swickert et al. (2004) reported a significant indirect effect of extraversion on self-esteem via positive effect. Thus, extraversion' influence on self-esteem was found to be significantly mediated by positive effect. A number of studies have investigated the individual personality and affective factors associated with self-esteem (e.g., Francis, 1996; Swickert, Hittner, Kitos, & Cox-Fuenzalida, 2004). Global self-esteem has also positively correlated with extraversion and negatively with neuroticism (Watson et al., 2002). Accordingly, personality variables are strongly related to self-esteem.

Gender Differences:

Research similarly reveals a trajectory of self-esteem for both females and males, with some divergence occurring during adolescence, where males attain slightly higher levels of self-esteem which persists until old age, where the gap narrows (Robins &Trzesniewski, 2005: 160). Some explanations for these differences are offered by Demo (2001: 148) which states that, in childhood, girls evaluate their athletic abilities as being inferior to that of boys. In adolescence, girls have a poorer appraisal of their body image and general appearance and n adolescence, girls view themselves as being academically superior, more responsible and being stronger in personal character than boys. These explanations provide some insight into the gender differences in self-esteem, however, there is a lack of empirical evidence and theoretical models explaining this process.

***Development and maintenance of Self-esteem in children and adolescents**:*

According to Harter, two factors play an important role in the development and maintenance of self-esteem in children and adolescents: (1) perceived competence in areas of importance, and (2) the experience of social support (Harter 1999). Domains of perceived competence not only have a direct impact on self-esteem but also influence the approval and support of parents and peers. That is, good academic competence and behavioural conduct elicit approval and support of parents, whereas good physical appearance, relationships to peers and athletic competence result in approval and support of peers (Harter 1999).

Many children and adolescents maintain a positive view of themselves by achieving success in domains of perceived competence (Crocker and Park 2002). For example, boys who are relatively good in football may play football more frequently

and may invest more time in training. As a consequence, their football skills increase even further and their self-esteem remains high. However, youths are not always capable of achieving success, which makes them engage in strategies to protect, maintain or enhance their self-esteem levels. In the face of failure children and adolescents may use strategies such as downward social comparison, external attributions (attributing failure to external causes), or reduce the importance of the domain on which they fail to achieve success (Crocker and Park 2002).

Self-esteem creates self-image (Judy &Arin,2004). People with high self-esteem take risks more easily than those with low self-esteem. Low self-esteem has many different manifestations; withdrawal, depression and lack of self-confidence are all symptoms of low self-esteem. Many adolescents' express anger and frustration because they do not complete certain tasks easily or efficiently. When these feelings are turned inward, they reinforce a feeling of low self-esteem (Richard,2005). Studies which have investigated the relationship between statements made by significant others and self-perceptions, Blake and Slate (1993) have found that positive interactions and statements made by significant others were related to high self-esteem and that negative interactions were associated with low self-esteem. According to Rosenberg and Owens(2006), low self-esteem people tend to be more sensitive to criticism and tend to interpret these events as signs of inadequacy and rejection. These researchers also found that when faced with life stressors, they tend to negative coping strategies. Large disparities between people with low self-esteem and high self-esteem in terms of self-confidence and self-actualization were also observed.

Factors Influencing The Development of Self-Esteem In Childhood And Adolescence

Self-esteem appears to be a universally experienced human phenomenon, some cultural differences may exist, but most people are influenced by how others evaluate them, have their feelings about themselves altered by their own actions, and would choose rather have good than bad feelings about themselves (Leary,2003). Some of the factors influencing the development of self-esteem:

Family Relations and Self-esteem: Parents, or the primary significant other, are considered to be the centre players in the development of a child's self-esteem. Most children and adolescents hold their parents in high regard and with great affection, and

as such the child's perception of the parent's evaluation of them, greatly impacts on the formation of their self-esteem (Demo, 2001)

According to Coopersmith (as cited in Bednar& Peterson, 1996), there are three main characteristics of parents of high self-esteem children. Firstly, the ability of the parents to communicate their acceptance of their child, giving the child a sense of belonging and value. Secondly, parents who create an environment which encourages a healthy balance between demands and limits communication to the child that they are confident in their abilities to meet the expected behaviour. Thirdly, parental respect nurtures individuality and uniqueness within healthy boundaries. According to Coopersmith, these qualities encourage the child to be self-motivated and confident in their own judgments of themselves, and thereby not relying on the reinforcement from others (Bednar& Peterson, 1996)

Peer Relations, School and Self-esteem:As children mature, the structure and size of their social networks change and develop. Also, the nature of friendships evolves from playmates in childhood to more intimate friendships in adolescence. As previously established, children and adolescents rely strongly on the appraisals of others for self-evaluation. In adolescence the importance of peer support and evaluation comes to the foreground as those of their parents begins to wane (Robins &Trzesniewski, 2005). A study by Harter, Stocker and Robinson, 1996 (as cited in Demo, 2001) examined the relationship between peer approval and self-worth in adolescents. These researchers were able to identify three ways in which adolescents categorized this relationship. The first group reportedly based their evaluations of their own sense of worth on the appraisals of their peers. The second group considered self-worth as preceding approval from peers; an individual with a positive sense of self-worth would receive a positive appraisal from their peers. The third group did not identify a connection between self-worth and peer approval and saw these constructs as being independent of each other. (Demo, 2001)

Social Inequality and Self-esteem: In western, democratic societies, the issue relating to the relationship between social inequality and self-esteem is one of great concern (Wells, 2001). Democratic societies advocate for the right of all to happiness and personal well-being. If social inequality, such as that experienced by ethnic minorities, women and those of lower social status, significantly influence the development of self-

esteem, particularly if this is in a derogatory way, then the values upheld by democracy become void.

Katz et al. (2002) identify three ways in which membership to a devalued social group may impact the development of personal identity and emotional adjustment. Firstly, membership to a devalued social group (such as those infected and affected by HIV/AIDS, or an orphan) may result in negative self-appraisal, as the person begins to internalize the negative introjections associated with membership to that group. Secondly, being devalued simply on the basis of membership to a group, despite personal qualities, may influence emotional well-being. Thirdly, members of a devalued group may become socialized to view themselves in a negative light, which may impact their behaviour and motivation.

Self Esteem &Behavioural Problems*:*Children who grow up in a society where they do not 'fit'; constantly strive for a sense of belonging, so as to avoid rejection. However, constant attempts to 'fit in', which are met with continued rejection, resulting in the onset of protective behaviour, so as to minimize the pain of rejection. The child abandons previous attempts to confirm, and motivation shifts from conforming to deviating.

There is a large body of empirical support for the position that low self-esteem is a strong predictor of later deviant behaviour (Kaplan, 2001), however, studies illustrate that in terms of aggression and hostility, it is not low self-esteem, but rather high, unstable self-esteem that is related to this negative, deviant behaviour. Narcissists, people with a high sense of self-worth and a low level of competence, are viewed as having unstable self-esteem. When their self-esteem is threatened, they typically act out with hostility (Kaplan, 2001).

Fennel (1999) identifies self-esteem as having an impact on our day-to-day functioning. This researcher makes note of how low self-esteem is negatively reflected in the thoughts we have and statements we make about ourselves, our behavioural responses, emotions and body states, as well as in our school and work achievements, relationships and self-care. According to this researcher, low self-esteem can either be a consequence of or a vulnerability factor for a number of negative outcomes. Low self-

esteem can, for example, be the result of a depressed mood, or may have been a vulnerability factor for the onset of depression (Rosenberg & Owens, 2001).
Low self-esteem has also been associated with a number of other psychopathologies including mood disorders, personality disorders, anxiety disorders, schizophrenia, eating disorders, learning disorders, substance abuse and conduct disorders (O'Brien, Bartoletti&Leitzel, 2006).

Emotional Maturity:

The word "Emotion" comes from the Latin word "Emovere", which means the move. Emotions are basic primaeval for as of agent power and influence designed by nature to enable the organism to cope with circumstances which demand the utmost effort for survival or success or add colour and spice to our living. Emotion is the inclusive term, which covers the concept of rightly stirred up the condition of the organism. It has, however, been subdivided by writers into various emotions (fear, love, anger, jealousy etc.) as cited by Kaurand Singh (2016).

Emotions can be defined as a feeling that occurs when a person is in a state or on interaction that is important to the individual, especially to his or her wellbeing. (Compos, Frankel &Camras, 2004).Emotions are a state of being stirred or aroused in some way. In adolescence, the behaviour gets influenced by their emotions. Studies on adolescents point out that the earlier notion of ―storm and stress is actually the natural outcome of youth learning to cope with new and unfamiliar situations. (Larson & Ham, 1993).Some of the theories of Emotion which need a mention areJames-Lange Theory, Cannon-Bard Theoryand Schachter-Singer theory.

William James (1884) and Carl Lange (1887) originated the theory of emotions with the same idea and around the same time, popularly known as the James-Lange theory. According to their theory, an event leads to a bodily response initiated by the emotion and not by the perception of an event. This means that, when a bodily response (e.g., increased breathing, increased heartbeat, sweaty hands) occurs, it is the response of an emotion. For example, my heart beat increases looking at a ferocious dog barking at me and perceiving my increased heart rate, my brain figures out that I am experiencing fear.

Another theory is that of Cannon-Bard Theory which began with the work of Walter Cannon with contemplation that the James-Lange theory was flawed for a number of reasons (Cannon, 1927). He observed through his experiments in certain animals like cats that even after the brain was cut off from the information about bodily responses, the emotions still occurred. Moreover, as per his observations, many different emotions were resultant of the same bodily responses. For example, when one is angry, the heartbeat increases, however, it may also signify that one is excited in a positive way. This means that our brain cannot just rely on our bodily responses to know which emotion we are experiencing (i.e., there must be something else that tells us whether we are angry or excited). Philip Bard in consensus with Cannon continued examining the emotions in the brain. Through their research, Cannon and Bard concluded that experience of an emotion independent of input from the body and the way it responds. Both the bodily response as well as experience of the emotion occurs at the same time independently of each other.The Schachter-Singer theory concluded that experiencing an emotion requires considering the particular situation the person is in at the moment along with the bodily response and an interpretation of the bodily response (Schachter& Singer, 1962).

The expression, "maturity," refers to a significant phase in the growth of a living organism. Maturity is achieved when individual growth is completed and the organism is ripe for propagation. The concept of maturity is used also in psychology and psychiatry. In this field, it designates that phase of personality development which corresponds to biological and psychological maturation. We call a person psychologically mature after he has reached a certain level of intelligence and emotional outlook. Hence the development of a person is undisturbed, biological and psychological maturation progress more or less parallel with each other. Usually, however, biological maturation proceeds ahead of emotional maturation.

Many criteria have been suggested to evaluate the concept of maturity. According to Bernard (1964) criteria for the mature behaviour are the following:Inhibition of direct expression of negative emotion, cultivation of positive emotions,development of higher tolerances for disagreeing circumstances, increasing satisfaction from socially approved responses,increasing dependence of actions, ability to make a choice and not brood about other choices, freedom from unreasonable fear, understanding and acting in accordance with limitations, awareness of the ability and

achievement of others, ability to err without disgraced, ability to carry victory and prestige with grace, ability to bounce from disappointing experiences,ability to delay gratification of impulses and the enjoyment of daily living

Emotional maturity can be understood in terms of the ability of self-control which in turn is aresult of thinking and learning. According to Chamberlain (1960), an emotionally matured person is one whose emotional life is well under control.Emotional Maturity is an effective determinant to shaping the personality, attitudes and behaviour of the adolescents into accepting responsibility, making a decision, teaming with groups, developing a healthy relationship and enhancing self-worth. Emotional maturity is defined as how well you are able to respond to situations, control your emotions and behave in an adult manner when dealing with others (Sinha, 2014).

The most outstanding mark of emotional maturity according to Coleman (1944) is the ability to bear the tension. According to Allport (1961), emotional maturity is the ability to integrate multiple emotional perspectives to form flexible and differentiated representations of oneself, others and situations. According to Skinner (1962), emotional maturity indicates that condition when a man experiences his feelings for his wellbeing and develops the ability to get pleasure out of the materials. According to Singh and Bharagava (1990) emotionally mature is not one who necessarily have resolved all conditions that aroused anxiety and hostile. But it is continually involved in a struggle to gain healthy integration of feeling, thinking and action. Jasbir (2000) studied emotional maturity in relation to environmental factors found a significant relationship between emotional maturity and school, home and psychological. Chaudhary and Bajaj (1993) in their study emotional maturity as a correlate of the Mental Health of adolescents compared the emotional maturity of adolescents staying at home and orphanage. Adolescents staying at home have a higher level of emotional maturity as compared to their counterparts staying at the orphanage. Mental health, along with Emotional maturity is also affected by the parent-child relationship. Aspiration and attitude of parents, overprotective environment, discrimination between siblings, rejection, acceptance, submissive, autocratic behaviour of parents, the relationship between parents, dominance etc. affects the mental health. It matters so much because of the many different relationships we form over the course of the lifespan, the relationship between parent and child is the most important.

According to Singh and Bhargava (1984), there are five board factors for emotional maturity:

Emotional Instability: This is a broad factor representing syndrome of lack of capacity to dispose of problems, irritability, needs, and constant help for one's day to day work, vulnerability, stubbornness and temper tantrums.

***Emotional regression*:** Broad group of factors representing such symptoms as a feeling of inferiority, restlessness, hostility, aggressiveness, and self-centeredness.

Social maladjustment: Such a person shows a lack of adaptability, exclusive but boasting, liar and shirker.

Personality Disintegration: those symptoms which represent the disintegration of personality, like reaction, phobias formation, rationalization, pessimism, immorality etc. Such a person suffers from inferiorities and hence reacts to the environment through aggressiveness, destruction and has a distorted sense of reality.

Lack of Independence*:* Such a person shows parasitic dependence on others, is egoistic and lacks objective interest. People think of him as an unreliable person.

Crow & Crow (1962), has also revealed "that emotionally mature or stable individual, regardless of his age, is the one who has the ability to overcome tension to disregard certain emotion stimulators that affect the young and view himself objectively, as he evaluates his assets and liabilities and strive towards an improved integration of his thought, his emotional attitude and his overt behaviour". Dosanjh (1956) says, 'Emotional maturity means a balanced personality. It means the ability to govern disturbing emotions, show steadiness and endurance under pressure and to be tolerant and free from neurotic tendencies.' Good (1973) has stated that emotional maturity refers to emotional patterns of an adult who has progressed through the inferior emotional stages characteristic of infancy, childhood and adolescence and is not fit to deal successfully with reality and in adult love relationship without under emotional strain.

Jersild (1963) says, 'Emotional maturity means the degree to which person has realized his potential for richness of living and has developed his capacity to enjoy things, to relate himself to others, to love and to laugh; his capacity for wholehearted sorrow, when an occasion arises and his capacity to show fear when there is occasion to be frightened, without feeling a need to use a false mask of courage, such as must be

assumed by persons afraid to admit that they are afraid'. Geoghagen et.al. (1963) says that a person is considered emotionally mature when his responses to a situation are- (a) Appropriate to his degree of development and (b) Proportionate to the demands of the situation. Smitson (1974) says, 'Emotional maturity is a process in which the personality is continually striving for a greater sense of emotional health, both intra-psychically and intrapersonal'. Singh (1990) says, 'Emotional maturity is not only the effect determinant of personality patterns but it also helps to control the growth of an adolescent's development. A person who is able to keep his emotions under control, which is able to rock delay and to suffer without self-pity, might still be emotionally stunted and childish'.

In the view of Murray (2003), there is no correlation between chronological age, intellectual age, social age or emotional age. Just because someone is 'grown-up' by chronological age does not mean they are 'grown-up' emotionally. Chronological maturity and intellectual maturity combined with emotional immaturity is not common and is potentially dangerous. A person whose body and mind is adult, but whose emotional development is that of a child can wreak havoc in the life of himself and of others. Our relationships are dependent upon one total emotional development. The best way to understand our relationships is to understand our self. The single most important task for any person wishing to improve his relationships is to increase his self-esteem and emotional maturity. One who opines to determine the level of one's emotional maturity, compare one's behaviour to the symptoms of emotional immaturity and the characteristics of emotional maturity. So, emotional maturity implies proper emotional control, which means neither repression nor violet expression. An emotionally mature person has in his possession almost all types of emotionally positive or negative and is able to express them at an appropriate time inappropriate degree.

Jerome Murray has given the following characteristics of emotionally mature people.

1) ***Easy Flow of Love &Affection****:*Emotionally mature people are open to love and affection. They have the ability to trust people and trust themselves for the receiving and giving of love. They do not have obstructions in their personalities, hampering their ability to believe in goodness of life. A mature person can show his vulnerability by expressing love and accepting expressions of love from those who love him.

2*)* ***Face To Face With Reality****: Emotionally* mature people do not waste their time and resources in living in denial like emotionally immature people. They see the situations in life for what they are and not manufacture their own truth and parallel reality. Emotionally mature people always eagerly face the truth of life and are not scared to deal with difficult situations. They do not have shells like emotionally immature people to hide into, while othersaround them clear up their mess. The immature avoid facing reality. Overdue bills, interpersonal problems, indeed any difficulties which demand character and integrity are avoided and even denied by the immature.

3***) Hands on Experience of Life****: Emotionally* mature people find it easy to learn from their life experiences. This comes from their ability to see everything in a positive light and accepting the reality of life. Whereas an emotionally immature person learns nothing from life; he always conceives the life situations in distortion and never in actuality.

4) ***Taking Criticism Positively****:*A mature person views life experiences as positive and he enjoys and revels in life. When they are negative, he accepts personal responsibility and is confident he can learn from them to improve his life. The immature person curses the rain while a mature person sells umbrellas. Being emotionally mature means that one knows his/her flaws and strengths.

5) ***Hopefulness****:* Emotionally mature people are hopeful in life, always hoping for the best. They see goodness in everything and never resort to pessimistic tendencies. This makes them confident individuals, always ready to face life with confidence and self-assurance.

6) ***Interested in Giving as in Receiving****:* He is a good loser. He can endure defeat and disappointment without whining or complaining. A mature person's sense of personal security permits him to consider the needs of others and give from his personal resources, whether money, time, or effort, to enhance the quality of life of those he loves. They are also able to allow others to give to them. Balance and maturity go hand in hand.

7) Ability to Learn from Experience*:* The ability to face reality and to relate positively to life experiences derive from the ability to learn from experience. He is honestly glad when others enjoy success or good fortune.

8) The Ability to Handle Hostility Constructively:When frustrated, the immature person looks for someone to blame. The mature person looks for a solution. Immature people attack people; mature people attack problems. The mature person uses his anger as an energy source and, when frustrated, redoubles his efforts to find solutions to his problems.

9) Open-Minded:He does not worry about things he cannot help. He is open-minded enough to listen thoughtfully to the opinions of others. He plans things in advance rather than trusting to the inspiration of the moment. He is not a chronic "fault-finder."

Kaplan and Baron (1986) elaborated the characteristics of an emotionally mature person say that he has the capacity to withstand delayin satisfaction of needs, He has belief in long term planningandis capable of delaying or revising his expectations in terms of demands of the situation. An emotionally mature child has the capacity to make an effective adjustment with himself, members of his family, and his peers in the school, society and culture. But maturity means notmerely the capacity for such attitude and functioning but also the ability to enjoy them fully. Therefore, the emotionally mature child is not one who necessarilyhave resolved all conditions that aroused anxiety and hostility but it is continuously in process of seeing himself in clearer perspective, continual involved in a struggle to gain healthy integration of feeling, thinking and action. So, emotional maturity can be called as the process of impulse control through the agency of self or ego.

Emotional Maturity is a personality trait, the result of emotional development and the display of emotion appropriate to one's chronological age. It usually reflects increased emotion adjustment and emotional stability and the attainment of emotional self-regulation. According to Menninger (1999), emotional maturity includes the ability to deal constructively with reality. Emotional maturity can be understood in terms of the ability of self-control which in turn is a result of thinking and learning. Emotional maturity is a rather a learning process thattakes place in a person while he is under parents' supervision, from infant state of helpless but total egocentricity to ideal adult state of sensible conformity coupled with emotional creativity. Thus, Emotional Maturity is a measure of one's capacity to create a positive mental attitude. It is a process of impulse control through the agency of self (Chuang, 2009). Learning to manage emotions requires that teens learn to distinguish how and when emotions are

functional from ways in which they can turn your world upside down, mislead and have dysfunctional consequences (Larson, Clore& Wood, 1999).

Kevin Fitz Maurice (1989, 1990) is one of the pioneers who went ahead and described 6 levels of emotional maturity.The first level is the *level of Basic Emotional Responsibility*: At this level, a person realizes that he/she can no longer view their emotional states as the responsibility of external forces such as people, place, things, forces and fate. The second level is the *level of Emotional Honesty*. This is the stage at which a person is willing to know his/her own feelings. This is a necessary step to understand the self. It is related solely to the person's conscious and unconscious fears of dealing directly with the critical voices he hears inside. The person in honest with oneself about how he really feels. The people learn to locate others with whom they can safely share their real feelings and their real selves. Level three is the *level of Emotional openers*. At this level, a person is willing to share their feelings in an appropriate manner and at an appropriate time. Persons at this level experience and learn the value of ventilating feelings and also the dangers invoked in hiding feelings from self and others. Level four is *Emotional Assertiveness*. The person at this level enters a new era of positive self-expression. The primary goal here is to be able to ask for and to receive the nurturing that one needs and wants first from self and then from others. As a secondary goal, persons should learn how to express any feeling appropriately in any situation, without aggressive overtones. Level five is the *level of emotional understanding*. Persons on this level understand the actual cause and effect process of emotional responsibility and irresponsibility. They realize that it is not possible to have so-called good self-concept without a complimentary bad self-concept. Knowing that though we may hide one half in unconsciousness it is still active in us; they begin to regularly leap beyond the pitfalls of self-concepts, self-images and self-constructs. This knowledge of the unity of opposites is applied to new situations daily. Self-knowledge is used to free the self from self-concepts on this level rather than to form them and imprison the self in them. The main work here is a total shift from identifying with any self-concepts to identifying only with the true self. Level six is the *level of Emotional Detachment*. At this level, the person lives without the burden and share of self-concepts, self-images, self-constructs and all group-concepts and thing concepts. True detachment from all self-concepts has occurred. This person remains unaffected for the Blame Game and even experiences unconditional love for their enemies. Emotions play

an important role in every person live, especially for adolescents. Adolescence is a period which is most demanding, where an adolescent has to deal with various anxieties, conflicts, confusions stress and so on. To deal with all this emotional maturity is the requirement. Emotional maturity is also important for maintaining positive mental attitudes, better adjustment and social relationships. Emotional maturity also shapes personality, attitudes, behaviour of adolescents into accepting responsibilities, decision making, teamwork, developing healthy relationships and enhancing self-worth.

George Bielay (2011) pointed out that an emotionally mature person is able to give and receive love and affection is able to deal with reality. Emotionally mature individuals learn from experience and deal with frustration, accepts constructive criticism, is optimistic and self-confident.

For Goleman, emotional maturity is related to emotional intelligence. The term intelligence comes from the Latin intelligence, which is to relate, organize or from the term interfere, which involves establishing relationships between people. Even the terminology suggests that intelligence overcomes thought which is limited to relations between the objectives and the essential characteristics of phenomena and not relations between people. How complex is this aspect of personality emerges in how it was approached in the history of philosophy and psychology. Views to intelligence ranged from acceptance and highlighting its role in knowledge, to diminish its significance or even to eliminate it from human existence. For Western thought, intelligence appears to be the essential attribute, fundamental for human beings, which makes man what he is, for Eastern thought intelligence was reduced to a minimum. This can be seen in individuals in the areas of their social life, their way of relating and responding to various difficulties of life. They are aware and better control their emotions, have more numerous values and know to recognize them to their own and the others.

This emotional intelligence makes people react well in practical life situations faced and act wisely in dealing with others. Emotional intelligence capacity can be extended to five main areas:

Knowledge of personal emotions – to recognize the feeling when it appears, is the cornerstone of emotional intelligence. People who recognize their own feelings have felt more secure in making personnel decisions in any field;

Managing emotions - is about mastering emotions so as to be the appropriate capacity to soothe, to get rid of depression, anxiety, irritability. Those who fail to master are constantly confronted with disappointment while emotionally mature individuals can quickly rebalance from obstacles;

Self-motivation - concern the emotions serving a purpose to rule and creativity. Emotional self-postpone rewards and achievements underlying pulse suppression increased efficiency and productivity;

Recognizing emotions in others - is done with empathy, the capacity to understand the other, they are mindful of the needs of others;

Handling relations – establishing relations means the ability to manage emotions of others. These capabilities lead to great popularity, to spiritual leadership, effectiveness in interpersonal relationships. (Goleman, 2001).

The major task of the adolescent is to establish a clear sense of identity. Intellectual skills that they acquired during this period enable them to reflect, to think about who they are and what defines them as a unique person, different from others. The sense of identity is built around two major areas (APA, 2002):_

Self-image*:*a set of beliefs about themselves, including roles, goals, interests, values, religious or political beliefs.

Self-esteem*:* what the person thinks and feels about his own image. In adolescence is nuanced the emotional life and emotions become more balanced than in puberty.

According to Murray (1997) symptoms of Emotional Immaturity involves volatile emotions such as explosive behaviour, temper tantrum, oversensitivity and fluctuation of moods. Another symptom of emotional Immaturity is over dependency Egocentricity and stimulation Hunger. Such people have superficial values and their loyalty to relationship is only as long as it is useful. They are self-centered. They have no regard for others and only slight regard for themselves. They demand constant attention, make unreasonable demands and do not take responsibility for his own mistakes.

Immaturity is "a term usually used to describe the affectivity of a child, teenager or adult, marked by lack of autonomy, need of protection and an exaggerated fixation on the parental image. Overriding interest of the child focuses on his own person in the

work field and its benefits. This particularly selfishness manifests itself by susceptible, vanity and stubbornness. Life relationship is also narrow: the development and structuring of personality are limited by the inability to find conflict resolution other than through economic solutions: downloading brutal emotional tension, the manifestation of these tensions in prestige, inhibition or opposition attitudes, defiance or of disinterest, making mental construction thought or active, less organized (mendacity, theft, delinquency)"as mentioned by Parot Doron (1999).

Behavioural problems

Behavioural problems can occur in children with all ages and very often they start in early life. Many risk factors have been proposed for the occurrence of mental disorders, among which social factors are clearly implicated in the genesis and maintenance of these and their extension into adulthood. Internalizing behaviour comes with anxiety, depression, and withdrawal from others. Developmental research proposes children with internalizing symptoms may, in certain cases, perform externalizing behaviour (Perle et al., 2013). Internalizing behaviour in children can result in mild to severe consequences. Since internalizing is drawn inward towards oneself it can affect the psychological and emotional state. Harmful as it sounds this behaviour can lead to a negative impact on the environment. Depression can be developed as young as three years old and mean age of 14 to 15 years old. Depression is feeling of sadness, loss of interest by not wanting to do much, and lonesomeness where you want to stay clear from the world (Perle et al., 2013).It is believed that life events play the primary role in depression. The most compelling ata indicate that the life event most often associated with the onset of an episode of depression is losing a parent before age 11. (Sadock& Sadock,2007).

The earliest age of a child having anxiety is 7.5 years old (Perle et al., 2013). There are five main anxiety disorders that occur in internalizing behaviour: separation, social, general, posttraumatic stress and obsessive-compulsive disorders (Chen et al., 2011). Anxiety is a response to a threat that is unknown, internal, vague and conflictual. The experience of anxiety has two components: the awareness of the physiological sensations (e.g., palpitations and sweating) and the awareness of being nervous or frightened. In addition to it, anxiety affects thinking, perception and learning. (Sadock&Sadock,2007)

Externalizing behaviour consists of a child acting out with aggression, violence, harassment, disruptiveness, and defiance. The construct of externalizing behaviour problems is grouping behaviour problems that are manifests in children's outward behaviour and reflect the child negatively acting on the external environment (Jianghong Liu, 2005).Childhood aggression can also be described as conduct problems and is more than likely the leading cause of adult crime and violence.

A significant amount of research has explored the relationship between externalizing and internalizing behaviour symptomatology and various types of risky behaviour. Extensive work by Achenbach and colleagues has led to the widely accepted distinction between internalizing and externalizing expressions of adolescent dysfunction (e.g., Achenbach, 1990). These terms were first introduced in 1966 to describe factor-analytically derived groupings of problems found for clinically referred children (Achenbach, 1966; Rescorla, Achenbach, Ivanova, Turner, Althoff et al, 2016). Currently, it is one of the most widely agreed upon classification systems of behaviour disorders in psychopathology research (Cicchetti&Natsuaki, 2014).

Externalizing behaviour problems*:*

Externalizing behaviour problems are considered under controlled behaviours and manifest in children's outward actions toward the external environment (Achenbach &McConaughy, 1997). Examples include aggression, opposition/defiance, disruptive behaviour, hyperactivity-impulsivity, and conduct problems.

These types of behaviours are characteristic of disorders such as Oppositional Defiant Disorder(ODD), Conduct Disorder (CD), and Attention-deficit/Hyperactivity Disorder (ADHD;American Psychological Association, 2013). Externalizing behaviours are often stable over time (Dowdy et al., 2016; Losel &Stemmler, 2012) and are predictive of violence, delinquency, substance use, and other negative outcomes during later adolescence and adulthood (Capaldi, Stoolmiller, Clark, & Owen, 2002; Copeland, Miller-Johnson, Keeler, Angold, & Costello, 2007; Fergusson, Horwood, &Ridder, 2007).

Attention-Deficit/Hyperactivity Disorder *(ADHD)* is characterized by a pattern of diminished sustained attention and higher levels of impulsivity in a child or adolescent than expected for someone of that age and developmental level. It is more prevalent in

boys than in girls with the ratio ranging from 2 to 1 to as much as 9 to 1. Children in institutions are frequently overactive and have poor attention spans. These signs result from prolonged emotional deprivation, and they disappear when derivational factors are removed such as through adoption or placement in a foster home. (Sadock&Sadock,2007). Attention deficit hyperactivity disorder (ADHD) is one of the most important psychiatric disorders of children. In terms of prevalence, 3 to 7% of school-age children and 2 to 4% of the adult population have this disorder (Hooman&Ganji, 2012). Boys are affected 2 to 9 times more than girls. (Ganji et.al,2012).

Conduct disorder is an enduring set of behaviours that evolves over time, usually characterized by aggression and violation of the rights of others. Children with conduct disorder are likely to demonstrate behaviours in the following four categories: physical aggression or threats of harm to people, destruction of their own property or that of others, thefts or acts of deceit, the frequent violation of age-appropriate rules. Parental psychopathology, child abuse and negligence often contribute to conduct disorder (Sadock&Sadock,2007).

Oppositional defiant disorder is characterized by enduring patterns of negativistic, disobedient, and hostile behaviour toward authority figures, as well as inability to take responsibility for mistakes, leading to placing blame on others. Children with oppositional defiant disorder frequently argue with adults and become easily annoyed by others, leading to a state of anger and resentment(Sadock&Sadock,2007).

Internalizing behaviour problems*:*

In contrast to externalizing behaviours, internalizing problems tend to be covert and represent an inner-directed pattern of behaviour (Achenbach &McConaughy, 1997), occurring when individuals try to control internal emotions or cognitions to an excessive and maladaptive extent (Merrell &Gueldner, 2010). Examples of internalizing behaviours include anxiety, depression, social withdrawal, somatic complaints, and negative self-thoughts. Internalizing problems are associated with impairment in academic performance and social and family functioning (Liu, Chen, & Lewis, 2011; Rapport, Denney, Chung, &Hustace, 2010). In fact, individuals with internalizing

problems often have impaired problem-solving abilities, pessimistic cognitive styles, distorted perceptions, low self-efficacy, and poor coping skills (Greenberg, Domitrovich, &Bumbarger, 2001). Further, significant internalizing problems, similar to externalizing problems, may result in negative effects on adult relationships, employment, and physical health (Perle et al., 2013; Woodward & Fergusson, 2001).

Mood and anxiety disorders are some of the most prevalent mental health issues in adults and the research has shown an increase in these disorders in children (Kessler et al., 2001; Merikangus et al., 2010). Mood and anxiety disorders have been identified in children and adolescents from eight to 15 years of age and are experienced more frequently by females, while males are more likely to exhibit externalizing disorders (Costello et al., 1996; Rescorla et al., 2007). A prevalence study conducted by Merikangus et al., (2010) on the topic of mental health disorders in children andadolescents found anxiety disorders are the most common at 31. 9 per cent, behaviour disorders occur in 19.1 per cent and mood and substance abuse disorders occur in 14.3 and 11.4 per cent respectively. In addition, the median age of onset for anxiety is six years old, age of onset for behaviour is at 11 years old and the median age for mood disorder onset is 13 (Merikangus et al., 2010).

Anxiety is a state of excessive worry and may include restlessness, irritability, difficulty concentrating, fatigue, muscle tension and sleep disturbances (AmericanPsychiatric Association, 2000) and occurs when an individual perceives a high level of threat (Derakshan&Eysenck, 2009). Anxiety disorders common among children include: separation anxiety, selective mutism, reactive attachment disorder and generalized anxiety (American Psychiatric Association, 2000); however, for this study, symptoms of anxiety will be incorporated under the general category of anxiety. Symptoms of anxiety can vary depending on the type of disorder; however, the National Institute of Mental Health (NIMH) identified “excessive, irrational fear or dread” as the common factor.

Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration. Moreover, depression often comes with symptoms of anxiety. These problems can become chronic or recurrent and lead to substantial impairments in an individual’s ability to take care of his or her everyday

responsibilities. At its worst, depression can lead to suicide. Almost 1 million lives are lost yearly due to suicide, which translates to 3000 suicide deaths every day. For every person who completes a suicide, 20 or more may attempt to end his or her life (WHO, 2012).

While depression is the leading cause of disability for both males and females, the burden of depression is 50% higher for females than males (WHO, 2008). In fact, depression is the leading cause of disease burden for women in both high-income and low- and middle-income countries (WHO, 2008). Research in developing countries suggests that maternal depression may be a risk factor for poor growth in young children (Rahman et al, 2008). This risk factor could mean that maternal mental health in low-income countries may have a substantial influence on growth during childhood, with the effects of depression affecting not only this generation but also the next.

Achenbach used an empirical approach to derive two broad dimensions (internalizing and externalizing) of child and adolescent problem behaviours. The syndromes of the internalizing dimension (depression, anxiety, somatic complaints) are characterized by inner distress and those of externalizing dimension (e.g., aggression, delinquent behaviours) are characterized by conflicts with others and society (Achenbach and McConaughy 1997).Factor analytic studies of psychiatric disorders have found support for two factors, internalizing and externalizing, underlying common psychopathology in adults (Krueger, Caspi, Moffitt, & Silva, 1998, Krueger, 1999; Krueger, McGue, &Iacono, 2001). Support for an internalizing-externalizing model for psychopathology has also been observed in adolescent samples. Hewitt et al. (1997) conducted factor analyses on major depressive disorder (MDD), separation anxiety disorder (SAD), overanxious disorder (OAD), oppositional defiant disorder (ODD), conduct disorder (CD), and attention-deficit/hyperactivity disorder (ADHD) in a sample of 8- to 16-year-olds and found evidence supporting the distinction between internalizing and externalizing disorders. Although ADHD symptoms were relatively independent of other domains, there were moderate to high correlations among separation anxiety disorder, overanxious disorder, and major depressive disorder as well as a high correlation between oppositional defiant disorder and conduct disorder.

Two broadband dimensions of behaviour which have been revealed from factor and cluster analysis are the dimensions of internalizing behaviours and externalizing

behaviours (Wilmshurst, 2005) which is one of the most classification used clinically and in research to identify problem behaviours in children and youth; These two fundamental dimensions of child psychopathology map well onto the adult psychopathology and fundamental personality temperaments (John, Robins, &Pervin, 2008) which acknowledge the significance of internalizing and externalizing problems in psychopathology of children, adolescents and adults. A general definition for internalizing disorder is "Mental disorders with primary symptoms that involve inner emotions as opposed to outward behaviour" (Thackery& Harris, 2003). Internalizing problems represent the continuum of over controlled responses indicating "problems within the self, such as anxiety, depression, somatic complaints without known medical basis, and social withdrawal from contact (Achenbach &Rescorla, 2001). In other words, Internalizing problems results from behaviours that are over controlled, compared to externalizing or under controlledbehaviours (Cicchetti&Toth, 1991). Internalizing spectrum behaviour includes social withdrawal, inhibition, shyness, anxiety, and depression and are more covert in their nature and therefore often more difficult to detect and assess (Wilmshurst, 2005). Externalizing behaviours refers to problems characterized by acting out, including aggressive and destructive behaviours.

Externalizing symptoms, include impulsivity, oppositional behaviours, attention difficulties, hyperactivity, and temper tantrums, while internalizing disorders are often difficult to diagnose and assess due to their covert and internal nature, externalizing problems are often intrusive, disruptive, and frequently involve aggressive responses that can be physically and verbally intimidating (Wilmshurst, 2005).Although younger boys and girls have similar prevalence rates for internalizing disorders (7–9%), in adolescent populations, females are approximately four times more likely to have internalizing disorders (15.7%) than males (3.9%) (Offord, Boyle, &Szatmari, 1987).They also noted in their research that parents are more likely to identify more troublesome or external behaviours than less observable internalizing disorders, and that parent and child agreements are better for observable behaviours and for older (rather than younger) children. Recent studies emphasize association of environmental factors like Contextual stress (Copeland-Linder, Lambert, Chen, &Ialongo, 2010), perceived social support (Martinez, Aricak, Graves, &Nellis, 2010) peer status (Modin, Östberg, &Almquist, 2010) victimization (Fredstrom, Adams, & Gilman, 2010) and emotional

dysregulation (Adrian, Zeman, Erdley, & Lisa, 2010) with internalizing and externalizing problems.

Relationship between internalizing and externalizing problems

In early childhood, internalizing and externalizing problems are the most reliably diagnosed types of psychopathology. Data suggest that these problems are closely related and are likely to co-occur not only in childhood but also in adolescence(Achenbach,1991). Internalizing symptoms are directed to oneself and thus may be more difficult to identify (Forns, Abad &Kirchner,2011). The internalizing symptomatology includes depression, anxiety and withdrawal. On the other hand, externalizing behaviours are outer-directed (Forns, Abad&Kirchner,2011), and they comprise behaviours like rule-breaking, aggression, impulsivity, and defiance. Furthermore, children with internalizing problems are more likely to experience sadness, low impulsivity(Eisenberg et.al,2001), and exhibit less social contact(Laukkanen,2002).

In contrast to children with internalizing problems, children with externalizing problems tend to experience anger and be impulsive, and they are also inclined to show health-compromising behaviours such as smoking (Laukkanen,2002).Moreover, these sets of problems are associated with differing psychopathologies; e.g., conduct disorders seem to be solely associated with externalizing problems, anxiety disorders with internalizing symptoms and dysthymia with both (Gould, Bird & Jaramillo, 1993). Gender is a variable that has been associated with either internalizing or externalizing problems. Apparently, in childhood and adolescence, males tend to exhibit externalizing behaviours whereas females are more likely to have internalizing problems (Achenbach,1991;Walden,1994).More specifically, girls tend to show more somatic complaints and symptoms of anxiety and depression, are less rule breaking and show less attention problems than males (Parco,2015). Another study by Lee and Bukowski(2012) showed that boys and girls in early adolescence have dissimilar increase patterns of elevation in externalizing and internalizing problems. Hence, males present a bidirectional progression of each set of problems to the other, whereas girls seem to have a unidirectional progression from externalizing to internalizing problems.

Link between Self-esteem &Behaviour Problems

The link between global self-esteem and aggression is currently being debated by researchers (Baumeister, Campbell, Krueger, &Vohs, 2003; DuBois&Tevendale, 1999) and in the popular media (Slater, 2002). Researchers on one side of the debate have argued that individuals with low self-esteem are prone to real-world externalizing problems such as delinquency and antisocial behaviour (Fergusson &Horwood, 2002;Rosenberg, Schooler, &Schoenbach, 1989; Sprott&Doob, 2000). However, others have questioned this claim, noting that several studies have failed to find a relation between low self-esteem and externalizing problems (Bynner, O'Malley, & Bachman, 1981; Jang & Thornberry, 1998; McCarthy &Hoge, 1984) or between low global self-esteem and laboratory measures of aggression (Bushman & Baumeister, 1998; Kirkpatrick, Waugh, Valencia& Webster, 2002; Twenge&Campbell, 2003). At least three distinct traditions in the social sciences posit a link between low self-esteem and externalizing problems.

Rosenberg (1965) suggested that low self-esteem weakens ties to society; according to social-bonding theory, weaker ties to society decrease conformity to social norms and increase delinquency (Hirschi, 1969). Humanistic psychologists such as Rogers (1961) have argued that a lack of unconditional positive self-regard is linked to psychological problems, including aggression. Finally, neo-Freudians also posit that low self-regard motivates aggression. For example, Horney (1950) and Adler (1956) theorized that aggression and antisocial behaviour are motivated by feelings of inferiority rooted in early childhood experiences of rejection and humiliation. More specifically, Tracy and Robins (2003) suggested that individuals protect themselves against feelings of inferiority and shame by externalizing blame for their failures, which leads to feelings of hostility and anger toward other people. Thus, three separate theoretical perspectives posit that externalizing behaviours are motivated, in part, by low self-esteem.

Baumeister and colleagues (1996) suggested that inflated high self-esteem (as captured by measures of narcissism) is a better predictor of aggression than low self-esteem. This suggestion seems to be based on the assumption that low self-esteem and narcissism are opposite ends of the same continuum (self-hate vs. self-love). For example, Baumeister et al. noted that ''an effective and valid self-esteem scale would identify the arrogant, conceited narcissist just as well as the person who holds an unbiased appreciation of his or her own well-recognized good qualities''

Findings suggest that self-esteem in children with ADHD may vary with the subtype of ADHD. The inattentive type showed more internalizing behaviour and lower self-esteem, whereas the hyperactive type showed more externalizing behaviour and higher self-esteem. However, the combined type (inattentive as well as hyperactive) also engaged more in externalizing behaviour, but, as opposed to the hyperactive type, their self-esteem was lower. They also appeared to have the most emotional and behavioural problems (Graetz et al., 2001). Possible explanations for the exaggerated self-esteem seen in the hyperactive type may be that it serves as a self-protective function which makes the children able to cope with their frequent failure. However, it could also be a result of diminished self-awareness due to impairment in their executive functioning (Mash & Wolfe, 2010).

Furthermore, low self-esteem appears to have predictive value for personality disorders and anxiety (Watson, 1998) and it plays a role in depression, along with unstable self-esteem and self-concept (Alfeld&Sigelman, 1998; Mash & Wolfe, 2010; Whitley & Gridley, 2003). Hymel, Bowker& Woody (1993) showed that withdrawn unpopular children express a more accurate self-concept, but also a more negative one. Again, this supports the general idea that internalizing behaviour has a negative effect on self-concept or self-esteem.

Link between Emotional Maturity&Behaviour Problems:

Although not much of review is available on this but in some of the studies done a relationship between emotional maturity and the behavioural problems have been observed. Moldovan (2017)in his study supposed relationships between emotional maturity and anxiety as trait and optimism, and also between the latter two and found that emotional maturity correlates positively with optimism and negatively with anxiety and the optimism correlates negative with anxiety.

Though a number of investigators made the efforts to study the emotional maturity and anxiety among students separately but there is dearth of studies which try to study the relationship of emotional maturity and anxiety among college students. Anxiety also called angst or worry is a psychological and physiological state characterized by somatic, emotional, cognitive, and behavioural components. Anxiety is considered to be a normal reaction to a stressor. It may help an individual to deal with a demanding situation by prompting them to cope with it. However, when anxiety

becomes overwhelming, it may fall under the classification of anxiety disorder, (National Institute of Mental Health, 2008).Due to high anxiety; child develops certain personality traits which inhibit his proper physical, emotional and social development. All these factors add to emotional tensions of the child and make him an unbalanced personality. The findings of study suggest that there exists significant difference in emotional maturity and anxiety among college students on the basis of gender and there exists a high correlation between emotional maturity and anxiety of college students. (Jitendra& Mona,2015)

Cramer (1998, 2002, 2009) indicated that use of immature defenses seen in internalizing and externalizing disorders, associated with behavioural and psychological immaturity while the use of more mature defense seen in normal adolescents is associated with the manifestations of psychological maturity. According to Ali and friends (2011),the use of mature defenses is more common in internalizing disorder while compare to externalizing and the use of immature defenses is more common in externalizing disorder while compared to internalizing disorder. Kwon and Lemon (2000) investigated defense mechanisms and attributional styles in depression considering that one of the major types of internalizing disorders are mood disorders (Stricker&Widiger, 2003). They showed that defense style maturity, if assessed more reliably, would be an even strong predictor of depressive symptomatology although immature defense also are associated with depressive symptoms.

Institutionalization and Behaviour Problems:

Among the behaviour problems associated with early institutional privation o staying in orphanage in this study, are inattention and hyperactivity, externalizing and internalizing problems, social and peer difficulties, and autistic-like features. Post Institutionalized children are at higher risk for these problems than parent-reared children, children adopted in their first few months, and non-institutionalized adopted children (Gunnar, 2001; MacLean, 2003).

Orphanages vary in their quality of care and degree of deprivation. Some of the most comprehensively studied Post Institutionalized children were adopted from Romanian orphanages in the early 1990s, which have been described as “globally depriving” environments (Rutter et al., 1998).These orphanages lacked adequate nutrition, medical care, sensory and motor stimulation, social-emotional interactions,

and opportunities to build relationships with caregivers. There is a high rate of behaviour problems among children adopted from these severely depriving environments. Other orphanages are characterized by deficiencies limited primarily to the social-emotional domain. These "relationship" or "socially-emotionally" depriving orphanage environments have also been associated with later behaviour problems (Gunnar, 2001).

Children adopted from these socially-emotionally depriving environments were described by their teachers as having more behaviour problems than their working-class, parent-reared classmates at both 8 (Tizard, 1977; Tizard& Hodges, 1978) and 16 years of age (Hodges &Tizard, 1989). Thus, even though their early deprivation was limited to the social-emotional domain, these children demonstrated vulnerability to behaviour problems many years later.

There is considerable heterogeneity of outcome among children adopted from orphanages. Factors such as time in an orphanage (age at adoption), time in an adoptive home, and age at assessment may contribute to whether or not children demonstrate problems.

Time in an orphanage (age at adoption) :

The older age at the time at adoption has often been associated with an increased risk of behaviour problems probably due to increased pre-adoption exposure to adverse circumstances. Across many other studies, it has been consistently found that the more time children spent in an orphanage the higher their rates of externalizing, internalizing, attention, social, and thought problems (Ames et al 1997; Fisher et al., 1997; Groza& Ryan, 2002; Gunnar et al., 2007; Hoksbergen et al., 2004; Kreppner et al., 2001; Marcovitch et al., 1997).

Various cutoffs, usually dichotomous, have been examined, including 6, 12, and 24 months. Some results suggest that children adopted from orphanages before 6-12 months may not be at increased risk of later behaviour problems (Fisher et al., 1997; MacLean, 2003; Rutter et al., 2001). Children adopted at various ages beyond 6-12 months may be at higher but *equal* risk for behaviour problems (Kreppner et al., 2007).

Time in an adoptive home*:*

There is some evidence that behavioural functioning, like physical growth and cognitive development (Johnson et al., 1992, 2001; Rutter& the ERA Study Team, 1998), improves with time in an adoptive home (Hoksbergen et al., 2004; Juffer& van IJzendoorn, 2005).Once adopted, children begin to experience more consistent parental care and a stable, advantaged environment relative to the orphanage.

Age at assessment:

In general, behaviour problems tend to be more common in older children. Although some studies of preschool-age Post Institutionalized children have indicated higher rates of behaviour problems (Fisher et al., 1997; Marcovitch et al., 1997), there is also some evidence that preschool-age Post Institutionalized children may not be at increased risk of behaviour problems (Rutter et al., 2007) and may have lower mean levels of behaviour problems than school-age Post Institutionalized.(Merz E.C.,2008).

The review of literature of the researches done on the children has highlighted important leads for the current study. Siyad and Muneer(2016) conducted a study to compare the self-esteem of orphan children with parental care children. The subjects for the study were 200 orphan children and 200 parental care children. The test item selected for this was "Rosenberg's self-esteem scale" by Rosenberg. The orphan children reported lower self-esteem than the children living with their parents. T test showed that there exista significant mean difference in self-esteem ('t'=14.43, $p<0.01$).

Tesla(2017) adopted a descriptive research design to study Self Esteem of the children staying in orphanages at Coimbatore District. In Coimbatore district, the researcher has collected 100 samples from the various orphanages by using purposive sampling method. Among the total respondents, nearly half of the respondents have a moderate level of self- esteem.

Mashkoor and Ganesan(2017) investigated on self - esteem and academic performance of family reared and institutionalized orphan children. The sample of the study was composed of 160 children (80 children from orphan institutions and 80 children living with their both parents in their homes (father and mother). In the present study non - probability purposive sampling method was used. Children of family reared i.e. living with their both parents (father and mother) were drawn from different private schools of Anantnag district of Jammu and Kashmir and orphan children were drawn from orphanages of the same area. Jonathan Berent's Self- esteem Scale (1994) was separately managed to all the research respondents. The children in orphanages account the inferior degree of self - esteem than children living their both parents. Further, the findings suggested no significant gender difference in self - esteem of the orphans and the children living with their parents**.**

Zhonghu He, Chengye Ji (2007) found that Depression, low self-esteem and lower quality of life were more frequent in orphans. These differences mainly existed in boys' groups. No significant differences were found between paternal, maternal and double orphans or orphans in orphanages or extended families. Regression analysis revealed that orphan hood leads to low self-esteem and more depression which contributes to lower quality of life and mediates the association between orphan hood and quality of life.

Jain&Prapsi(2018) studied the level of self-esteem and self-efficacy among orphan adolescents and adolescents living with their parents. All the participants were administered Rosenberg self-esteem scale (1965) to assess the level of self-esteem and self-efficacy scale developed by Jerusalem&Schwarzer(1992) to assess the level of self-efficacy. Independent Sample‘t’ test and Pearson’s Product Moment Coefficient of Correlation were employed for data analysis. The findings of the study indicate that there is a significant difference in the level of self-esteem and self-efficacy among orphan adolescents and adolescents living with their parents. A positive high correlation between self-esteem and self-efficacy among adolescents was observed.

An epidemiologic survey was conducted by Kannan (2016) and colleagues among 11-15 years old orphanage children and obtained data were compared with other school going children in Kanchipuram district of Tamil Naduon 221 orphanage children and 221 school going children. A cluster random sampling methodology was used for the selection of orphanage children. Stratified random sampling methodology was used to select schoolchildren according to the age and sex to match the orphanage children. Data were collected using the self-esteem questionnaire developed by Rosenberg in 1965. Statistical analysis was done using the Pearson Chi-square test and Student’s t-test. High level of self-esteem was seen more among school going children compared to orphanage children and it was statistically significant. The results of this study indicated that orphanage children had low self-esteem score and a high level of self-esteem score was more in school going, children.

Wanjiru andGathogo(2014)assessed therelationship between the gender of orphans and self-esteem among secondary school students in Kirinyaga and Nyeri Counties, Kenya, as a build-up to the above hypothesis. In this research, the total number of students was 58,492. Out of this 426 were sampled. The major finding in their study was that Self-esteem was found to be influenced bythe gender of orphans and the self-esteem, in turn, influenced the aspiration of education level as well as jobs. Their study recommended that the socialization by society should not be gender discriminative that is all children should be treated the same way.

Farooqi and Inteza(2009) investigated differences in the self-esteem of orphan children and children living with both parents in their homes. The sample was composed of 150 children (75 children from orphanages of Lahore city of Pakistan and 75 living with both parents in their homes which was drawn from different private schools).The children in orphanages reported a lower degree of self-esteem than children living with their parents and no significant gender difference in self-esteem of the orphan children and the children living with both parents.

Asif(2017) examined the level of depression and self-esteem among the orphan and non-orphan children.Participants of this study were 50 orphan children and 50 non-orphan children selected randomly. Totally, 100 orphan and non-orphan children participated in the study. Data about participants were collected through a questionnaire. The results revealed that there is a positive relationship (r = 0.69, $P<0.01$) between depression and self-esteem between orphan and non-orphan children. A t-test revealed significant depression (t = 3.78, p<0.001), between orphan and non-orphan children. Orphan children obtained a higher score on a depression scale than non- orphan children. On the other hand, non-orphan children obtained a high score on self-esteem (t = 4.85, p<0.001), than their counterparts of orphan children.

Amongin and friends (2012) conducteda **cr**oss-sectional study to examine the relationship between self-esteem and attitudes to education among orphaned and non-orphaned adolescent secondary school girls in Kampala, Uganda.Questionnaire including the socio-economic indicators, Rosenberg General Self-Esteem Scale and the Attitude Scale were administered to 225 students who were selected by simple random sampling in six secondary schools in Kampala, Uganda. And the results indicated that, orphaned girls had lower self-esteem and most had a negative attitude to education compared to non-orphans. However, girls orphaned to HIV/AIDS had a higher self-esteem compared to those orphaned by other causes and there was a positive correlations between self-esteem and attitude towards education among orphaned adolescent girls in Kampala,Uganda.

Gitumu and colleagues (2010) carried out survey research to find out the relationship between the self-esteem of orphaned secondary students and their socio-economic status in Kirinyaga, Nyeri North and South Nyeri districts of Kenya. 426

students constituted the sample of the study. The major finding of the study was that the socio-economic status of orphans influences the development of self-esteem. The results indicated that students' feelings of worth may be influenced by the environment which includes what the parent/guardian has at home as in the society. The orphans find themselves in an environment of suspicion and more so, probably affect their self-esteem.

Chaudhary and Bajaj (1993) in their study emotional maturity as a correlate of the Mental Health of adolescents compared the emotional maturity of adolescents staying at home and orphanage. Adolescents staying at home have a higher level of emotional maturity as compared to their counterparts staying at the orphanage.

Kumar and his colleagues (2015)tried to study Psychosocial Adjustment among Orphan children living with HIV/AIDS. They used a sample of 400 orphans and non-orphans with HIV/AIDS. Results indicated that orphans had a low level of adjustment than the non-orphans. On Social Adjustment subscale orphan children were lower than the non-orphans. The gender difference was also observed wherein orphan girls were significantly lower than the orphan boys on social adjustment.

Singh and Dawar(2013) conducted a study to predict the Mental Health of Adolescents on the basis of Emotional Maturity and Parent Child Relationship. He conducted his study on 200 9^{th} class adolescents (100 boys and 100 girls) from Government Secondary Schools of Ludhiana City. The result showed that the emotional maturity and parent-child relationship conjointly predict mental health significantly higher as compared to their separate prediction for adolescents. They concluded that this may be due to the positive and significant relationship between mental health and emotional maturity.

Jan Nuzhat (2013)made an attempt to assess and compare the emotional maturity of Male and Female University Distance Learners. A sample of 120 students (60 Male and 60 Female University Distance Learners) was drawn from distance education university of Kashmir (J&K) India. The data was collected by administering Yashvir Singh and Mahesh Bhargava Emotional maturity Scale (EMS) (1984). The results revealed that the Female University distance learners and Male University distance learners do not differ significantly on emotional maturity so far as the

composite score is concerned. However, on factor wise of emotional maturity scale Female University distance learners have emotional instability than Male University distance learners. They have a lack of capacity to dispose of problems, irritability and needs constant help for one's day to day work, venerability, stubbornness and temper tantrum. Male University distance learners have more emotional regression than female university distance learners. Male University Distance Learners have inferiority complex, restlessness, hostility, aggressiveness and self-centeredness of being pursuing education through distance mode. They experience a sense of discomfort and lack of peace of mind. And on other factors, their emotional maturity is almost the same.

Upreti,and Sharma(2018)assessed and compared the emotional maturity of adolescents in orphanages, single-parent families and intact families on 300 respondents in the age group of 14-16 years, from the four selected cities of Punjab (Ludhiana, Jalandhar, Patiala, &Hoshiarpur). 100 school going adolescents were picked from the selected orphanages and 100 adolescents were selected under both single-parent families and intact families from the government schools. The sample was equally distributed across both the genders (50 each. The study revealed that overall, more numbers of orphans were found emotionally immature. Adolescents living with intact families were significantly more emotionally progressed, socially adjusted, independent and overall analysis also showed that they were more emotionally mature. In order to cultivate emotional maturity of adolescents, parents or caretakers should try to become a good and effective listener, avoid comparisons, and teach the problem-solving skills and model good behaviour in front of adolescents.

Mary Jeba (2018) intended to find out any relationship between aggressive behaviour and emotional maturity of adolescents on 300 secondary school students studying in various schools of Kanyakumari district. The investigator used a random sampling technique to collect data. The investigator used the mean, standard deviation, t-test and ANOVA (analysis of variance) to analyze the data and results were tabulated. The adolescent students show more aggressive behaviour than emotional maturity.

Aleem Sheema (2005) have found that there is a significant difference between the mean scores of male and female students on emotional stability. Female students are less emotionally stable as compared to male students. Subbarayan& Visvanathan (2011)

concluded that the sex, community and the family type they belong did not play any role in the emotional maturity of the college students. Rajkumar and. Soundararajan (2012) found significant differences between male and female`s emotional maturity score. Kaur and Singh (2016) revealed an insignificant difference in emotional maturity between boys and girls.

Krishna Duhan and his associates (2017) did a comparison of Male and Female Adolescents on Emotional Maturity. It was revealed that there were no significant differences in the emotional maturity of adolescents as per their gender. However, on the basis of mean scores results depict that male adolescent were on the lower side on emotional instability, social maladjustment and lack of independence as compared to their counterparts. This shows that male adolescents were having better emotional stability, social adjustment and independence in behaviour as compared to female adolescents. Emotional regression and personality disintegration were higher in males (25.60 & 20.83) as compared to female adolescents respectively (25.57&20.70) as they obtained higher mean scores than their counterparts.

Another study by Kumbhar and colleagues (2016) tried to see behavioural problem among orphan children as orphans are not probably socialized and deprived of parental love and affection. The study was conducted on 60 orphan children of 8-12 years living in orphanages of Delhi. For the purpose of comparison equal numbers of non-orphan government school children of similar age group were also taken. Quay and Peterson's (1987)used RPBC to behaviour problems whereas Singh &Bhargava (1998) emotional maturity scale was used to see the level of maturity among the children. The result indicated that orphans were significantly high on behaviour problem and low on emotional maturity. The two variables were found inversely related to each other.

Margooband colleagues (2006)carried out a study on Children in the age group of 5-12 yrs in Kashmir, India. Their results showed Post Traumatic Stress Disorder was the commonest psychiatric disorders(40.62%), easily attributable to the prevailing mass trauma state of almost two decades. Next commonest diagnoses were Major Depressive Disorder (25%) and conversion disorder (12.5%).

Thabet and colleagues (2007) conducted a study that aimed to establish the level of emotional problems among 115 children aged 9–16years (average 13.4), who were living in two orphanages in the Gaza Strip. The children's age of admission to the orphanage (average 8.8 years) was higher than in traditional orphanages in other countries. Thiswas related to the reasons for admission, following their father's death, and the inability of their remaining family to care for them. Standardized mental health measures completed by the children and their main caregiver demonstrated high rates of Anxiety, Depressive and Post-traumatic stress reactions. These mental health problems were strongly inter-related but were not found to be associated with social/care variables. No significant gender differences on any of the mental health measures were reported.

A cross-sectional descriptive study was carried out by Rahmanand colleagues (2012)to find out the prevalence of the behavioural and emotional disorder among the children living in an orphanage in Dhaka city, and to assess the possible factors associated with the presence of disorders. The study results indicated that the overall prevalence of behavioural and emotional disorders was 40.35%, in which Behavioural disorder was 26.9%, Emotional disorder was 10.2% and both Behavioural and Emotional disorder was 3.2%. Higher length of stay and low level of education of foster mother were significantly associated with psychiatric morbidity of the respondents. A Total 342 cases were included in the study and it was concluded that behavioural and emotional disorders are highly prevalent among orphan children.

Another cross-sectional study by Mohamed and colleagues (2012) identified the prevalence of emotional and behavioural problems and the associated factors Cairo among 265 children of ages ranging from 6 to 12 years in orphanage children in three private orphanages. The prevalence of behavioural disturbances was 64.53% among those in institutional care and the most prominent psychiatric disorders were nocturnal enuresis (23.3%), attention deficit hyperkinetic disorder (ADHD) (19.62%), oppositional defiant disorder (17.36%). Age at first admission, causes of receiving institutional care, and moves 2 or more times between institutions were significantly associated with an increased risk of behavioural and emotional problems. Their study concluded that children living in institutions are prone to suffer from psychiatric disorders and the stability of the caregiver acts as a protective variable.

Fawzy and Fourad (2010)studied emotional and development disorders among orphanages children in Sharkia governorate. The sample comprised of 294 children from 4 orphanages of Sharkia. Students were subjected to psychiatric assessment for depression, anxiety, self-esteem and pediatric developmental disorders. The finding showed that the rate of depression was 21%, anxiety was 45%, low self-esteem was 23% and development disorder was 61%. It further included that there was a high rate of emotional and development disorders among orphanage children and strongly interrelated to socio-demographic characteristics.

Bhatt, N.M, (2014) compared the mental health status among orphan and non-orphan secondary school students of Kashmir valley. The sample consisted of 210 secondary schools students (131 orphans) and (79 non-orphan) from different schools and orphanages. Age of sampling group ranges from 13-17 years with a mean age of 15 yrs. Results revealed a significant difference in emotional stability and depression levels between two groups. Orphans were found at the lower side of emotional stability and higher levels of depression as compared to the non-orphans secondary school students.

Ramagopal and colleagues (2016) conducted cross sectional descriptive study, involving 180 children in the age group of 12-18 years living in the orphanage was conducted. Hamilton depression scale was administered to assess depression. Results indicated 53% were the age group of 12-14 years and 46% were 15-17 years, 52% females and 48% males, 35% had depression, most of them who had depression were in the age group of 15-17 years and the majority were females. According to the severity of depression 52% had mild depression, 23% had moderate depression, 14% had severe depression, 9% had very severe depression and 38% of depressed children had suicidal intentions.

Mohamed and colleagues (2012) **i**dentified the prevalence of emotional and behavioural problems and the associated factors in orphanage children. Sample consisted of 265 children of 6-12 years of age group living in three different orphanages care systems. Results revealed prevalence of behavioural disturbances was 64.53% among those in institutional care and the most prominent psychiatric disorders were nocturnal enuresis 23.3% attention deficit hyperkinetic disorder (ADHD) 19.62% oppositional defiant disorder 17.36%.

Majeed and friends (2014) investigated the personality difference between adolescent institutionalized orphans, non-institutionalized orphans and non-orphans. The study was conducted in five orphanages and twelve schools of Lahore. Sample consisted of 240 adolescents, aged between 13-19 years divided into three group of nonorphan (n=80), institutionalized orphans (n=80) and non-institutionalized (n=80). Results revealed that there was a significant difference in hostility and world view of institutionalized orphans, non-institutionalized orphans and non-orphans, although there was no significant difference in dependency, self-esteem, self-adequacy, emotional responsiveness and emotional stability among the three groups.

Sujata. and Jacob(2014) viewed the psychosocial well- among 40 adolescent children of 12-17 years of age selected from two orphanages in Mangalore. Results showed 7.5% at risk for hyperactivity disorder, 37.5% at risk for peer problems and 12.5% with severe peer problem. Regarding prosocial behaviour 22.5% were at risk while 5% had abnormal prosocial behaviour. No child was found to have conduct problems.

Makaya and coleagues (2002), conduct a study on orphans and found 20% experiencing psychological difficulties, including depression, anxiety and irritability (34%), fugue, offending and hyperactivity (27%), and PTSD (39%).

Manuel P. (2002) found orphans (n = 76) more likely than controls (n = 74) to be depressed and bullied, and less likely to have a trusted adult or friend. Carersof orphans showed more depression and less social support.Atwine and friends (2005) conducted a study on 123 orphans and they were compared to a control sample of 110 children in rural Uganda. The age range was from 11 -15 years. The results indicated that orphans have a greater level of anxiety, depression and anger compared to non-orphans.

Gregson and collegues (2005) also found that orphans and vulnerable children have heightened risks of adverse reproductive health outcomes and higher risks of HIV infection. Kirya (2005) conducted a study and found the impact of AIDS-related parental loss on the self- esteem of children and on their sociability at school. A sample of 70 orphans was compared with a sample of 70 non-orphans. Orphans and non-

orphans did not differ in terms of interpersonal relationships (sociability) at school; orphans had ever slightly higher skills than non-orphans. In terms of self-confidence, on the other hand,orphan scored notably lower than non-orphan.

Cluver and Gardner (2005) conducted a study of 30 orphaned and 30 nonorphaned children ages 6-19 living in poor urban areas found that orphans were more likely to have difficulty concentrating, to report somatic systems, and to have constant nightmares. Orphans scored 73% above the cutoff for Post-Traumatic-StressDisorder. There were no differences based on the child's age, gender, or time since parental death, although the sample was small.

Atwine and friends (2005) conducted a study on a population which consisted of 123 children whose parents (one or both) were reported to have died from AIDS and 110 children of similar age and gender living in intact households in the same neighbourhood. Orphans had a greater risk (vs. non-orphans) for higher levels of anxiety, depression and anger.Furthermore, orphans had significantly higher scores than non-orphans on individual items in the Beck Youth Depression Inventory that are regarded as particularly "sensitive" to the possible presence of a depressive disorder, i.e. vegetative symptoms, feelings of hopelessness, and suicidal ideation. High levels of psychological distress found in AIDS orphans suggest that material support alone is not sufficient for these children.

Makame, V., Ani,C., Grantham-McGregor,S., (2002)Observed the forty-one orphanswhose fathers and/or mothers had died from AIDS and were living in the poor suburbs of Dar Es Salaam, Tanzania, were compared with 41 matched non-orphans from the same neighbourhoods. The scale of internalizing problems comprised 21 items adapted from the Rand MentalHealth and Beck Depression Inventories(Beck, Ward, Mendelson, Mock, &Erbaugh, 1961) concerning mood, pessimism, somatic symptoms, sense of failure, anxiety, positive affect and emotional ties. Compared with non-orphans, they were significantly less likely to be in school but those who did attend school had similar arithmetic scores. Significantly more orphans went to bed hungry. Orphans had markedly increased internalizing problems compared with non-orphans ($p < 0.01$) and 34% reported they had contemplated suicide in the past year, compared to only 12% of non-orphans. Multiple regression analysis indicated that the independent

predictors of internalizing problem scores were sex (females higher than males), going to bed hungry, no reward for good behaviour, not currently attending school, as well as being an orphan.

Boadu(2015)conducted a comparative study and investigated behavioural and emotional problems among children living in selected private, public and religiously owned orphanages in Ghana.150 participants were conveniently sampled and administered with Strengths and Difficulties Questionnaire (Goodman, 1997) whilst the 15 participants in the interview were selected using systematic random sampling technique. Results from the quantitative data revealed that significant differences existed in terms of behavioural and emotional problems among children in orphanages. There was also a significant negative relationship between the length of stay and behavioural and emotional problems. However, no difference was found between males and females in terms of emotional problems. Qualitative results revealed the emotional and behavioural problems as well as the coping strategies of children living in orphanages.

Hussain (2017) conducted a study at various orphanages of Jaipur (Rajasthan).The data were collected from 100 adolescent respondents. The findings of the study revealed a significant difference among the orphan and non-orphan children on EI (emotional intelligence) but on the other side, they have a low level of social intelligence when compared to orphans. As far as the personality trait is concerned the dominant personality attributes possessed by the orphans are active but on the other hand, they are emotionallyunstable than non-orphan children. A significant difference was seen from the findings of the study among boys and girls on EI (emotional intelligence), whereas there was no significant difference in SI (social intelligence) among boys and girls. The results of the study also showed that the girls are more active and the dominant personality trait among boys comes out to be assertive.

Bhat(2014) conducted a study to assess emotional stability and depression among orphans and non-orphans. 210 senior secondary students (131 orphans & 79 non orphans) taken from different schools and orphanages of Kashmir Valley. The age of the sample group ranges from 13 to 17 years with mean age of 15 years. Research findings suggest significant differences in Emotional stability and Depression levels

between the two groups. Orphans were found at the lower side of Emotional stability and higher levels of depression as compared to their counterpart non-orphans secondary school students.

Pastey,G.S.andAminbhavi,V.A (2006) made an attempt is made in the present study to find out the impact of emotional maturity of adolescents on their stress and self-confidence. Sample of the study consists of 105 adolescents in Dharwad city Karnataka State, India. The findings revealed that adolescents with high emotional maturity have significantly high stress ($t=10.44$; $p< 0.001$) and self-confidence ($t=-2.92$; $p< 0.01$) when compared to those with low emotional maturity. Adolescents with a greater number of siblings have shown a significantly higher level of self-confidence ($t = 2.96$; $p< 0.01$) than their counterparts. It is also found that the educational level of the father has significantly influenced the stress of their adolescent children ($F= 5.303$; $p< 0.01$). Adolescent boys tend to have significantly higher stress than girls ($t=1.72$) and girls tend to have significantly high self-confidence ($t=1.83$).

Factor, Rosen, and Reyes (2013) examined the relation of deficient emotional self-awareness to externalizing behaviour problems in children with ADHD, and the role of emotional reactivity in this relationship. Method: Fifty-one 8- to 12-year-old children with ADHD and their parents completed measures of the children's emotional and behavioural functioning, as well as a diagnostic structured interview. Logistic regression suggested that more impaired emotional self-awareness was strongly associated with the diagnosis of a comorbid externalizing disorder. Hierarchical regression analyses strongly supported the relationship of poor emotional awareness to reactivity driven externalizing behaviour, but not too proactive externalizing behaviour. These effects were evident across reporters. This study suggested that poor emotional self-awareness is significantly linked to externalizing problems in children with ADHD and that dysregulated emotional reactivity plays an important role in this relationship.

Kaur and colleagues (2018) conducted a study on a sample which consisted of 292 orphans and OVCA in institutional homes of Visakhapatnam city. The sociodemographic data were collected using a semi-structured questionnaire. The Strengths and Difficulties Questionnaire (SDQ) with impact supplement was used to assess the behavioural and emotional problems in them. In the study, 49 (16.78%) out

of 292 children and adolescents were found to be having behavioural and emotional problems. Factors such as age, sex, the reason for being in the institute, age of admission, and years of stay in the home were all seen to be significantly associated ($P < 0.05$) with emotional and behavioural problems. Conduct problems (34.90%) were found to be most prevalent followed by peer problems (15.80%), emotional problems (14.70%), hyperactivity (8.60%), and low prosocial behaviour (3.40%).

Abdel Aziz Mousa Thabet and friends (2017) aimed to find the prevalence rate of PTSD, anxiety and depression among orphaned children in Gaza Strip. The study sample consisted of 81 orphaned children from Al-Amal Institute for Orphans. The minimum age was 9 years and the maximum age was 18 years, Mean = 13.34 years. The study showed that 67.9% showed depression. Depression was more in children from north Gaza had more depression than those coming from the other four areas of the Gaza Strip. The results showed that 30.9% of children rated as anxiety cases. Children 13 - 15 years old had more anxiety than those younger and older age than them and children coming from north Gaza had more anxiety than those coming from the other four areas of the Gaza Strip. The result showed that there was a positive correlation with statistical significance between depression and anxiety, intrusion, and avoidance. While total depression was negatively correlated with arousal symptoms of PTSD.

Hosseini and Khazali(2013) conducted a study to compare the level of anxiety in male and female students at Tehran elementary schools. To this end, 1200 students (600 girls and 600 boys) at middle schools were selected using the random cluster sampling method and tested with Reynolds & Richmond's Anxiety Scale (RCMAS). Results of data analysis suggested that female students scored higher in the subscales of physiological anxiety and worry than male students, implying that the girls' level of anxiety is higher in these subscales and there is a significant difference in the 95-per cent level of confidence between girls and boys. In the same way, in the subscale of concentration, no significant difference was observed between girls and boys. Still, based on the overall score of anxiety, a significant difference was observed between girls and boys.

Kaur, R, Vinnakota, A, panigrahi, S &Manasa, R.V (2018) conducted a study on 292 orphans and other vulnerable children and adolescents (OVCA) in institutional

homes of Visakhapatnam city. The sociodemographic data were collected using a semi-structured questionnaire. The Strengths and Difficulties Questionnaire (SDQ) with impact supplement was used to assess the behavioural and emotional problems in them. 49 (16.78%) out of 292 children and adolescents were found to be having behavioural and emotional problems. Factors such as age, sex, the reason for being in the institute, age of admission, and years of stay in the home were all seen to be significantly associated ($P < 0.05$) with emotional and behavioural problems. Conduct problems (34.90%) were found to be most prevalent followed by peer problems (15.80%), emotional problems (14.70%), hyperactivity (8.60%), and low prosocial behaviour (3.40%)In the subscales of SDQ in the study, the number of boys having emotional problems, conduct problems, hyperactivity, and peer problems was significantly higher than the girls. The girls were more likely to have poor prosocial behaviour. Further, the adolescents had a higher frequency of emotional problems, conduct problems, and hyperactivity as compared to younger children.

Lowe and Reynolds (2005), showed that the factor structure of scores on the Adult Manifest Anxiety Scale-College Version (AMAS-C), a new self-report measure of chronic, manifest anxiety, is examined across gender for a sample of 943 college students (608 women and 335 men). Values for the coefficient of congruence and salient variable similarity index are calculated between each of five matched factors (Physiological Anxiety, Social Concerns/Stress, Test Anxiety, Worry/Oversensitivity, and Lie) and the Total Anxiety factor. Values obtained suggest that the factors are similar across gender and provide support for the existence of the AMAS-C scales for college women and men. Examination of the mean levels of performance across gender indicates that college women report more anxiety than college men on all the anxiety scales, except one, the Social Concerns/Stress subscale, and the Lie scale.

Based on the literature available which are done at different parts of the world about children in an orphanage having various psychological problems and the need for intervention invites the present study, the statement of the present study is presented in next chapter.

CHAPTER – II
STATEMENT OF THE PROBLEM

The negative effects of institutional rearing are well documented. Poor caregiving; lack of stimulation and the absence of a consistent caregiver have been implicated in the negative outcomes among institutionalized children (Rutter,Kreppner and O'Connor, 2001).And from the brief review on Orphan children, it is clear that these children go through much psychological turmoil as a result of staying in an orphanage and without a consistent caregiver which are normally the parents. In general, Children and adolescents have always been an important focus of study for mental health researchers. And many studies have highlighted emotional problems such as depression, anxiety, low self-esteem and difficulties in social interaction as well as behavioural problems such as hyperactivity and conduct problems in them. Among the children too, some groups are more at risk of developing these psychological problems than the other groups.

Children and adolescents who are orphans, runaways, or abandoned by families and bring reared in institutional homes form one such vulnerable group according to the Integrated Child Protection Scheme, India. (2017). From the literature it can be noted that emotional and behavioural problems are more among orphans and other vulnerable children because they are exposed to abuse, exploitation, neglect, lack of love and care of parents. They are also more likely to be emotionally needy, insecure, and poor. In addition to these factors, most of them are brought up in institutional homes where individual care is inadequate. All these factors can socially and emotionally impair these children.

About Manipur State (Targeted Population):

Manipur State is the place where the samples are drawn from the present study. It is one of the states in Northeastern India with Imphal as its capital. It is bounded by the Indian states of Nagaland to the north, Mizoram to the south, and Assam to the west and also shares an international border with Myanmar (Burma) to the east. It covers an area of 22,327 square km. With a population of 27, 21,756 according to census 2011, Manipur consist of Meitei, Meitei Pangal (Muslim), Naga, Kuki, Mizo. Manipur came under the British rule after the defeat in the Anglo-Manipuri War of 1891 as a princely

state till 1947 and thereafter the Maharaja of Manipur ruled with the help of interim council. On 21st September1949, the Maharaja of Manipur signed the Merger Agreement with the Governor of Assam on behalf of Govt. of India, thus ending the rule of the monarchy in Manipur. With the backdrop of the merger agreement, the council of ministers and state Assembly were dissolved in 15th Oct.1949. It became a full-fledged state of India on the 21st January 1972 (Battle, 1977; Singh, 2011)

According to data provided by the Department of Social Welfare, Government of Manipur (Singh, 2011), there are twenty-one registered NGO and Government runChildren home and Shelter home in Manipur under Integrated Child Protection Scheme(ICPS). Although the number is high, researches and studies done in this population are minimal. And furthermore, the available data is scanty. Prior separate studies have also explored the variables of the present study like self-esteem, emotional maturity and the behavioural problems separately. However, the current study aims to asses and explore the level of the variables – self-esteem, emotional maturity, and behavioural problems (externalized and internalized behaviour problems) and the relationship between the variables among children in orphanages. The study also aims to compare the above-mentioned variables with non- orphaned children.

Identifying the levels of self-esteem and emotional maturity and the prevalence of behavioural problems among the groups is an important first step in understanding how best to support children living in the orphanage and these findings can be useful in planning out interventions for the benefit of children living in an orphanage and their overall personality development.

Operational Definitions of The Terms

Self Esteem

Self-Esteem Is A Stable Sense Of Personal Worth Or Worthiness. It Is Understood As An Attitude, Either Positive Or Negative, A Person Has About Him- Or Herself.

Emotional Maturity

Emotion May Be Defined As The Stirred Up Condition Of Organism Involving Internal And External Changes In Body.

Maturity Is Achieved When Individual Growth Is Completed And The Organism Is Ripe For Propagation. It Designates That Phase Of Personality Development Which Corresponds To Biological And Psychological Maturation.

Emotional Maturity Is Defined As How Well You Are Able To Respond To Situations, Control Your Emotions And Behave In An Adult Manner When Dealing With Others.

Emotionally Matured Individual Is Continually Involved In A Struggle To Gain Healthy Integration Of Feeling, Thinking And Action.

Behavioural Problems

Behavioural Problems Can Occur In Children With All Ages And Very Often They Start In Early Life.

The Construct Of Externalizing Behaviour Problems Is Grouping Behaviour Problems That Are Manifested In Children's Outward Behaviour And Reflect The Child Negatively Acting On The External Environment

In Contrast To Externalizing Behaviours, Internalizing Problems Tend To Be Covert And Represent An Inner-Directed Pattern Of Behaviour Occurring When Individuals Try To Control Internal Emotions Or Cognitions To An Excessive And Maladaptive Extent.

Orphans:

A Child Who Is Below 18 Years Of Age And Who Has Lost One Or Both Parents May Be Defined As An Orphan.

Objectives:

Given the theoretical and methodological foundations, the objectives of the present study were formed viz,

I) To establish the psychometric adequacy of the psychological tests used, in order to find applicability in the selected population.

II) To explore any significant differences between the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems of the selected samples.

III) To explore any significant relationship between the sub-scales/scales of Self-Esteem, Emotional Maturity and Behavioural problems (externalizing and internalizing) in the selected population.

IV) To explore whether there is any significant independent effect of 'gender' and 'orphanage' on the sub-scales/scales of Self Esteem Emotional Maturity and Behavioural problems (externalizing and internalizing) in the selected population.

V) To explore whether there is any significant interaction effect of 'gender and orphanage' on the sub-scales/scales of Self Esteem, Emotional Maturity and Behavioural problems (externalizing and internalizing) in the selected population.

Hypotheses:

To meet the objectives of the study the following hypotheses are set forth for the study:

I) It is expected that the selected Psychological measures would find applicability in the selected population as it is going to be one of the few endeavours in the selected population.

II) It is expected that there will be a significant mean difference between the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems (externalizing and internalizing) of the selected samples.

III) It is expected there will be a significant relationship between the sub-scales/scales of Self-Esteem, Emotional Maturity and Behavioural problems (externalizing and internalizing) in the selected population.

IV) It is expected that there will be an independent effect of 'gender' and 'orphanage' on the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems (externalizing and internalizing) among the sample.

V) It is expected that there will be an interaction effect of 'gender and orphanage' on the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems (externalizing and internalizing) among the sample.

CHAPTER –III

METHODS AND PROCEDURE

To meet the objectives and hypotheses, the methodology used for the present as under:

Sample

200 Children {(2 groups of Children (100 Orphans and 100 Controls) and 2 Genders (Boys and Girls)} was selected through multistage sampling method. Of which, 100 was children living in an Orphanage in Manipur and whose age range falls between 11 years to 16 years.

Data was also obtained from another matched group of the orphan children on extraneous variables, comprising of 100 children who are currently staying with their biological parents at home for control group/comparison group. According to CRC (1998)**,** 'every human being below the age of 18 years unless, under the law applicable to the child, the majority is attained earlier' is considered a Child.

*Inclusion criteria***:**

The Child should have completed at least a period of one year of stay in an orphanage

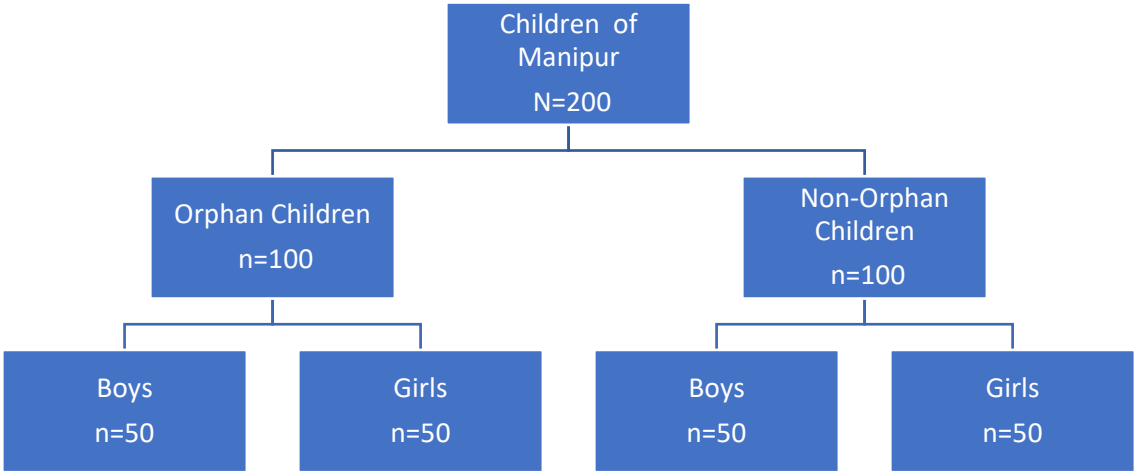
- Children who are willing to participate and able to give consent or ascent from their primary caregiver.

Exclusion criteria: For the control group,

- The Child not staying with both the parents is excluded.
- No prior history of staying away and neglect from parents.

Design of the study-The 2x2 factorial design {2 Children groups (orphan and non-orphan children) and 2 genders (boys and girls)}, comprises of four cells of comparison groups was employed as it aims to elucidate the differences between the comparison groups on self-esteem, emotional maturity and behavioural problems including its subscales among the samples.

Figure-1: Illustrate the design of the study (2 x 2 factorial design).



Psychological tools to be used:

1. ***Rosenberg's Self-esteem Questionnaire (SES); Rosenberg, 1965***: Used to assess self-worth and self-acceptance of children and adolescents. It contains 10 items which each investigate a feeling. Statement for items 1, 2, 4, 6 and 7: is answered as (3) strongly agree, (2) agree, (1) disagree or (0) strongly disagree, but for items 3, 5, 8, 9 and 10 (reversed in valence). The scale ranges from 0-30. Scores between 15 and 25 are within normal range; scores below 15 suggest low self-esteem. Internal consistency reliability is 0.77 and Test-retest reliability ranges from 0.63 to 0.85.

2. ***Emotional Maturity Scale (EMS); Yasvir Singh and Mahesh Bhargava, 1984***: Will be used for measuring emotional maturity of the children. The scale has five components viz., *instability, emotional regression, social maladjustment, personality disintegration and lack of independence*. The scale consists of a total of 48 items, 10 items in each component except for the component i.e. lack of independence which has 8 items. The responses are scored according to weight age of 5 to 1 (very much to never). Higher the score on the scale, lesser is the degree of emotional maturity and vice versa. The test has a test-retest reliability of r= 0.75.

3. ***Child Depression Inventory (CDI); Kovacs,1985***: The CDI is a standardized self-report questionnaire of depressive symptomatology. This has been developed for children and young people aged 7–17 years. The CDI includes 37 items, each scored on a 0–2 scale (from 'not a problem' to 'severe'), for the previous two weeks. The total score ranges between 0 and 54, and a score of 19 has been found to indicate the likelihood of a depressive disorder. The CDI has a reliability ranging from .80 to .88 in normative samples. And it has adequate validity for use with children between the age of 7 to 17 years.

4. ***Revised Children's Manifest Anxiety Scale(***Reynolds, C.R., & Richmond, B.O, 1985)***.:***The RCMAS is a standardized 37-itemself-report questionnaire for children aged 6–19 years. It measures the presence or absence of anxiety-related symptoms ('yes/no' answers) in 28 anxiety items and nine lie items.Coefficient alpha reliability ranges from .79 to .85. Test-retest reliability ranges from .68 to .98. It measures 3 types of Anxiety: Physiological Anxiety, Over sensitiveness/Worry and Social concerns/Concentration anxiety.

5. ***Strengths and Difficulties Questionnaire (SDQ); Goodman, 2001***: The SDQ is a widely used measure of behavioural and emotional problems. It includes 25 items, of which 14 describe perceived difficulties, ten perceived strengths and one is neutral. The SDQ consists of the 5-subscales of *Hyperactivity, Emotional, Conduct and Peer problems, as well as a pro-social subscale*.This scale also gives externalizing and internalizing score. The *externalizing score* ranges from 0 to 20 and is the sum of the conduct and hyperactivity scales. *The internalizing score* ranges from 0 to 20 and is the sum of the emotional and peer problems scales. Reliability is satisfactory, whether judged by internal consistency (mean Cronbach α: .73), or retest stability after 4 to 6 months (r= 0.62).

***Procedure*:**

A list of Orphanages which were registered was obtained from the Social welfare Department of the Government of Manipur for selection of samples as per designs. Altogether 21 orphanages/children homes which were registered to the Integrated Child Protection Scheme, Govt. of Manipur was obtained from the Social

welfare Department of Manipur were identified. Out of which 13 orphanages were short listed and were contacted. Permission was taken from the concen authorities for conduction of the present research. Following which 6 Children Homes gave permission for conducting of the study, where the inmates age range falls between 11 years to 16 years which are located in 4 different districts of Manipur: **Imphal East, Imphal West, Thoubal and Senapati district.** The six orphanages/ children homes are : Destitute Children home run by Kanglatombi orphanage Home, Kanglatombi; Destitute Children home run by the Manipur Mahila,Kalyan,Samiti, Dewlahland,Imphal; Destitute Children Home run by Meitei Phurup, Terakeithel,Imphal; Punya Shelter Home for Girls run by Integrated Women and Children Development centre, Thangmeiband,Imphal; Shelter Home for Girls run by Women Income Generation Centre, Thoubal,Imphal,& Human Empowerment for Social Integration (HESI), Khurai,Imphal.

20 children were randomly selected using lottery method from the list from each homes (selected 6 Homes) with equal match of boys and girls for Psychological evaluation as per objectives of the study which comprises of 120 children for experimental group (orphans). Then, another 120 non-orphans were selected children who are currently staying with their biological parents at home with a due care to well match the experimental group on ground of age, location, gender, education, religion, except on orphanage status; and also cross checked with the help of sociodemographic profiles. The age range was falls between 11 years to 16 years following the inclusion and exclusion criteria of the study.the final sample size was 200 chiuldren in total. All necessary informations regarding the purpose of the study, how confidentiality to keep on information given, time reguirement and others to the selected samples. Any doubt or queries of them were clarified. Then, consent of the was taken from the samples as prescribed by APA code of research ethics.

Since original Psychological Scales were in English while the target population is not well versed with English, it was decided to translate the scales into Manipuri language. For methodological concern, the translated Manipuri was backed translated into English by employing ABBA technique to check the psychometric adequacy for the population under study and showed that the selected psychological scales were reliable for the further purpose. The sociodemographic profiles and the selected psychological scales were ready for administration to the samples.

Children were distributed the question booklet which comprised of a Sociodemographic (semi-structured performa) and the psychological tools. The Sociodemographiccontains few items for which the information was obtained from the caregiver of the Orphanage for validation of the samples as per objectives of the study.

The Semi- Structured performa consists of Demographic details like gender, age, religion, educational qualification, number of years of stay at the orphanage, reason for staying, previous history of any psychological and psychiatric problem to cross check the true representation of comparison groups as per design.The analysis of the data is given in the next chapter.

CHAPTER – IV

RESULTS AND DISCUSSION

The present study entitled, 'Self-Esteem, Emotional Maturity and Behavioural Problems among Orphans: A Study in Manipur'was conducted by following the scientific methodology which could be replicated in future to cross checking or to get more information in the selected population for framing prevention and developing intervention strategies for psychological problems.

For the study, initially 240 children {(2 groups of Children (120 Orphans and 120 Controls) and 2 Genders (120 Boys and 120 Girls)} were selected through random sampling method. Of which, 120 was children living in an Orphanage in Manipur and whose age range falls between 11 years to 16 years and another 120 children who are currently staying with their biological parents at home for control group/comparison group.To meet the objectives and the hypotheses set forth for the present study, the psychological tests: 1)Rosenberg's Self-esteem Questionnaire (SES; Rosenberg, 1965); 2)Emotional Maturity Scale (EMS; Yasvir Singh and Mahesh Bharagava, 1984); 3) Child Depression Inventory (CDIKovacs,1985); 4) Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds, C.R., & Richmond, B.O, 19851985); and 5) Strengths and Difficulties Questionnaire (SDQ; Goodman, 2001)were employed to tap the selected dependent variables.

The data collected was screened for missing and outlier, any of which were delated from data matrix. Then at the final stage, the sample size was 200 children {(2 groups of Children (100 Orphans and 100 Controls) and 2 Genders (100 Boys and 100 Girls)}, and the data were analyzed in stepwise.

Firstly, the Psychometric adequacy of the Psychological test was done to confirm the trustworthiness of the selected scales for the target population by employing Brown-Forsythetest and the reliabilityof the psychological tests were calculated. Secondly, the descriptive statistics were computed including the mean, standard deviation, Standard Error of Mean, Kurtosis and Skewness on the behavioural measures of (i) Self-Esteem Scale, (ii) Emotional Maturity Scale, (iii) Child Depression Inventory (iv) Revised Children's Manifest Anxiety Scale and (v) Strengths & Difficulties Questionnaire. Thirdly, mean differencewas computed for the whole sample. Fourthly,

Pearson Correlation showing the relation of the whole sample on the behavioural measures of Self Esteem, Depression and subscales of Manifest Anxiety, Emotional Maturity and Strengths and difficulties questionnaire. Lastly, 2 X 2 ANOVA with Post-hoc multiple mean comparisonswere employed to illustrate the independent and interaction effect of the independent variables on selected dependent variables for the whole samples.

Psychometric Adequacy:

The psychological tests used for the present study were originally made for other culture, and therefore to rule out the difference on cultural norms, the psychometric adequacy of the psychological test was checked before going further analysis. Levenes' Test of Homogeneity of Variance, Robust Tests of Equality of Means (Brown-Forsythe)and Reliability measure (Cronbach Alpha) were employed for the same.

The preliminary analyses of the psychometric properties of the behavioural measures were computed was felt necessary that scale constructed and validated for measurement of the theoretical construct in a given population when taken to another cultural milieu may not be treated as reliable and valid unless specific checks are made (Witkin& Berry, 1975).The reliability and predictive validity of the scales and sub-scales were ascertained to ensure the psychometric adequacy of the scales used for the study. Internal consistency reliability was estimated for each of the scales used in the study using Cronbach's coefficient alpha (Cronbach, 1951). The results in Table- 1 revealed that the reliability of Self-Esteem (α=.79) , Depression (α=.58) and subscales of Emotional Maturity Scale (Emotional Instability, α=.71; Emotional Regression,α=.65; Social Maladjustment, α= .72; Personality Disintegration, α=.64 and Lack of Independence, α= .78). The total coefficient of correlation of the subjects emerged to be satisfactory over the levels of analysis for the whole sample, which indicating the trustworthiness of the scales such as Self Esteem, Children Depression and emotional Maturity. The Reliability test of Cronbach Alpha shows reliability scores all falling above .50 showing the reliability and the validly proved the trustworthiness of the selected psychological scale for the present population under study. Brown-Forsythe Test of Homogeneity of Variances was used, which is a Robust test of the Levene's Test. From the test it was ascertained that there is homogeneity of thevariance within the whole sample.

Table-1:Showing Mean, SD, SEM, Skewness, Kurtosis, Homogeneity Test (Levenes's Test &Brown-Forsythe) and Reliability measure (Cronbach Alpha)for Self-esteem, Depression and subscales of Emotional Maturity for the whole sample.

Variables	**Subscales of the Variables**	**Mean**	**SEM**	**SD**	**Skewness**	**Kurtosis**	**Homogeneity Test** (Brown-Forsythe)	**Levene's Test of Homogeinty**	**Reliability test** (Alpha)
Self- Esteem	-	19.16	.28	3.99	-.02	-.75	.00**	**.11**	**.79**
Depression	-	27.12	.26	3.62	-.05	-.82	.00**	**.06**	**.58**
Emotional Maturity	Emotional Instability	19.01	.31	4.38	.02	-.73	.00**	**.08**	**.71.**
	Emotional Regression	17.33	.28	3.89	.06	-.75	.00**	**.12**	**.65.**
	Social maladjustment	19.02	.31	4.38	.02	-.71	.00**	**.15**	**.72**
	Personality Disintegration	17.37	.27	3.88	.04	-.74	.00**	**.09**	**.64**
	Lack of independence	18.10	.30	4.19	.11	-.66	.00**	**.15**	**.78**

**. Correlation is significant at the 0.01 level (2-tailed).

Similarly, the results in Table- 2 revealed that the reliability of subscales of Revised Children Manifest Anxiety Scale (Physiological Anxiety, α=.51; Oversensitivity/Worry, α=.73; Social Conerns/Concentration, α=.63) and subscales of Strengths and Difficulties Questionnaire(Emotional Problems, α=.74; Conduct Problems,α=.79; Hyperactivity, α= .78; Peer Problem, α=.77, Prosocial, α= .57; Externalizing,α= .78 and Internalizing, α= .67). The total coefficient of correlation of the subjects emerged to be satisfactory over the levels of analysis for the whole sample, which indicating the trustworthiness of subscales of Children Manifest Anxiety and Strengths and Difficulties Questionnaire for the whole sample.. The Reliability test of Cronbach Alpha shows reliability scores all falling above .50 showing the reliability and the validly proved the trustworthiness of the selected psychological scale for the present population under study. Brown-Forsythe Test of Homogeneity of Variances and Levene's Test was used. From the test it was ascertained that their homogeneity of the variance within the whole sample.

Table-2:Showing Mean, SD, SEM, Skewness, Kurtosis, Homogeneity Test(Levenes's Test &Brown - Forsythe) and Reliability measure (Cronbach Alpha)for subscales of Children Manifest Anxiety and Strengths and Difficulties Questionnaire for the whole sample.

Variables	Subscales of the Variables	Mean	SEM	SD	Skewness	Kurtosis	Homogeneity Test (Brown-Forsythe)	Levene's test of Homogeneity	Reliability test (Alpha)
Manifest Anxiety	Physiological anxiety	4.02	0.15	21.09	-.03	-.71	.00**	.08	.51
	Oversensitivity/ Worry	5.32	0.19	.75	.07	-.60	.00**	.12	.73
	Social Concerns/ Concentration	3.55	0.14	.93	-.05	-.95	.00**	.09	.63
Strengths and Difficulties Questionairre	Emotional Problems	4.47	0.17	.40	.03	-.77	.00**	.12	.74
	Conduct Problems	4.73	0.19	.64	.14	-.72	.00**	.15	.79
	Hyperactivity	4.85	0.18	.61	.09	-.74	.00**	.14	.78
	Peer Problem	4.96	0.18	.56	.03	-.73	.00**	.14	.77
	Pro Social Behaviour	.74	0.68	.15	.40	.86	.00**	.07	.57
	Externalizing	8.27	0.27	2.87	-.13	-.78	.00**	.14	.78
	Internalizing	9.16	0.24	23.37	-.04	-.67	.00**	.10	.67

Descriptive Statistics:

The results (Table-3) highlight the Mean and SD of the scales/subscales of (i)Self-Esteem Scale, (ii)Emotional Maturity Scale, (iii)Child Depression Inventory (iv)Revised Children's Manifest Anxiety Scale and (v)Strengths & Difficulties Questionnaire. The results revealed the mean and standard deviation as well as Skewness and Kurtosis as indices for normality of the scores on the measured variables. All the skewness statistics falls between 1.0 to 2.0 which showing none of the skew and kurtosis were greater than twice the standard error within an acceptable range, and that revealed the applicability of parametric statistics for further analysis (Miles & Shevlin, 2001).

Results presented in **Table-3** highlights the Mean comparison among the four comparision groups: Orphan Girls, Orphan Boys, Non-orphan Girls & Non-orphan Boys.It indicated that for the measure of Self Esteem, the Non-orphan Boys had highest score (M=22.56) followed by Non-orphan Girls (M=20.98), then by Orphan Boys (M=17.80) and lowest score was observed among Orphan Girls (M=15.30). Results also highlighted that the Non-orphans have higher score in Self-esteem than the Orphans (M=21.19; 18.14; $p<.01$) and the boys are higher than girls (M=20.18; 18.14) on Self-esteem for the whole sample as showed in Table. This findings are supported by studies

by Wanjiru,M&Gathogo, J, (2014). Robinson (1995) in Steinberg (1999) in his studies found that self-esteem is enhanced by having the approval of others especially of parents and peers. Erango & Ayka (2015) found similar pattern and cited the lack of psychosocial support (good guidance, counseling and treatment, physical protection and amount of love shared, financial and material support, and fellowship with other children, poor social life of parents, and death of parents as factors that negatively affect the self-esteem of orphans. Though orphaned, boys registered a better self-esteem than the girls, probably boys still feel that they are the most valued in the society where the study was conducted as the society view the boy child with esteem while the girls are looked down upon(Guthman et al 2002 in Kiyapi 2007).

On the measure of Depression using the Child Depression Inventory,the Orphans had more depressive symptoms(M= 29.01) than the Non-Orphans (M=25.22). Orphan Girls had the highest score (M=29.96) followed by Orphan Boys (M=28.06), Non-Orphan Girls (M=26.54) and lowest by Non=Orphan Boys (M=23.90). The findings of the current study supports the previous separate studies by Atwine, Cantor et a1.(2005), Manuel P. (2002) where orphans were more likely than controls to be depressed and bullied suggesting that high levels of psychological distress found in orphans that material support alone is not sufficient for these children The cross sectional descriptive study by Ramagopal,G, Narasimhan,S, Devi,L.U (2016)involving 180 children in the age group of 12-18 years living in orphanage also indicted, 35% had depression, most of them who had depression were in the age group of 15-17 years and majority were females.A study by Abdel Aziz Mousa Thabet., et al (2017) on orphan childrenalso highlighted that 67.9% showed depression. Nasir Mohammad Bhatt (2014) also revealed significant difference in emotional stability and depression levels between two groups. Orphans were found at the lower side of emotional stability and higher levels of depression as compared to the non-orphan secondary school students. Orphans and vulnerable children have no one to share their grief with, and this can compound their sense of helplessness. Lack of support during the grieving process and inadequate help in adjusting to an environment without their parents may lead children to become depressed. In addition, when orphans are placed with poorer households, anxiety about the future, including the prospect of not finishing school, may lead to depression.(USAID. Psychosocial support. Resources for communities working with orphans and vulnerable children. Washington, DC. 2003)

Similarly, on all the subscales of Emotional Maturity the mean values calculated for the orphans are: Emotional Instability(M=21.33), EmotionalRegression(M= 18.64), Social Maladjustment(21.33), Personality Disintegration (M=18.96) and Lack of Independence(M=19.89). Orphans scored higher mean value than Non-Orphans, from which it can be ascertained that Emotional Maturity was higher in Non-Orphans than the Orphans, since higher score in emotional maturity scale means lower level of Emotional Maturity.This findings supported previous studies by Chaudhary and Bajaj (1993), Upreti,R& Sharma, S(2018) where they found that adolescents staying at home have higher level of emotional maturity as compared to their counterparts staying at the orphanage.Nasir Mohammad Bhatt (2014) revealed significant difference in emotional stability between two groups. Orphans were found at the lower side of emotional stability as compared to the non-orphan secondary school students. Upreti, Rashmi & Sharma, Seema (2018) found in their study that adolescents living with intact families were significantly more emotionally progressed, socially adjusted, independent and more emotionally mature. A happy home or healthy family is the first base in a person's life for developing emotional maturity.

Table-3: Showing Mean comparison between groups on Self-Esteem, Depression and subscales of Emotional Maturity for the whole sample.

Groups	Self-Esteem	Depression	Emotional Maturity				
			Instability	Regression	Social Maladjustment	Personality Disintegration	Lack of independence
Orphan Girls	15.30	29.96	22.76	20.22	22.76	20.22	20.58
Orphan Boys	17.80	28.06	19.90	17.06	19.90	17.70	19.20
Non-Orphan Girls	20.98	26.54	17.82	15.98	17.82	16.14	17.46
Non-Orphan Boys	22.56	23.90	23.90	15.58	16.06	15.58	15.42
Total Orphans	16.55	29.01	21.33	18.64	21.33	18.96	19.89
Total Non-Orphans	21.77	25.22	20.86	16.02	16.70	15.78	16.30
Total Girls	18.14	28.25	20.29	18.10	17.74	18.18	19.02
Total Boys	20.18	25.98	21.9	16.56	20.29	16.56	17.17
Total	19.16	27.12	19.01	17.33	19.02	17.37	18.10

Figure-2: Showing the mean comparison between Orphans & Non-Orphans on Self -Esteem, Depression and subscales of Emotional Maturity

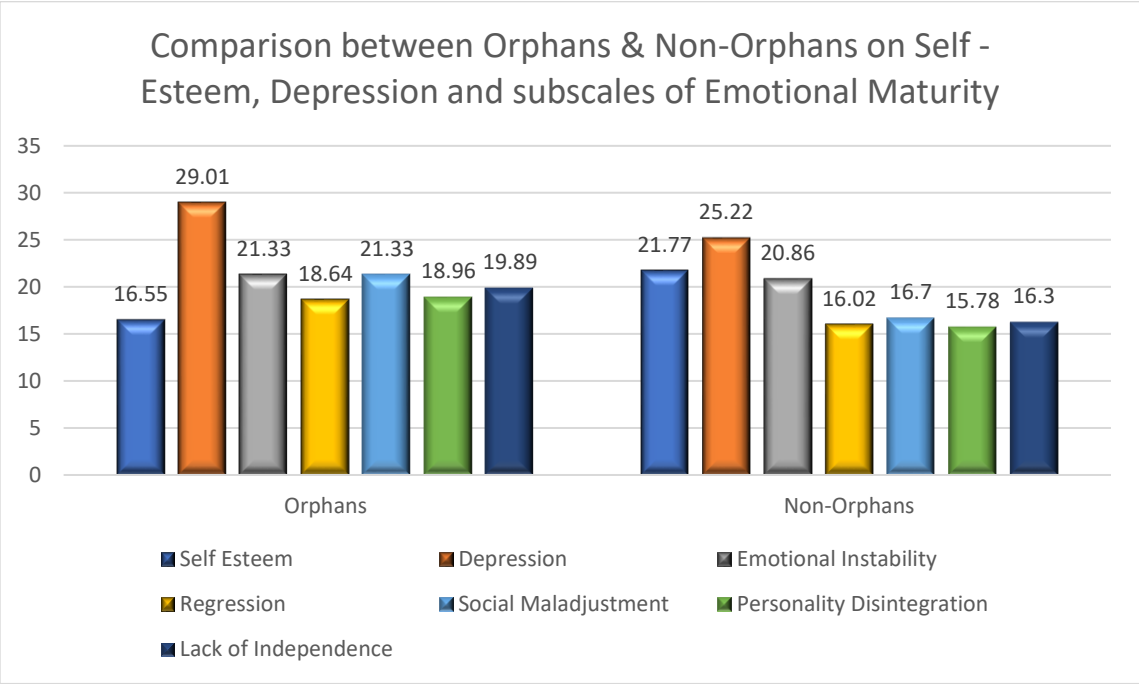
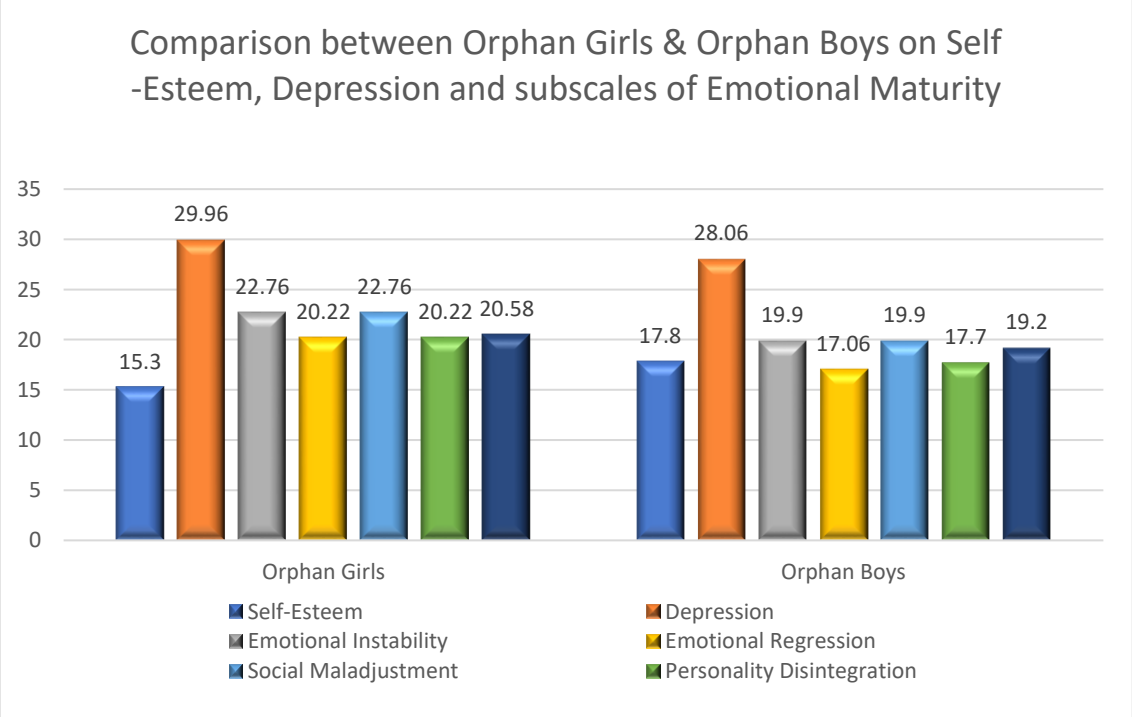


Figure-3: Showing the mean comparison between Orphan girls & Non-Orphan boys on Self -Esteem, Depression and subscales of Emotional Maturity



As indicated in Table-3, the Orphans girls obtained higher mean values than the other comparison groups in all the subscales of Emotional Maturity viz;Emotional Instability, Emotional Regression, Social Maladjustment, Personality Disintegration and Lack of Independence.Similar findings were observed in study done by Kumar,S and his colleagues (2015) where significant gender difference was also observed wherein orphan girls were significantly lower than the orphan boys on social adjustment.Jan Nuzhat (2013) also found female University distance learners have more emotional instability than Male University distance learners. The results of the current study conform with the study done by Krishna Duhan and his associates (2017) where they did a comparison of Male and Female Adolescents on Emotional Maturity and in that female adolescents were on higher side on emotional instability, social maladjustment and lack of independence as compared to their counterparts. Aleem Sheema (2005) also observed significant difference between the mean scores of male and female students on emotional stability.Reviews of a different line of research also indicated that male university distance learners have more emotional regression than female university distance learners (Jan Nuzhat,2013). Similar results were observed by Krishna Duhan and others (2017) where Emotional regression and personality disintegration was higher in males as compared to female adolescents asthey obtained higher mean scores than their counterparts.

Table no:4 indicated the results of the mean values calculated for the Revised Children Manifest Anxiety Scale. The orphans scored higher mean values than the non-orphans on the Oversensitivity/ WorryFactor(M=29.01; 25.22) and Social concerns/ Concentration factor(M=16.70). Among all the groups, orphan boys group showed higher mean values than the orphan girls on the Oversensitivity/ WorryFactor(M=29.96,28.06) and on the Social concerns/ Concentration factor(M=22.76,19.90). Whereas, orphan girls scored lower than the non- orphans on the Physiological factor (M=21.77; 16.55). In this factor, the orphan girls group scored higher mean value than the orphan boys (M=17.80, 15.30).The results of the study are in line with studies in the past by Thabet and colleagues (2007) high rates of Anxiety among orphans on health measures completed by the children and their main care-giver living in two orphanages in the Gaza Strip.

Study by Nagy Fawzy and AmiraFourad (2010) showed that rate of depression was 21%, anxiety was 45%, low self-esteem was 23% and development disorder was

61%. Likewise,Abdel Aziz Mousa Thabet., et al (2017) on orphan childrenshowed that 30.9% of children rated as anxiety cases. In rural Uganda when orphans were compared with non-orphans, results indicated that orphans have greater level of anxiety, depression and anger compared to non-orphans (Atwine,Cantor et a1.,2005).

Overall, boys scored higher mean than the girls on Oversensitivity/ WorryFactor (M=28.25; 25.98) and on the Social concerns/ Concentration factor(M=20.29; 17.74) and girls were found to have scored higher on Physiological factor than the boys with a mean value of (M=20.18; 18.14).In a previous study by Lowe and Reynolds (2005),examination of the mean levels of performance across gender indicates that college women report more anxiety than college men on all the anxiety scales, except one, the Social Concerns/Stress subscale. The results were found to be contradictory to one another. Hence, this needs to be further explored.

Table-4:Showing Mean comparison between groups on the subscales of Revised Children Manifest Anxiety.

Groups	**Children Manifest Anxiety**			
	Physiological Factor	Oversensitivity/ Worry Factor	SocialConcerns/Concentration Factor	Anxiety Total
Orphan Girls	17.80	28.06	19.90	21.92
Orphan Boys	15.30	29.96	22.76	22.67
Non-Orphan Girls	22.56	23.90	15.58	20.68
Non-Orphan Boys	20.98	26.54	17.82	21.78
Total Orphans	16.55	29.01	21.33	22.29
Total Non-Orphans	21.77	25.22	16.70	21.23
Total Girls	20.18	25.98	17.74	21.30
Total Boys	18.14	28.25	20.29	22.22

Figure-4: Showing the mean comparison between Orphans & Non-Orphans on the subscales of Revised Children Manifest Anxiety

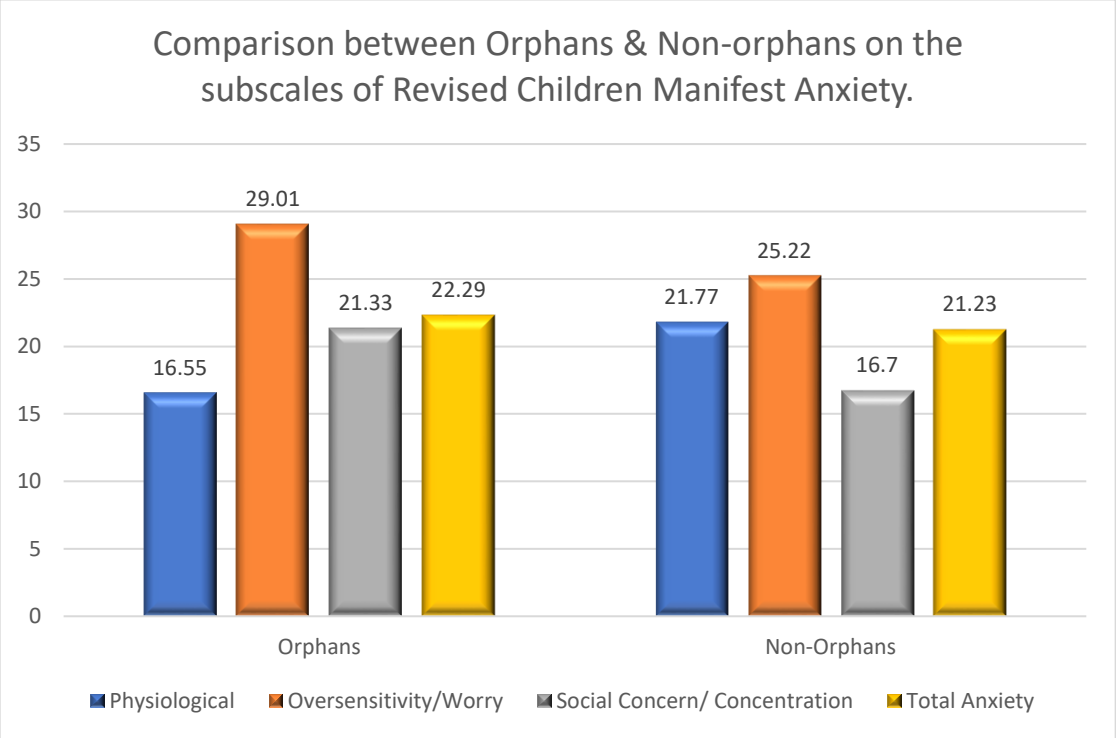


Figure-5: Showing the mean comparison between Orphan girls& Non-Orphan boys on the subscales of Revised Children Manifest Anxiety

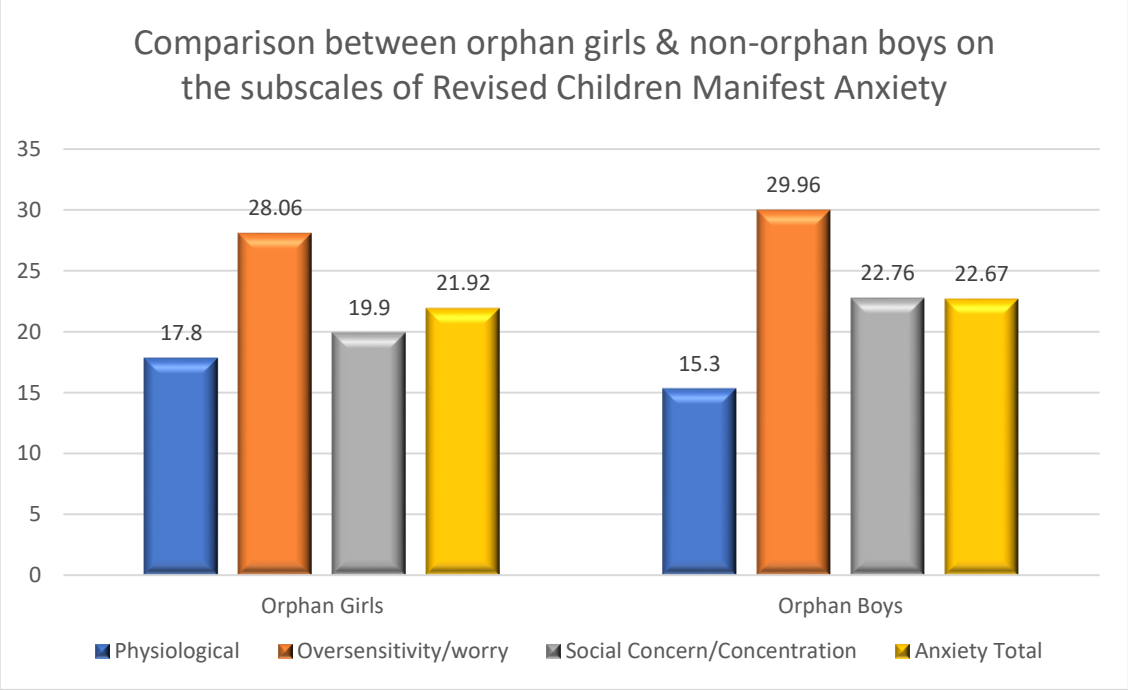


Table - 5 highlights the results of the mean values calculated for the subscales of Strengths and Difficulties subscales for the whole sample.The mean values on emotional problem subscale were higher among the orphans (M=18.64) than the non-orphans (M=16.02).Similarly, the Orphans group was observed to have higher mean value than the non-orphan group on the subscales of conduct problems (M=21.33; 16.70), hyperactivity (M=18.96; 15.78), prosocial behaviour (M=19.89; 16.30), externalizing (M=20.14; 16.24) and internalizing (M=19.26; 16.14) problems. However, peer problem was observed to be more among non-orphans than the orphans(M=16.27; 13.64). Among all the groups, orphan boys group showed higher mean values than the orphan girls on the emotional problem (M=20.22; 17.06), conduct problem(M=20.22; 17.06), hyperactivity (M=20.22; 17.06), peer problem(M=14.80; 12.48), prosocial (M=20.58; 19.20), externalizing (M=21.49; 18.80) and internalizing (M=17.51; 14.74) problems.

Overall, boys were found to have higher mean values than the girls on emotional problem (M=18.10; 16.56), conduct problems (M=20.29; 17.74), hyperactivity (M=18.18; 16.56), prosocial behaviour (M=19.02; 17.17), peer problem(M=15.74; 14.17), externalizing (M=19.23; 17.15) and internalizing (M=16.92; 16.56) problems. Previous studies found prosocial behaviour to be lower among orphans than the non-orphans, as orphans have lower expectations from behaviour of others and also contribute less to the public good.(Mc Cannon & Rodrigrez ,2019) (Kaur et.al 2017) in this study, Orphans group had lesser mean value in peer problem (M=16.30, 19.89) than the non orphans. This finding is contradictory to studies done by Lazzi and colleagues (1996) wherein they found 84% children had peer problem.

Makame,V, Ani,C, Grantham-McGregor,S, (2002) Orphans had markedly increased internalizing problems compared with non-orphans ($p < 0.01$) and 34% reported they had contemplated suicide in the past year. Another study by Boadu, S.O(2015) investigated behavioural and emotional problems among children and results from the quantitative data revealed that significant differences existed in terms of behavioural and emotional problems among children in orphanages. They also found a significant negative relationship between length of stay and behavioural and emotional problems. However, no difference was found between males and females in terms of emotional problems. This current study's results are supported by previous research conducted by Kaur R and colleagues(2018) on 292 orphans and vulnerable children in

institutional homes of Visakhapatnam city wherein, 49 (16.78%) out of 292 children and adolescents were found to be having behavioural and emotional problems. Factors such as age, sex, reason for being in the institute, age of admission, and years of stay in the home were all seen to be significantly associated ($P < 0.05$) with emotional and behavioural problems. Conduct problems (34.90%) were found to be most prevalent followed by peer problems (15.80%), emotional problems (14.70%), hyperactivity (8.60%), and low prosocial behaviour(3.40%).

Table-5: Showing Mean comparison between groups on the subscales of Strengths and Difficulties subscales for the whole sample.

Groups	Strengths and Difficulties Questionnaire						
	Emotional problem	**Conduct problems**	**Hyperactivity**	**Peer problem**	**Prosocial**	**Externalizing**	**Internalizing**
Orphan Girls	17.06	19.90	17.70	12.48	19.20	18.80	14.74
Orphan Boys	20.22	22.76	20.22	14.80	20.58	21.49	17.51
Non-Orphan Girls	16.06	15.58	15.42	15.86	15.14	15.5	15.96
Non-Orphan Boys	15.98	17.82	16.14	16.68	17.46	16.98	16.33
Total Orphans	18.64	21.33	18.96	13.64	19.89	20.14	19.26
Total Non-Orphans	16.02	16.70	15.78	16.27	16.30	16.24	16.14
Total Girls	16.56	17.74	16.56	14.17	17.17	17.15	16.56
Total Boys	18.10	20.29	18.18	15.74	19.02	19.23	16.92
Total	17.33	19.02	17.37	14.96	18.10	18.19	16.14

Figure-6: Showing the mean comparison between Orphans& Non-Orphanson the subscales of Strengths and Difficulties Questionnaire

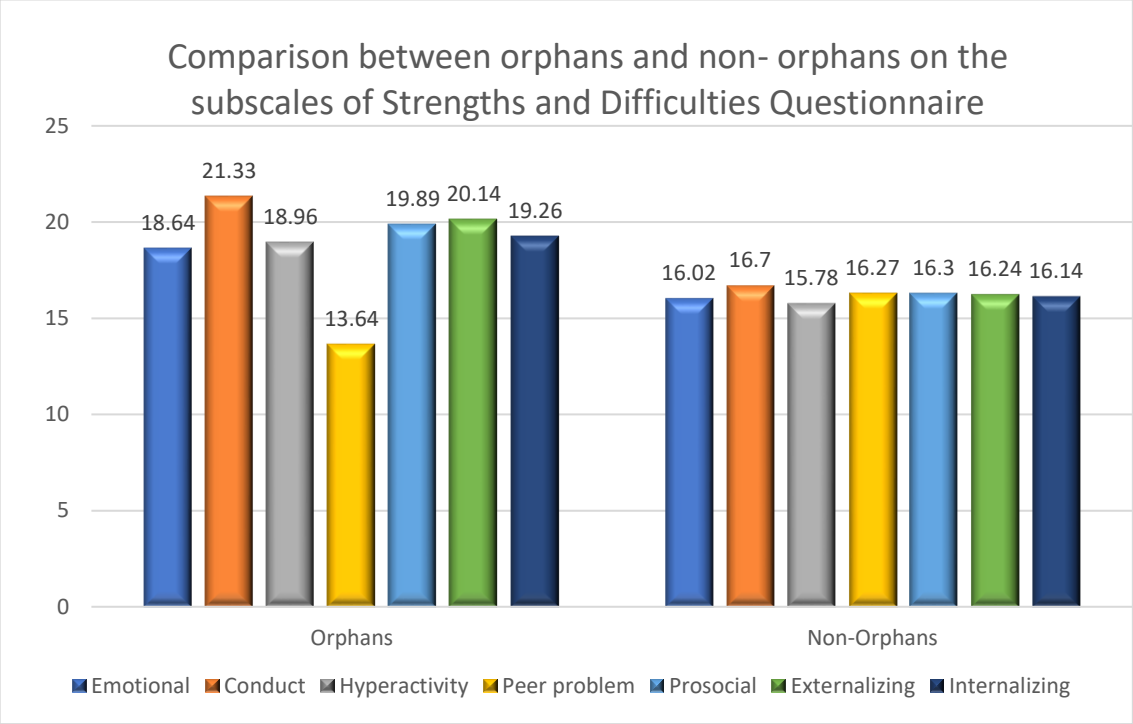
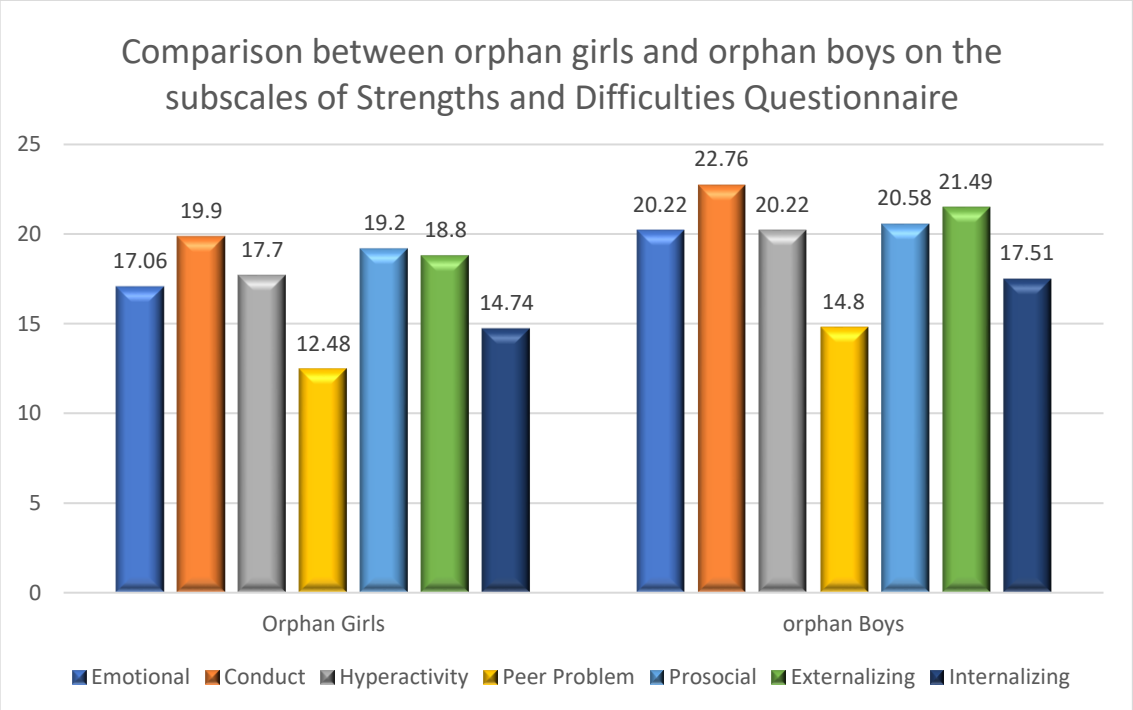


Figure-7: Showing the mean comparison between Orphan girls & Non-Orphanboyson the subscales of Strengths and Difficulties Questionnaire



Correlation Statistics:

The correlation matrix of the psychological variables of Self Esteem, Depression and subscales of Revised Children Manifest Anxiety Scale and Emotional Maturity Scale is presented in Table-6.The results (Table - 6) revealed thatSelf-esteem had significant negative correlation with Depression(r= -.46; p<.01)which means that as Self Esteem increased, Depressive symptoms decreases. This finding is well supported by Sowislo, J.F(2012) analyzed 77 studies on depression and self-esteemand it was found that decreases in self-esteem were predictive of increases in depression. It was also revealed that Self-esteem had significant negative correlation withEmotional Instability (r= -.43; p<.01), Emotional Regression (r=-.27; p<.01), Social Maladjustment(r=-.43; p<.01), Personality Disintegration (r= -.35; p<.01), Lack of Independence (r= -.38; p<.01).

Similarly, increase in Self Esteem will decrease the scores in the subscales of Emotional Maturity. Overall it means that Increase in Self Esteem will increase Emotional Maturity among the children. Leung, Jupian J.; Sand, Margaret C.(1981) also found that students high in self-esteem were found to be more emotionally mature than students low in self-esteem.These findings are in agreement with the findings ofDagenais, F. (1981) ,Zervas, L.J. and Sherman, M.F. (1994), who found that self-esteem score correlated with personality factors indicating positive relationship with emotional maturity, psychological adjustment and intellectual behaviour. Self Esteem is also found to have significant negative correlation with Anxiety subscales viz; Physiological Anxiety (r= -.34; p<.01), Oversensitivity/Worry (r= -.35; p<.0) and Social Concerns/Concentration(r= -.37; p<.01).As Self Esteem increased, anxiety will decrease. This is in line with other studies where Low self-esteem has also been associated with anxiety disorders and a number of other psychopathologies including mood disorders, personality disorders,schizophrenia, eating disorders, learning disorders, substance abuse and conduct disorders (O'Brien, Bartoletti&Leitzel, 2006).According to the results, Depression was positively corelated with Emotional Instability (r= .31; p<.01), Emotional Regression (r= 00.23; p<.01), Social Maladjustment(r=.31; p<.01), Personality Disintegration (r= .25; p<.01), Lack of Independence (r= .31; p<.01). Depression is also found to have significant positive

correlation with Anxiety subscales viz; Physiological Anxiety(r=-.34;p<.01), Oversensitivity/Worry (r=-.35;p<.01) and Social Concerns/Concentration (r= -.37; p<.01). This finding is supported by study done on orphans by Abdel Aziz Mousa Thabet., et al (2017) where the results showed that there was positive correlation with statistical significance between depression and anxiety, intrusion, and avoidance.

Emotional maturity subscale: emotional instability is found to have significant positive correlation with Anxiety subscales viz; Physiological Anxiety (r= .19; p<.01), Oversensitivity/Worry (r= .31; p<.01) and Social Concerns/ Concentration (r= .32; p<.01). Emotional regression has significant positive correlation withPhysiological Anxiety (r= .26; p<.01), Oversensitivity/Worry (r= .33; p<.01) and Social Concerns/ Concentration (r= .21; p<.01). Social Maladjustment have significant positive correlation withPhysiological Anxiety (r= .19; p<.01), Oversensitivity/Worry (r= .31; p<.01) and Social Concerns/ Concentration (r= .32; p<.01). The results also revealed that Personality Disintegration have significant positive correlation withPhysiological Anxiety (r= .25; p<.01), Oversensitivity/Worry (r= .36; p<.01) and Social Concerns/ Concentration (r= .21; p<.01). the subscale of lack pf independence was also seen to have positive correlation with Physiological Anxiety (r=.30; p<.01), Oversensitivity/Worry (r= .17; p<.01) and Social Concerns/ Concentration (r= .22; p<.01). Higher scores on the subscales of emotional maturity means lower Emotional Maturity. Hence, from these results it can be ascertained that as the level of Emotional Maturity increases anxiety level will decrease. Previous studies also found that emotional maturity correlates positively with optimism and negatively with anxiety and the optimism correlates negative with anxiety (Moldovan ,2017).

Table-6: Showing the relationship between Self-Esteem, Depression and subscales of Emotional Maturity for whole sample.

	Self Esteem	Depression	Emotional Instability	Emotional Regression	Social Maladjustment	Personality Disintegration	Lack of Independence	Physiological anxiety	Worry	Social concern
Self Esteem	1	-.46**	-.43**	-.27**	-.43**	-.35**	-.38**	-.34**	-.35**	-.37**
Depression		1	.31**	.23**	.31**	.25**	.31**	.31**	.33**	.34**
Emotional Instability			1	.15*	1.00**	.22**	.24**	.19**	.31**	.32**
Emotional Regression				1	.15*	.88**	.26**	.26**	.33**	.21**
Social Maladjustment					1	.22**	.24**	.19**	.31**	.32**
Personality Disintegration						1	.28**	.25**	.36**	.21**
Lack of Independence							1	.30**	.17*	.22**
Physiological Anxiety								1	.35**	.43**
Oversensitivity /Worry									1	.38**
Concentration										1

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Results in Table -7 indicates the correlation between the measures of Self-Esteem, Depression and subscales of Revised Children Manifest Anxiety Scale and Strengths and Difficulties Questionnaire. Self-Esteem has been found to have negative correlation with emotional problem (r=-.42, p<.01), conduct problem (r=-.47; p<.01), hyperactivity(r=-.45;p<.01),peer problem(r= -.47; p<.01) and internalizing problems (r=-.40,p<.01). Interestingly, Self-Esteem was found to have positive correlation with the Externalizing problems (r= .39,p<.01), this finding needs to be further explored. Findings of the current study supports previous studies that suggest that self-esteem in children with ADHD may vary with the subtype of ADHD. The inattentive type showed more internalizing behaviour and lower self-esteem, whereas the hyperactive type showed more externalizing behaviour and higher self-esteem (Graetz et al., 2001). Possible explanations for the exaggerated self-esteem seen in the hyperactive type may be that it serves as a self-protective function which makes the children able to cope with their frequent failure. However, it could also be a result of diminished self-awareness due to impairment in their executive functioning (Mash & Wolfe, 2010).

From the table Depression was observed to have significant positive correlation with emotional problem(r= .32; p<.01), conduct problem(r= .38; p<.01), hyperactivity (r= .38; p<.01),peer problem (r= .28; p<.01), prosocial behaviour (r= .14; p<.05) and internalizing behaviour ((r= .32; p<.01).Depression was found to have negative correlation with externalizing behaviour (r=-.34,p<.01). Similarly, Vinnakota,A& Kaur,

R (2017) in their study found externalizing and internalizing behaviours were positively correlated with depression while prosocial behaviour was negatively correlated with depression. They found Depression has high prevalence in institutionalized adolescent and those adolescents who show signs of externalizing or internalizing behaviours should be especially screened for depression.

The analysis revealed that the subscales of Anxiety: Physiological anxiety, Oversensitivity/worry and Social concerns/Concentration are positively corelated with each other (r= .35, .43, .38; p<.01). The externalizing subscale is found to have significant negative correlation with the Internalizing subscale (r= -.28; p<.01) of the Strengths and Difficulties Questionnaire.Supportive finding was observed in an endeavor by Tahir,M.A&Faiz, H(2014) where a significant inverse relationship was seen between internalizing behaviour problems, externalizing behaviour problems, and secure attachment style among children. This finding is contradictory to several studies with non-clinical samples which showed a positive relationship between internalizing and externalizing problems. For example, in a study of 4th graders Cole and Carpentieri(1990) found correlations from .40 to .73 between conduct problems and depressive symptoms as measured by self-report, peer and teacher reports.Other correlations between externalizing and internalizing symptoms were also found by Bornstein, Hahn, and Haynes(2010).From the results table it is also seen that only the Externalizing subscale of the Strengths and Difficulties Questionnairehavea significant negative relationship with all the Anxiety subscales; Physiological anxiety(r=-.31;p<.01), Oversensitivity/worry(r=-.41;p<.01) and Social concerns/Concentration(r= -.35; p<.01). Similarly, Externalizing subscale has significant negative correlation (r values as indicated in the table) with other subscales of Strengths and Difficulties Questionnaire viz emotional problem, conduct problem, prosocial, peer problem, hyperactivity and internalizing problem at p<.01. Similar result was observed in another study where children who were low in prosocial behaviour had significantly more internalizing and externalizing problems at school entry if they lived in disadvantaged neighborhoods. (Flouri, E &Sarmadi, Z;2016).

Table-7: Showing the relationship between Self Esteem, Depression and the subscales of Manifest Anxiety and Strengths and Difficulties Questionnaire for whole sample.

			Manifest Anxiety					Strengths and Difficulties				
	Self Esteem	Depression	Physiological anxiety	Worry	Social concern	Emotional Problem	Conduct problem	Hyper activity	Peer problem	Prosocial	Externalizing	Internalizing
Self Esteem	1	-.46**	-.34**	.35**	-.37**	-.42**	-.47**	-.45**	-.47**	-.11	.39**	-.40**
Depression		1	.31**	.33**	.34**	.32**	.38**	.38**	.39**	.14*	-.34**	.32**
Physiological anxiety			1	.35**	.43**	.32**	.32**	.31**	.31**	.11	-.31**	.34**
Worry				1	.38**	.33**	.30**	.30**	.28**	.16*	-.41**	.25**
Social concern					1	.41**	.42**	.40**	.41**	.18**	-.35**	.35**
Emotional Problem						1	.88**	.83**	.79**	.20**	-.35**	.26**
Conduct problems							1	.95**	.91**	.16*	-.34**	.28**
Hyperactivity								1	.96**	.17*	-.36**	.27**
Peer problem									1	.19**	-.37**	.26**
Prosocial										1	-.25**	.09
Externalizing											1	-.28**
Internalizing												1

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Results from Table - 8 depicted the correlation between the subscales of emotional maturity and the strengths and difficulties questionnaire. Here it is revealed that, Emotional Instability have positive correlation with emotional problem (r=.30, p<.01), conduct problem (r=.30; p<.01), hyperactivity(r=.27;p<.01),peer problem(r= .31; p<.01) and internalizing problems (r=.42,p<.01). which implies that as emotional instability increases, emotional problem, per problem, conduct problem, hyperactivity and internalizing problems will also increase. But it was seen to have negative correlation with externalizing behaviour (r=-.39;p<.01). On the subscale of emotional regression positive correlation with emotional problem (r=.28, p<.01), conduct problem (r=.28; p<.01), hyperactivity (r=.27;p<.01),peer problem(r= .28; p<.01) and internalizing problems (r=.22,p<.01) was found. But a negative correlation was found with externalizing behaviour(r=-.20;p<.01). Social maladjustment had significant positive correlation with emotional problem (r=.30, p<.01), conduct problem (r=.32; p<.01), hyperactivity (r=.27;p<.01),peer problem(r= .31; p<.01) and internalizing problems (r=.43,p<.01).). Similarly, Personality Disintegration have significant positive correlation with emotional problem (r=.31, p<.01), conduct problem (r=.31; p<.01), hyperactivity (r=.33;p<.01),peer problem(r= 34.; p<.01) and internalizing problems (r=.28,p<.01). Lack of independence also have positive correlation with

emotional problem (r=.26, p<.01), conduct problem (r=.31; p<.01), hyperactivity (r=.31; p<.01), peer problem (r= 32.; p<.01) and internalizing problems (r=.26, p<.01). From the results externalizing problem is found to have negative correlation with all other subscales of emotional maturity. Prosocial subscale did not have any significant relationship with any other subscales of Emotional Maturity.

Table-8: Showing the relationship between the subscales of Emotional Maturity and Strengths and Difficulties Questionnaire for whole sample.

hi	Emotional Maturity					Strengths and Difficulties						
	Emotional Instability	Emotional Regression	Social Maladjustment	Personality Disintegration	Lack of independence	Emotional Problem	Conduct problem	Hyperactivity	Peer problem	Prosocial	externalizing	Internalizing
Emotional Instability	1	.15*	1.00**	.22**	.24**	.30**	.30**	.27**	.31**	.11	-.39**	.42**
Emotional Regression		1	.15*	.88**	.26**	.28**	.28**	.27**	.28**	.05	-.20**	.22**
Scial Maladjustment			1	.20**	.25**	.30**	.32**	.27**	.31**	.11	-.39**	.43**
Personality Disintegration				1	.28**	.31**	.31**	.33**	.34**	.06	-.29**	.28**
Lack of independence					1	.26**	.31**	.31**	.32**	.12	-.28**	.26**
Emotional Problem						1	.88**	.83**	.79**	.20**	-.35**	.26**
Conduct problems							1	.95**	.91**	.16*	-.34**	.28**
Hyperactivity								1	.96**	.17*	-.36**	.27**
Peer problem									1	.19**	-.37**	.26**
Prosocial										1	-.25**	.09
externalizing											1	-.28**
Internalizing												1

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Prediction of the effect of independent variables:

Analysis of Variance (ANOVA) to illustrate the independent effect of two independent variables (Orphanage & Gender) on dependent variables (Self-Esteem, Depression, Anxiety, subscales of Emotional Maturity and subscales of the Strengths & Difficulties Questionnaire) and also interaction effects(Orphanage X Gender) on dependent variables under study. Two-way ANOVA was computed and the findings are presented under Table-9**.**

The ANOVA results in Table-9 showed significant independent effect of Orphanage on Self-Esteem with 43% effect (F=149.50; p< .01, η^2=.43). Several previous studies supported the study findings of the current study that self-esteem was lower among the children living in orphanages as comparedto those who are living with

both parents (Siyad.B.R. & Muneer.P;2016) (Mashkoor, A.L & Ganesan, P; 2017) (Jain, V & Prapsi, A;2018) (Kannan,R;2016). Similarly, **s**ignificant independent effect of Orphanage was found on Depression with 27% ($F=75.47$; $p<.01$, $\eta^2=.27$). Supporting findings were observed by studies done by Bhatt, N.M, (2014), Atwine, Cantor et a1.(2005) , Makameet.al (2002).

Significant independent effect of Orphanage was also found on subscales of Emotional Maturity viz; Emotional Instability with 28% ($F=77.14$; $p<.01$, $\eta^2=.27$) , Emotional Regression with11% ($F=25.46$; $p<.01$, $\eta^2=.11$), Social Maladjustment with 28% ($F=77.14$; $p<.01$, $\eta^2=.27$), Personality Disintegration with 14% ($F=40.29$; $p<.01$, $\eta^2=.14$), and Lack of Independence with 18% ($F=44.85$; $p<.01$, $\eta^2=.18$). This result is in agreement with the various studies done by Chaudhar& Bajaj(1993)Upreti,R& Sharma, S(2018); andKumbhar,S, Krishnan,B,Sokhi,R.K.,Hussain,A.(2016). Here independent effect of Orphanage was also found with the subscales of Anxiety: Physiological Anxiety with 17% ($F=41.95$; $p<.01$, $\eta^2=.17$), Oversensitivity/Worry with 20% (49.48; $p<.01$, $\eta^2=.20$) and Social Concerns/ Concentration with 18%($F=43.21$; $p<.01$,$\eta^2=.18$). Supporting findings were observed by studies done by Makame and others (2002) , also by Atwine, Cantor et a1.(2005).

Results also depicted the significant independent effect of Gender on Self-Esteem with 6% effect ($F=13.92$; $p< .01$, $\eta^2=.06$). This finding is supported by Wanjiru,M and Gathogo, J(2014) where they observed that Self-esteem was found to be influenced by gender of orphans and the self-esteem in turn influenced the aspiration of education level as well as jobs. The study recommends that the socialization by the society should not be gender discriminative that is all children should be treated the same way. Similar results were seen in study by Amongin H.C,OonyuJ.C,BagumaP.K and Kitara D.L (2012). Other line of studies contradicted the results and suggested no significant gender difference in self-esteem of the orphans and the children living with their parents**. (**Mashkoor, A.L&Ganesan,P; 2017) (Farooqi and Inteza;2009).

Significant independent effect of Gender on Depression with 9% ($F=21.76$; $p<.01$, $\eta^2=.09$). Ramagopal,G, Narasimhan,S, Devi,L.U (2016) also found similar line of results.Gender also had significant independent effect on subscales of Emotional Maturity viz; Emotional Instability with 8% ($F=18.40$; $p<.01$, $\eta^2=.8$) , Emotional

Regression with 4% (F=8.11; p<.01, η^2=.11), Social Maladjustment with 8% (F=18.40; p<.01, η^2=.08) , Personality Disintegration with 4% (F=9.09; p<.01, η^2=.04), Lack of Independence with 5% (F=10.65; p<.01, η^2=.05). In support to these findings are few studies done by Kumar,S and his colleagues (2015) ,Jan Nuzhat (2013), Aleem and Sheema (2005), Rajakumar and Soundararajan (2012). Another study by Kaur (2006) and Krishna Duhan& his associates(2017) contradicts the current study findings and revealed that there were no significant differences in emotional maturity of adolescents as per their gender.

Here independent effect of gender was also found with the subscales of Anxiety: Physiological Anxiety with 5% (F=10.65; p<.01, η^2=.5), Oversensitivity/Worry with 6% (F=13.20; p<.01, η^2=.06) and Social Concerns/ Concentration with 7%(F=15.90; p<.01, η^2=.7). Hosseini, L &Khazali, H(2013) also revealed similar line of results where female students scored higher in the subscales of physiological anxiety and worry than male students. In the same way, in the subscale of concentration, no significant difference was observed between girls and boys. Still, based on the overall score of anxiety, a significant difference was observed between girls and boys. Study by Lowe and Reynolds (2005) also found gender differences,that college women report more anxiety than college men on all the anxiety scales, except one, the Social Concerns/Stress subscale.The significant Interaction effect of 'Orphanage and Gender' was also found on Self-Esteem with 49% (F=65.14; p<.01, η^2=.49), Depression with 37% (F=39.64; p<.01, η^2=.37) and subscales of Emotional Maturity viz; Emotional Instability with 36% (F=37.83; p<.01, η^2=.36) , Emotional Regression with 19% (F=16.02; p<.01, η^2=.19), Social Maladjustment with 36% (F=37.83; p<.01, η^2=.36) , Personality Disintegration with 23% (F=19.13; p<.01, η^2=.23), Lack of Independence with 24% (F=20.28; p<.01, η^2=.24). Here interaction effect of 'Orphanage and Gender' was also found with the subscales of Anxiety: Physiological Anxiety with 22% (F=19.07; p<.01, η^2=.22), Oversensitivity/Worry with 27% (F=24.14; p<.01, η^2=.27) and Social Concerns/ Concentration with 28%(F=25.88; p<.01, η^2=.28).

Table-9: Showing the independent and interaction effect of orphanage and gender on Self-Esteem, Depression, Emotional Maturity and Manifest Anxiety for the whole samples.

Dependent Variable	Independent Variable	F	Sig.	Eta sq.
Self-esteem	Orphanage	149.50	0.00**	.43
	Gender	13.92	0.00**	.06
	Orphanage x gender	65.14	0.00**	.49
Depression	Orphanage	75.47	0.00**	.27
	Gender	21.76	0.00**	.09
	Orphanage x gender	39.64	0.00**	.37
Instability	Orphanage	77.14	0.00**	.28
	Gender	18.40	0.00**	.08
	Orphanage x gender	37.83	0.00**	.36
Regression	Orphanage	25.46	0.00**	.11
	Gender	8.11	0.00**	.04
	Orphanage x gender	16.02	0.00**	.19
Social maladjustment	Orphanage	77.14	0.00**	.28
	Gender	18.40	0.00**	.08
	Orphanage x gender	37.83	0.00**	.36
Disintegration	Orphanage	40.29	0.00**	.14
	Gender	9.09	0.00**	.04
	Orphanage x gender	19.13	0.00**	.23
Lack of independence	Orphanage	44.85	0.00**	.18
	Gender	10.21	0.00**	.05
	Orphanage x gender	20.28	0.00**	.24
Physiological Anxiety	Orphanage	41.95	0.00**	.17
	Gender	10.65	0.00**	.05
	Orphanage x gender	19.07	0.00**	.22
Oversensitivity/ Worry	Orphanage	49.48	0.00**	.20
	Gender	13.20	0.00**	.06
	Orphanage x gender	24.14	0.00**	.27
Social concerns/ Concentration	Orphanage	43.21	0.00**	.18
	Gender	15.90	0.00**	.07
	Orphanage x gender	25.88	0.00**	.28

**. Mean differenceis significant at the 0.01 level

The ANOVA results in Table-10 highlighted significant independent effect of Orphanage on subscales of Strengths and Difficulties Questionnaire viz; Emotional Problems with 27% ($F=73.62$; $p<.01$, $\eta^2=.27$) , Conduct Problems with 33% ($F=96.15$; $p<.01$, $\eta^2=.33$), Hyperactivity with 28% ($F=78.11$; $p<.01$, $\eta^2=.28$), Peer Problems with 26% ($F=71.13$; $p<.01$, $\eta^2=.26$),Externalizing with 19% ($F=47.58$; $p<.01$, $\eta^2=.19$) and Internalizing with 35% ($F=106.42$; $p<.01$, $\eta^2=.35$). Orphanage did not have any significant effect on prosocial behaviour.(Makame, V, Ani,C, Grantham-McGregor,S, (2002) also found similar trend of results in their study.

Significant independent effect of Gender on subscales of Strengths and Difficulties Questionnaire viz; Emotional Problems with 6% ($F=14.52$; $p<.01$, $\eta^2=.6$) , Conduct Problems with 4% ($F=9.21$; $p<.01$, $\eta^2=.4$), Hyperactivity with 7% ($F=14.26$;

p<.01, η^2=.7), Peer Problems with 13% (F=28.66; p<.01, η^2=.13) except for Internalizingbehaviours was found in the current study.Past studies by Kaur, R, Vinnakota, A, panigrahi, S &Manasa, R.V (2018)Makame, V, Ani,C, Grantham-McGregor,S, (2002) supported the current study findings. Kaur R and colleagues(2018) conducted a study and found similar line of results where factors such as age, sex, reason for being in the institute, age of admission, and years of stay in the home were all seen to be significantly associated with emotional and behavioural problems.

The significant Interaction effect of 'Orphanage and Gender' was also found on subscales of Strengths and Difficulties Questionnaire viz; Emotional Problems with 34% (F=33.91; p<.01, η^2=.34) , Conduct Problems with 37% (F=39.41; p<.01, η^2=.37), Hyperactivity with 36% (F=37.36; p<.01, η^2=.07), Peer Problems with 38% (F=40.04 p<.01, η^2=.38),Prosocial with 19% (F=11.01; p<.01, η^2=.19), Externalizing with 49% (F=63.48; p<.01, η^2=.49) and Internalizing with 36% (F=38.13; p<.01, η^2=.36).

Table-10: Showing the independent and interaction effect (ANOVA) of orphanage and gender on subscales of strengths and difficulties for the whole samples.

Dependent Variable	Independent Variable	F	Sig.	Eta Sq
Emotional Problem	**Orphanage**	73.62	0.00**	.27
	Gender	14.52	0.00**	.06
	Orphanage x gender	33.91	0.00**	.34
Conduct Problem	**Orphanage**	96.15	0.00**	.33
	Gender	9.21	0.00**	.04
	Orphanage x gender	39.41	0.00**	.37
Hyperactivity	**Orphanage**	78.11	0.00**	.28
	Gender	14.26	0.00**	.07
	Orphanage x gender	37.36	0.00**	.36
Peer Problem	**Orphanage**	71.13	0.00**	.26
	Gender	20.59	0.00**	.09
	Orphanage x gender	40.04	0.00**	.38
Prosocial	**Orphanage**	1.78	0.18	.04
	Gender	28.66	0.00**	.13
	Orphanage x gender	11.01	0.00**	.14
Externalizing	**Orphanage**	47.58	0.00**	.19
	Gender	79.80	0.00**	.28
	Orphanage x gender	63.48	0.00**	.49
Internalizing	**Orphanage**	106.42	0.00**	.35
	Gender	3.38	0.07	.02
	Orphanage x gender	38.13	0.00**	.36

**. Mean difference is significant at the 0.01 level

As indicated in Table:11,the post-hoc comparisons showed the significant difference between groups on self-esteem that orphan girls had a significant difference with non-orphan girls(-4.76; p< .01), and non-orphan boys at (-7.26; p< .01) on self-esteem. Wanjiru,M and Gathogo, J(2014), AmonginH.C,OonyuJ.C,BagumaP.K and Kitara D.L (2012) also found similar results in separate studies.No significant difference was found between orphan girls and boys. This is in contradiction with previous study by Safdar,S(2018) which showed that there is significant difference in childhood depression and self-esteem among orphan boy and girls. In the current studyorphan boys had a significant difference with non-orphan girls at (-3.18; p<.01) and non-orphan boys at (-5.60; p<.01) on self-esteem. Similar difference among non-orphans and orphans was revealed in study by Asif,A(2017). Non-orphan girls group had significant difference with non-orphan boysgroup at (-2.50; p<.01) on Self Esteem.

Similarly, for Depression significant difference between groups was found wherein orphan girls had a significant difference with orphan boys (2.64; p< .01), non-orphan girls(4.16; p< .01), and non-orphan boys at (6.06; p< .01). Safdar,S (2018) study also showed that there is significant difference in childhood depression among orphan boys and girls. Orphan boys had a significant difference with non-orphan girls at (1.52; p<.01) and non-orphan boys at (3.42; p<.01) on Depression. Non-orphan girls group had significant difference with non-orphan boys group at (1.90; p<.01) on Depression. Contradictory results were seen in study done by Thabet and colleagues (2007) found no significant gender differences on any of the mental health measures like depression, anxiety, PTSD.

From table no:11, on the subscale of Emotional Instability, Orphan girls had a significant difference with orphan boys (2.24; p<.01), non-orphan girls at (4.32; p<.01) and non-orphan boys at(-7.18; p<.01) . Orphan boys had a significant difference with non-orphan girls at (2.08; p<.01) and non-orphan boys at (-4.94; p<.01) on Emotional Instability. Non-orphan girls group had significant difference with non-orphan boys' group at (-2.86; p<.01) on Emotional Instability as well. On Emotional Regression, Orphan girls had a significant difference with non-orphan boys at (4.16; p<.01). Orphan boys had a significant difference with non-orphan boys at (4.24; p<.01). Non-orphan girls group also had significant difference with non-orphan boys' group at (-3.16; p<.01). Orphan boys did not have any significant difference from orphan girls and non-orphan girls in emotional regression.

Orphan girls on Social Maladjustment had a significant difference with orphan boys (2.24; p<.01), non-orphan girls at (4.32; p<.01) and non-orphan boys at(7.18; p<.01). Orphan boys had a significant difference with non-orphan girls at (2.08; p<.01) and non-orphan boys at (4.94; p<.01). Non-orphan girls group had significant difference with non-orphan boys' group at (2.86; p<.01) as well.On the subscale Personality Disintegration orphan girls had a significant difference with orphan boys (7.20; p<.01),non-orphan girls at (4.06; p<.01) and non-orphan boys at(5.44; p<.01). Orphan boys had a significant difference with non-orphan boys at (3.12; p<.01). Non-orphan girls didn't have any significant difference with non-orphan boys on Personality Disintegration.Aleem and Sheema (2005) have found that there is a significant difference between the mean scores of male and female students on emotional stability. Female students are less emotionally stable as compared to male students. Subbarayan&Visvanathan (2011) concluded that the sex, community and the family type they belong did not play any role in the emotional maturity of the college students. Rajakumar and. Soundararajan (2012) found significant differences between male and female`s emotional maturity score. Kaur (2006) revealed insignificant difference on emotional maturity between boys and girls. Whereas, Krishna Duhan and his associates(2017) revealed that there were no significant differences in emotional maturity among Male and Female Adolescents on Emotional Maturity.

Table:12 highlights the post-hoc comparisons between the four groups. The results showed the significant difference between groups on Physiological Anxiety and in that orphan girls had a significant difference with non-orphan boys at (-1.70; p< .01). No significant difference was found between orphan girls and boys and also between non-orphan girls and boys in the experience of physiological anxiety. But Orphan boys had a significant difference with non-orphan boys at (-1.78; p<.01).

Similarly, on Oversensitivity /worry significant difference between groups was found wherein orphan girls had a significant difference with non-orphan girls(1.98; p< .01), and non-orphan boys at (3.82; p< .01). Orphan boys had a significant difference with non-orphan boys at (2.92; p<.01). Non-orphan girls group had significant difference with non-orphan boys group at (-1.84; p<.01).

On Social concerns/concentration anxiety, significant difference between groups was found wherein orphan girls had a significant difference with non-orphan girls(0.96;

p< .01), and non-orphan boys at (2.68; p< .01). Orphan boys had a significant difference with non-orphan boys at (2.30; p<.01). Non-orphan girls group had significant difference with non-orphan boys group at (-1.72; p<.01). Atwine, Cantor et a1.(2005) also found similar significant difference among the orphans and the non-orphans on the level of anxiety. Hosseini, L &Khazali, H(2013) also found significant difference among the boys and girls on the level of anxiety.

Table-11: Significant Mean groups difference between Self-Esteem, Depression and subscales of Emotional Maturity for whole samples (post hoc mean comparision: Scheffe).

	Orphan girls	Orphan boys	Non orphan girls	Non orphan boys
		Self Esteem		
Orphan girls	1	-1.58	-4.76*	-7.26*
Orphan boys		1	-3.18*	-5.60*
Non orphan girls			1	-2.50*
Non orphan boys				1
		Depression		
Orphan girls	1	2.64*	4.16*	6.06*
Orphan boys		1	1.52*	3.42*
Non orphan girls			1	1.90*
Non orphan boys				1
		Emotional Instability		
Orphan girls	1	2.24*	4.32*	-7.18*
Orphan boys		1	2.08*	-4.94*
Non orphan girls			1	-2.86*
Non orphan boys				1
		Emotional Regression		
Orphan girls	1	0.08	1.00	4.16*
Orphan boys		1	1.08	4.24*
Non orphan girls			1	3.16*
Non orphan boys				1
		Social Maladjustment		
Orphan girls	1	2.24*	4.32*	7.18*
Orphan boys		1	2.08*	4.94*
Non orphan girls			1	2.86*
Non orphan boys				1
		Personality Disintegration		
Orphan girls	1	7.20	2.28*	4.80*
Orphan boys		1	1.56	4.08*
Non orphan girls			1	2.52*
Non orphan boys				1
		Lack of Independence		
Orphan girls	1	2.32*	4.06*	5.44*
Orphan boys		1	1.74	3.12*
Non orphan girls			1	1.38
Non orphan boys				1

*. Mean difference is significant at the 0.05 level

Similarly results from Strengths and Difficulties Questionnaire showed that on Emotional Problems subscale, Orphan girls had a significant difference with orphan boys (-1.48; p<.01),non-orphan girls at (2.72; p<.01) and non-orphan boys at(3.74; p<.01). Orphan boys had a significant difference with non-orphan girls at (1.24; p<.01) and non-orphan boys at (2.26; p<.01). Non-orphan girls group did not have any significant difference with non-orphan boys group. On Conduct problems, Orphan girls had a significant difference with orphan boys (-1.48; p<.01)non-orphan girls at (3.38; p<.01) and non-orphan boys at (4.12; p<.01). Orphan boys had a significant difference with non-orphan girls at (1.90; p<.01) and non-orphan boys at (2.64; p<.01). Non-orphan girls group also had significant difference with non-orphan boys group at (3.16; p<.01). In Conduct problem non-orphan girls group did not have any significant difference with non-orphan boys group.

On Hyperactivity, orphan girls had a significant difference with orphan boys (-1.96; p<.01) non-orphan girls at (3.38; p<.01)and non-orphan boys at(4.12;p<.01) . Orphan boys had a significant difference with non-orphan girls at (1.42 p<.01) and non-orphan boys at (2.16; p<.01). Likewise, on Peer Problem orphan girls had a significant difference with orphan boys (-2.32; p<.01) non-orphan girls at (3.38; p<.01) and non-orphan boysat(4.20;p<.01) . Orphan boys had a significant difference with non-orphan girls at (1.88 p<.01).

Orphan girls had a significant difference with orphan boys (-0.62; p<.01) on Prosocial subscale. Similar difference was observed with non-orphan boys group at non-orphan girls at (0.62; p<.01). Difference was found to be insignificant between other groups.

In Externalizing score which was computed, it was found that, orphan girls had a significant difference with orphan boys (-3.30; p<.01), non-orphan girls at (2.56 p<.01) and non-orphan boys at(7.54;p<.01) . Orphan boys had a significant difference with non-orphan boys at (4.24; p<.01) on the Externalizing behaviours. Significant difference was found between non- orphan girls and non-orphan boys at(-4.98;p<.01) on this subscale. Kaur R and colleagues(2018) conducted a study and found similar line of results where factors such as age, sex, reason for being in the institute, age of admission, and years of stay in the home were all seen to be significantly associated with emotional and behavioural problems.

Lastly on the internalizing behaviours, Orphan girls had a significant difference with,non-orphan girls at (4.28; p<.01) and non-orphan boysat (4.84; p<.01) . Orphan boys had a significant difference with non-orphan girls at (3.10; p<.01) and non-orphan boys at (3.66; p<.01). Supporting findings were seen in study by Makame, V, Ani,C, Grantham,S, (2002) wherein orphans had markedly increasedinternalizing problems compared with non-orphans (p < 0.01) and 34% reportedthey had contemplated suicide in the past year and multiple regression analysis indicatedthat the independent predictors of internalizing problem scores were sex (femaleshigher than males).Makame et.al (2002) found similar trend of findings.

Table-12: Significant Mean difference (post hoc mean comparison: Scheffe) between groups on subscales of Revised Children Manifest Anxiety Scale and Strengths and Difficulties Questionnaire.

	Orphan girls	Orphan boys	Non orphan girls	Non orphan boys
Physiological Anxiety				
Orphan girls	1	0.90	-1.70*	-2.68*
Orphan boys		1	-0.80	-1.78*
Non orphan girls			1	0.98
Non orphan boys				1
Oversensitivity/Worry				
Orphan girls	1	-0.90	1.98*	3.82*
Orphan boys		1	.08	2.92*
Non orphan girls			1	-1.84*
Non orphan boys				1
Social Concern/ Concentration				
Orphan girls	1	-0.38	0.96*	2.68*
Orphan boys		1	.58	2.30*
Non orphan girls			1	-1.72*
Non orphan boys				1
Emotional Problem				
Orphan girls	1	-1.48*	2.72*	3.74*
Orphan boys		1	1.24*	2.26*
Non orphan girls			1	-1.02
Non orphan boys				1
Conduct Problem				
Orphan girls	1	-1.48*	3.38*	4.12*
Orphan boys		1	1.90*	2.64*
Non orphan girls			1	-0.74
Non orphan boys				1
Hyperactivity				
Orphan girls	1	-1.96*	3.38*	4.12*
Orphan boys		1	1.42*	2.16*
Non orphan girls			1	-0.74
Non orphan boys				1
Peer Problem				
Orphan girls	1	-2.32*	3.38*	4.20*
Orphan boys		1	1.06	1.88*
Non orphan girls			1	-0.82
Non orphan boys				1
Prosocial				
Orphan girls	1	-0.62*	0.26	0.62*
Orphan boys		1	0.36	0.00
Non orphan girls			1	-0.36
Non orphan boys				1
Externalizing				
Orphan girls	1	-3.30*	2.56*	7.54*
Orphan boys		1	0.74	4.24*
Non orphan girls			1	-4.98*
Non orphan boys				1
Internalizing				
Orphan girls	1	-1.18	4.28*	4.84*
Orphan boys		1	3.10*	3.66*
Non orphan girls			1	0.56
Non orphan boys				1

*. Mean difference is significant at the 0.05 level

The overview of the results:

To meet the objectives of the study, the hypotheses were set forth. Overview of the results of the study confirmed those hypotheses which can be summarized as follow:

Hypothesis -1*: It is expected that the selected Psychological measures would find applicability in the selected population as it is going to be one of the few endeavors in the selected population.*

The psychological test used in the present study were standardized but constructed for other culture. The preliminary analyses of the psychometric properties of the behavioural measures were computed as it was felt necessary that scale constructed and validated for measurement of the theoretical construct in a given population when taken to another cultural milieu may not be treated as reliable and valid unless specific checks are made (Witkin& Berry, 1975). The reliability and predictive validity of the scales and sub-scales were ascertained to ensure the psychometric adequacy of the scales used for the study. Internal consistency reliability was estimated for each of the scales used in the study using Cronbach's coefficient alpha (Cronbach, 1951). As per the results in Table- 1, it revealed the reliability of Self-Esteem (α=.79), Depression (α=.58) and subscales of Emotional Maturity Scale that Emotional Instability (α=.71); Emotional Regression (α=.65); Social Maladjustment(α= .72); Personality Disintegration (α=.64) and Lack of Independence (α= .78). Similarly, the results in Table- 2 revealed that the reliability of subscales of Revised Children Manifest Anxiety Scale (Physiological Anxiety - α=.51; Oversensitivity/Worry- α=.73; Social Concerns/Concentration - α=.63) and subscales of Strengths and Difficulties Questionnaire (Emotional Problems- α=.74; Conduct Problems-α=.79; Hyperactivity - α= .78; Peer Problem - α=.77, Prosocial - α= .57; Externalizing - α= .78 and Internalizing - α= .67). The total coefficient of correlation of the subjects emerged to be satisfactory over the levels of analysis for the whole sample, which indicating the trustworthiness of the scales such as Self Esteem, Children Depression and emotional Maturity. The Reliability test of Cronbach Alpha shows reliability scores all falling above .50 showing the reliability and the validly proved the trustworthiness of the selected psychological scale for the present population under study. Brown-Forsythe Test of Homogeneity of Variances and Levene's Test were used. From the test it was

ascertained that there is homogeneity of the variance within the whole sample. Thus, we accept hypthesis1of the current study.

Hypothesis -2*: It is expected that there will be significant differences between the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems of the selected sample.*

Descriptive statistics post hoc means comparisionswere computed to excavate any significant difference present in dependent variables in relation to the groups. Results confirmed the hypothesis-2 by showing the significant mean difference between the groups: orphan girls, orphan boys, non-orphan girls and non-orphan boys in almost on all dependent variables as provided by the mean tables, **table no:3, 4 & 5** and the post hoc comparision table.

Hypothesis-3:*It is expected there will be significant relationship between the sub-scales/scales of Self-Esteem, Emotional Maturity and Behavioural problems in the selected population.*

The correlation matrix of the psychological variables of Self Esteem, Depression and subscales of Revised Children Manifest Anxiety Scale and Emotional Maturity Scale and the strengths and difficulties questionnaire are presented in **Table-6, 7 & 8**. The results. Results confirmed the hypothesis-3 by showing the significant correlation between almost all the variables. The results in **Table - 6** revealed that Self-esteem had significant negative correlation with Depression. It was also revealed that Self-esteem had significant negative correlation with Emotional Instability, Emotional Regression, Social Maladjustment. Personality Disintegration, Lack of Independence. Overall it means that Increase in Self Esteem will increase Emotional Maturity among the children. Self Esteem is also found to have significant negative correlation with Anxiety subscales viz; Physiological Anxiety, Oversensitivity/Worry and Social Concerns/ Concentration. Depression was found to have positive correlation with Emotional Maturity subscales. It also had significant correlation with the anxiety factors/subscales. Results in **Table no:7** indicates the correlation between the measures of Self-Esteem, Depression and subscales of Revised Children Manifest Anxiety and Strengths and Difficulties Questionnaire. And it was revealed that all the variables had significant correlation with each other except for the prosocial subscale with self-esteem and physiological anxiety. Results from **Table no:8** depicted significant correlation

between almost all the subscales of emotional maturity and the strengths and difficulties questionnaire except for the Prosocial subscale of the strengths and difficulties questionnaire which did not have any significant relationship with any other subscales of Emotional Maturity among orphans and non-orphans.

Hypothesis-4:*It is expected that there will be independent effect of 'gender' and 'orphanage' on the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems among sample.*

The ANOVA results in **Table-9** showed significant independent effect of Orphanage on Self-Esteem, Depression, and subscales of Emotional Maturity viz; Emotional Instability, Emotional Regression, Social Maladjustment, Personality Disintegration and Lack of Independence. Independent effect of Orphanage was also found with the subscales of Anxiety: Physiological Anxiety, Oversensitivity/Worry Social Concerns/ Concentration and with the subscales of strengths and difficulties questionnaire: emotional problem, conduct problem, hyperactivity, peer problem, externalizing and internalizing behaviours. Results also depicted the significant independent effect of Gender on Self-Esteem with, Depression, Emotional Maturity and Anxiety and with subscales of strengths and difficulties questionnaire except internalizing behaviour. Results confirmed the Hypothesis-4 that significant independent effect of Gender and orphanage will be observed on the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems among orphans and non-orphans.

Hypothesis-5:*It is expected that there will be interaction effect of 'gender' and 'orphanage' on the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems among sample.*

The ANOVA results in Table-9 showed significant interaction effect of Orphanage on Self-Esteem, Depression, and subscales of Emotional Maturity viz; Emotional Instability, Emotional Regression, Social Maladjustment, Personality Disintegration and Lack of Independence, with the subscales of Anxiety: Physiological Anxiety, Oversensitivity/Worry Social Concerns/ Concentration and with the subscales of strengths and difficulties questionnaire: emotional problem, conduct problem, hyperactivity, peer problem, externalizing and internalizing behaviours. Thus, the

results confirmed the Hypothesis-5 that significant interaction effect of Gender and orphanage will be observed on the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems among orphans and non-orphans.

CHAPTER-V

SUMMARY AND CONCLUSION

The present study entitled, 'Self-Esteem, Emotional Maturity and Behavioural Problems among Orphans: A Study in Manipur'was conducted by following the scientific methodology which could be replicated in future to cross checking or to get more information in the selected population for framing prevention and developing intervention strategies for psychological problems.The operation areas of the present study was Manipur State of India.

For the final inclusion, 200 Children {(2 groups of Children (100 Orphans and 100 Controls) and 2 Genders (Boys and Girls)} was selected through random sampling method. Of which, 100 was children living in an Orphanage in Manipur and whose age range falls between 11 years to 16 years and another100 children who are currently staying with their biological parents at home for control group/comparison group.

To meet the objectives and the hypotheses set forth for the present study, the psychological tests: (1)Rosenberg's Self-esteem Questionnaire (SES; Rosenberg, 1965);(2)Emotional Maturity Scale (EMS; Yasvir Singh and Mahesh Bharagava, 1984); (3) Child Depression Inventory (CDIKovacs,1985);(4) Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds, C.R., & Richmond, B.O, 1985); and (5) Strengths and Difficulties Questionnaire (SDQ; Goodman, 2001)were employed to tap the selected dependent variables.

The data collected were analyzed in stepwise.

Firstly, the Psychometric adequacy of the Psychological test was done to confirm the trustworthiness of the selected scales for the target population by employing Brown-Forsythetest and the reliabilityof the psychological tests were calculated.

Secondly, the descriptive statistics were computed including the mean, standard deviation, Standard Error of Mean, Kurtosis and Skewness on the behavioural measures of (i) Self-Esteem Scale, (ii) Emotional Maturity Scale, (iii) Child Depression Inventory(iv) Revised Children's Manifest Anxiety Scale and (v) Strengths & Difficulties Questionnaire.

Thirdly, mean differencewas computed for the whole sample.

Fourthly, Pearson Correlation showing the relation of the whole sample on the behavioural measures of Self Esteem, Depression and subscales of Manifest Anxiety, Emotional Maturity and Strengths and difficulties questionnaire. Lastly, 2 X 2 ANOVA with Post-hoc multiple mean comparisonswere employed to illustrate the independent and interaction effect of the independent variables on selected dependent variables for the whole samples.

Psychometric Adequacy:

The psychological tests used for the present study were originally made for other culture, and therefore to rule out the difference on cultural norms, the psychometric adequacy of the psychological test was checked before going further analysis by employing Levenes' Test of Homogeneity of Variance (Levene 1960)to test the assumption that variances are equal across groups or samples, Robust Tests of Equality of Means (Brown& Forsythe, 1974)and Reliability measure(Cronbach Alpha; Cronbach, 1951).

The preliminary analyses of the psychometric properties of the behavioural measures were computed was felt necessary that scale constructed and validated for measurement of the theoretical construct in a given population when taken to another cultural milieu may not be treated as reliable and valid unless specific checks are made (Witkin& Berry, 1975).The reliability and predictive validity of the scales and sub-scales were ascertained to ensure the psychometric adequacy of the scales used for the study. Internal consistency reliability was estimated for each of the scales used in the study using Cronbach's coefficient alpha (Cronbach, 1951)was employed to cross check the Cronbach's coefficient alpha for methodological confinement of the internal consistencyi.e.; how well the test components contribute to the construct that's being measured.

The results in Table- 1 revealed that the reliability of Self-Esteem (α=.79) ,Depression (α=.58) and subscales of Emotional Maturity Scale (Emotional Instability, α=.71; Emotional Regression,α=.65; Social Maladjustment, α= .72; Personality Disintegration, α=.64 and Lack of Independence, α= .78). Similarly, the results in Table- 2 revealed that the reliability of subscales of Revised Children Manifest Anxiety

Scale (Physiological Anxiety- α=.51;Oversensitivity/Worry- α=.73; Social Concerns/Concentration -α=.63) and subscales of Strengths and Difficulties Questionnaire(Emotional Problems - α=.74; Conduct Problems,α=.79; Hyperactivity, α= .78; Peer Problem, α=.77, Prosocial, α= .57; Externalizing,α= .78 and Internalizing, α= .67). The total coefficient of correlation of the subjects emerged to be satisfactory over the levels of analysis for the whole sample, which indicating the trustworthiness of the scales such as Self Esteem, Children Depression and emotional Maturity. The Reliability test of Cronbach Alpha shows reliability scores all falling above .50 showing the reliability and the validly proved the trustworthiness of the selected psychological scale for the present population under study. Brown-Forsythe Test of Homogeneity of Variances was used, and Levene's Test from the test it was indicative of homogeneity of the variance within the whole sample.

Descriptive Statistics:

The results (Table-3) highlight the Mean and SD of the scales/subscales of (i) Self-Esteem Scale, (ii) Emotional Maturity Scale, (iii) Child Depression Inventory (iv) Revised Children's Manifest Anxiety Scale and (v) Strengths & Difficulties Questionnaire. The results revealed the mean and standard deviation as well as Skewness and Kurtosis as indices for normality of the scores on the measured variables. All the skewness statistics falls between 1.0 to 2.0 which showing none of the skew and kurtosis were greater than twice the standard error within an acceptable range, and that revealed the applicability of parametric statistics for further analysis (Miles & Shevlin, 2001).

Results presented in Table-3 highlights the Mean comparison among the four comparision groups: Orphan Girls, Orphan Boys, Non-orphan Girls & Non-orphan Boys. It indicated that for the measure of Self Esteem, the Non-orphan Boys had highest score (M=22.56) followed by Non-orphan Girls (M=20.98), then by Orphan Boys (M=17.80) and lowest score was observed among Orphan Girls (M=15.30). Results also highlighted that the Non-orphans have higher score in Self-esteem than the Orphans (M=21.19;18.14; $p<.01$) and the boys are higher than girls (M=20.18;18.14) on Self-esteem for the whole sample as showed in Table. This findings are supported by studies by Guthman et al (2002); and also by Wanjiru and Gathogo (2014). The gender

difference may be explained by different socializations. Boys feel they are more valued by the society (Guthman et al ,2002).

On the measure of Depression using the Child Depression Inventory, the Orphans had more depressive symptoms (M= 29.01) than the Non-Orphans (M=25.22). Orphan Girls had the highest score (M=29.96) followed by Orphan Boys (M=28.06), Non-Orphan Girls (M=26.54) and lowest by Non=Orphan Boys (M=23.90). The findings of the current study supports the previous separate studies by Atwine, Cantor and others(2005), Manuel (2002) where orphans were more likely than controls to be depressed and bullied. The cross sectional descriptive study by Ramagopal and others (2016) involving 180 children in the age group of 12-18 years living in orphanage also indicted, 35% had depression, most of them who had depression were in the age group of 15-17 years and majority were females. A study by Abdel Aziz Mousa Thabet and others (2017) on orphan children also highlighted that 67.9% showed depression. Nasir Mohammad Bhatt (2014) also revealed significant difference in emotional stability and depression levels between two groups. Orphans were found at the lower side of emotional stability and higher levels of depression as compared to the non-orphan secondary school students.

Similarly, on all the subscales of Emotional Maturity the mean values calculated for the orphans are: Emotional Instability(M=21.33), Emotional Regression (M= 18.64), Social Maladjustment (21.33), Personality Disintegration (M=18.96) and Lack of Independence (M=19.89). Orphans scored higher mean value than Non-Orphans, from which it can be ascertained that Emotional Maturity was higher in Non-Orphans than the Orphans, since higher score in emotional maturity scale means lower level of Emotional Maturity. This findings supported previous studies by Chaudhary and Bajaj (1993), Upreti and Sharma, S(2018) where they found that adolescents staying at home have higher level of emotional maturity as compared to their counterparts staying at the orphanage. Nasir Mohammad Bhatt (2014) revealed significant difference in emotional stability s between two groups. Orphans were found at the lower side of emotional stability as compared to the non-orphans secondary school students.

As indicated in Table - 3, the Orphans girls obtained higher mean values than the other comparison groups in all the subscales of Emotional Maturity viz; Emotional Instability, Emotional Regression, Social Maladjustment, Personality Disintegration and

Lack of Independence. Similar findings were observed in study done by Kumar,S and his colleagues (2015) where significant gender difference was also observed wherein orphan girls were significantly lower than the orphan boys on social adjustment. Jan Nuzhat (2013) also found female University distance learners have more emotional instability than Male University distance learners. The results of the current study conform with the study done by Krishna Duhan and his associates (2017) where they did a comparison of Male and Female Adolescents on Emotional Maturity and in that female adolescents were on higher side on emotional instability, social maladjustment and lack of independence as compared to their counterparts. Aleem Sheema (2005) also observed significant difference between the mean scores of male and female students on emotional stability. Reviews of a different line of research also indicated that male university distance learners have more emotional regression than female university distance learners (Jan Nuzhat,2013). Similar results were observed by Krishna Duhanand others (2017) where Emotional regression and personality disintegration was higher in males as compared to female adolescents as they obtained higher mean scores than their counterparts. Upreti, Rashmi & Sharma, Seema (2018) found in their study that adolescents living with intact families were significantly more emotionally progressed, socially adjusted, independent and more emotionally mature. A happy home or healthy family is the first base in a person's life for developing emotional maturity.

Table -4 indicated the results of the mean values calculated for the Revised Children Manifest Anxiety Scale. The orphans scored higher mean values than the non-orphans on the Oversensitivity/ Worry Factor (M=29.01; 25.22) and Social concerns/ Concentration factor (M=16.70). Among all the groups, orphan boys group showed higher mean values than the orphan girls on the Oversensitivity/ Worry Factor(M=29.96; 28.06) and on the Social concerns/ Concentration factor (M=22.76; 19.90). Whereas, orphan girls scored lower than the non- orphans on the Physiological factor (M=21.77; 16.55). The results of the study are in line with studies in the past byThabet and colleagues (2007);Nagy Fawzy and Amira Fourad (2010); Abdel Aziz Mousa Thabet and others (2017);and Atwine, Cantor and colleagues (2005).

Table -5 highlights the results of the mean values calculated for the subscales of Strengths and Difficulties subscales for the whole sample. The mean values on emotional problem subscale were higher among the orphans (M=18.64) than the non-orphans (M=16.02). Similarly, the Orphans group was observed to have higher mean

value than the non-orphans group on the subscales of conduct problems (M=21.33; 16.70), hyperactivity (M=18.96; 15.78), prosocial behaviour (M=19.89; 16.30), externalizing (M=20.14; 16.24) and internalizing (M=19.26; 16.14) problems. However, peer problem was observed to be more among non-orphans than the orphans(M=16.27; 13.64). Among all the groups, orphan boys group showed higher mean values than the orphan girls on the emotional problem (M=20.22; 17.06), conduct problem (M=20.22, ; 17.06), hyperactivity (M=20.22; 17.06), peer problem(M=14.80; 12.48), prosocial (M=20.58; 19.20), externalizing (M=21.49; 18.80) and internalizing (M=17.51;14.74) problems. Overall, boys were found to have higher mean values than the girls on emotional problem (M=18.10;16.56), conduct problems (M=20.29; 17.74), hyperactivity (M=18.18; 16.56), prosocial behaviour (M=19.02; 17.17) peer problem(M=15.74; 14.17), externalizing (M=19.23; 17.15) and internalizing (M=16.92; 16.56) problems. Previous studies found prosocial behaviour to be lower among orphans than the non-orphans, as orphans have lower expectations from behaviour of others and also contribute less to the public good.(Mc Cannon & Rodrigrez ,2019) (Kaur et.al 2017)

The results (Table - 6) revealed that Self-esteem had significant negative correlation with Depression(r= -.46; p<.01)which means that as Self Esteem increased, Depressive symptoms decreases. This finding is well supported by Sowislo, J.F(2012) analyzed 77 studies on depression and self-esteem and it was found that decreases in self-esteem were predictive of increases in depression. It was also revealed that Self-esteem had significant negative correlation with Emotional Instability (r= -.43; p<.01), Emotional Regression (r=-.27; p<.01), Social Maladjustment(r=-.43; p<.01), Personality Disintegration (r= -.35; p<.01), Lack of Independence (r= -.38; p<.01). Similarly, increase in Self Esteem will decrease the scores in the subscales of Emotional Maturity Overall it means that Increase in Self Esteem will increase Emotional Maturity among the children. Leung, Jupian J.; Sand, Margaret C.(1981) also found that students high in self-esteem were found to be more emotionally mature than students low in self-esteem. These findings are in agreement with the findings of Dagenais (1981),Zervas, and Sherman (1994), and Battle (1977).Who found that self-esteem score correlated with personality factors indicating positive relationship with emotional maturity, psychological adjustment and intellectual behaviour.

Self Esteem is also found to have significant negative correlation with Anxiety subscales viz; Physiological Anxiety (r= -.34; p<.01), Oversensitivity/Worry (r= -.35; p<.01) and Social Concerns/Concentration(r= -.37; p<.01). As Self Esteem increased, anxiety will decrease .According to the results, Depression was positively corelated with Emotional Instability (r= .31; p<.01), Emotional Regression (r= 00.23; p<.01), Social Maladjustment(r=.31; p<.01), Personality Disintegration (r= .25; p<.01), Lack of Independence (r= .31; p<.01). Depression is also found to have significant positive correlation with Anxiety subscales viz; Physiological Anxiety(r=-.34;p<.01), Oversensitivity/Worry (r=-.35;p<.01) and Social Concerns/Concentration (r= -.37; p<.01).

Emotional maturity subscale: emotional instability is found to have significant positive correlation with Anxiety subscales viz; Physiological Anxiety (r= .19; p<.01), Oversensitivity/Worry (r= .31; p<.01) and Social Concerns/ Concentration (r= .32; p<.01). Emotional regression has significant positive correlation with Physiological Anxiety (r= .26; p<.01), Oversensitivity/Worry (r= .33; p<.01) and Social Concerns/ Concentration (r= .21; p<.01). Social Maladjustment have significant positive correlation with Physiological Anxiety (r= .19; p<.01), Oversensitivity/Worry (r= .31; p<.01) and Social Concerns/ Concentration (r= .32; p<.01). The results also revealed that Personality Disintegration have significant positive correlation with Physiological Anxiety (r= .25; p<.01), Oversensitivity/Worry (r= .36; p<.01) and Social Concerns/ Concentration (r= .21; p<.01). the subscale of lack pf independence was also seen to have positive correlation with Physiological Anxiety (r=.30; p<.01), Oversensitivity/Worry (r= .17; p<.01) and Social Concerns/ Concentration (r= .22 p<.01). Higher scores on the subscales of emotional maturity means lower Emotional Maturity. Hence, from these results it can be ascertained that as the level of Emotional Maturity increases anxiety level will decrease.

Results in Table no:7 indicates the correlation between the measures of Self-Esteem, Depression and subscales of Revised Children Manifest Anxiety and Strengths and Difficulties Questionnaire. Self-Esteem has been found to have negative correlation with emotional problem (r=-.42, p<.01), conduct problem (r=-.47; p<.01), hyperactivity(r=-.45;p<.01),peer problem(r= -.47; p<.01) and internalizing problems (r=-.40,p<.01). Interestingly, Self-Esteem was found to have positive correlation with the Externalizing problems (r= .39,p<.01), this finding needs to be further explored.

From the table Depression was observed to have significant positive correlation with emotional problem(r= .32; p<.01), conduct problem(r= .38; p<.01), hyperactivity (r= .38; p<.01),peer problem (r= .28; p<.01), prosocial behaviour (r= .14; p<.05) and internalizing behaviour ((r= .32; p<.01).Depression was found to have negative correlation with externalizing behaviour (r=-.34,p<.01).

The analysis revealed that the subscales of Anxiety: Physiological anxiety, Oversensitivity/worry and Social concerns/Concentration are positively corelated with each other(r= .35, .43, .38; p<.01). The externalizing subscale is found to have significant negative correlation with the Internalizing subscale(r= -.28; p<.01) of the Strengths and Difficulties Questionnaire. From the results table it is also seen that only the Externalizing subscale of the Strengths and Difficulties Questionnaire have a significant negative relationship with all the Anxiety subscales; Physiological anxiety(r=-.31;p<.01), Oversensitivity/worry(r=-.41;p<.01) and Social concerns/Concentration(r= -.35; p<.01). Similarly, Externalizing subscale has significant negative correlation (r values as indicated in the table) with other subscales of Strengths and Difficulties Questionnaire viz emotional problem, conduct problem, prosocial, peer problem, hyperactivity and internalizing problem at p<.01.

Results from Table - 8 depicted the correlation between the subscales of emotional maturity and the strengths and difficulties questionnaire. Here it is revealed that, Emotional Instability have positive correlation with emotional problem (r=.30, p<.01), conduct problem (r=.30; p<.01), hyperactivity(r=.27;p<.01),peer problem(r= .31; p<.01) and internalizing problems (r=.42,p<.01). which implies that as emotional instability increases, emotional problem, per problem, conduct problem, hyperactivity and internalizing problems will also increase. But it was seen to have negative correlation with externalizing behaviour (r=-.39;p<.01). On the subscale of emotional regression positive correlation with emotional problem (r=.28, p<.01), conduct problem (r=.28; p<.01), hyperactivity (r=.27;p<.01),peer problem(r= .28; p<.01) and internalizing problems (r=.22,p<.01) was found. But a negative correlation was found with externalizing behaviour(r=-.20;p<.01). Social maladjustment had significant positive correlation with emotional problem (r=.30, p<.01), conduct problem (r=.32; p<.01), hyperactivity (r=.27;p<.01),peer problem(r= .31; p<.01) and internalizing problems (r=.43,p<.01).). Similarly, Personality Disintegration have significant positive correlation with emotional problem (r=.31, p<.01), conduct problem (r=.31;

p<.01), hyperactivity (r=.33;p<.01),peer problem(r= 34.; p<.01) and internalizing problems (r=.28,p<.01). Lack of independence also have positive correlation with emotional problem (r=.26, p<.01), conduct problem (r=.31; p<.01), hyperactivity (r=.31; p<.01), peer problem (r= 32.; p<.01) and internalizing problems (r=.26, p<.01). From the results externalizing problem is found to have negative correlation with all other subscales of emotional maturity. Prosocial subscale did not have any significant relationship with any other subscales of Emotional Maturity.

Prediction of the effect of independent variables:

Analysis of Variance (ANOVA) to illustrate the independent effect of two independent variables (Orphanage & Gender) on dependent variables (Self-Esteem, Depression, Anxiety, subscales of Emotional Maturity and subscales of the Strengths & Difficulties Questionnaire) and also interaction effects (Orphanage X Gender) on dependent variables under study. Two-way ANOVA was computed, and the findings are presented under Table-9.

The ANOVA results in Table-9 showed significant independent effect of Orphanage on Self-Esteem with 43% effect (F=149.50; p< .01, η^2=.43). Similarly, **s**ignificant independent effect of Orphanage was found on Depression with 27% (F=75.47; p<.01, η^2=.27).

Significant independent effect of Orphanage was also found on subscales of Emotional Maturity viz; Emotional Instability with 28% (F=77.14; p<.01, η^2=.27) , Emotional Regression with11% (F=25.46; p<.01, η^2=.11), Social Maladjustment with 28% (F=77.14; p<.01, η^2=.27), Personality Disintegration with 14% (F=40.29; p<.01, η^2=.14), and Lack of Independence with 18% (F=44.85; p<.01, η^2=.18). Here independent effect of Orphanage was also found with the subscales of Anxiety: Physiological Anxiety with 17% (F=41.95; p<.01, η^2=.17), Oversensitivity/Worry with 20% (49.48; p<.01, η^2=.20) and Social Concerns/ Concentration with 18%(F=43.21; p<.01,η^2=.18).

Results also depicted the significant independent effect of Gender on Self-Esteem with 6% effect (F=13.92; p< .01, η^2=.06). Significant independent effect of Gender on Depression with 9% (F=21.76; p<.01, η^2=.09). Gender also had significant

independent effect on subscales of Emotional Maturity viz; Emotional Instability with 8% (F=18.40; p<.01, η^2=.8) , Emotional Regression with 4% (F=8.11; p<.01, η^2=.11), Social Maladjustment with 8% (F=18.40; p<.01, η^2=.08) , Personality Disintegration with 4% (F=9.09; p<.01, η^2=.04), Lack of Independence with 5% (F=10.65; p<.01, η^2=.05). In support to these findings are few studies done by Kumar and his colleagues (2015),Jan Nuzhat (2013), Aleem and Sheema (2005), andRajakumar and Soundararajan (2012). But other findings such such as Kaur (2006), Krishna Duhanand his associates(2017) contradicts the current findings, and revealed that there were no significant differences in emotional maturity of adolescents as per their gender.

Here independent effect of gender was also found with the subscales of Anxiety: Physiological Anxiety with 5% (F=10.65; p<.01, η^2=.5), Oversensitivity/Worry with 6% (F=13.20; p<.01, η^2=.06) and Social Concerns/ Concentration with 7%(F=15.90; p<.01, η^2=.7). The significant Interaction effect of 'Orphanage and Gender' was also found on Self-Esteem with 49% (F=65.14; p<.01, η^2=.49), Depression with 37% (F=39.64; p<.01, η^2=.37) and subscales of Emotional Maturity viz; Emotional Instability with 36% (F=37.83; p<.01, η^2=.36) , Emotional Regression with 19% (F=16.02; p<.01, η^2=.19), Social Maladjustment with 36% (F=37.83; p<.01, η^2=.36) , Personality Disintegration with 23% (F=19.13; p<.01, η^2=.23), Lack of Independence with 24% (F=20.28; p<.01, η^2=.24). Here interaction effect of 'Orphanage and Gender' was also found with the subscales of Anxiety: Physiological Anxiety with 22% (F=19.07; p<.01, η^2=.22), Oversensitivity/Worry with 27% (F=24.14; p<.01, η^2=.27) and Social Concerns/ Concentration with 28%(F=25.88; p<.01, η^2=.28).

The ANOVA results in Table-10 highlighted significant independent effect of Orphanage on subscales of Strengths and Difficulties Questionnaire viz; Emotional Problems with 27% (F=73.62; p<.01, η^2=.27) , Conduct Problems with 33% (F=96.15; p<.01, η^2=.33), Hyperactivity with 28% (F=78.11; p<.01, η^2=.28), Peer Problems with 26% (F=71.13; p<.01, η^2=.26),Externalizing with 19% (F=47.58; p<.01, η^2=.19) and Internalizing with 35% (F=106.42; p<.01, η^2=.35). Orphanage did not have any significant effect on prosocial behaviour; the same finding conformed the findings of Makame and his colleagues (2002) which found similar trend of results in their studies.

Significant independent effect of Gender on subscales of Strengths and Difficulties Questionnaire viz; Emotional Problems with 6% (F=14.52; p<.01, η^2=.6) ,

Conduct Problems with 4% (F=9.21; p<.01, η^2=.4), Hyperactivity with 7% (F=14.26; p<.01, η^2=.7), Peer Problems with 13% (F=28.66; p<.01, η^2=.13) except for Internalizing behaviours was found in the current study. Past studies by Kaurand colleagues (2018), also by Makame and colleagues (2002) supported the current study findings.

The significant Interaction effect of 'Orphanage and Gender' was also found on subscales of Strengths and Difficulties Questionnaire viz; Emotional Problems with 34% (F=33.91; p<.01, η^2=.34) , Conduct Problems with 37% (F=39.41; p<.01, η^2=.37), Hyperactivity with 36% (F=37.36; p<.01, η^2=.07), Peer Problems with 38% (F=40.04 p<.01, η^2=.38),Prosocial with 19% (F=11.01; p<.01, η^2=.19), Externalizing with 49% (F=63.48; p<.01, η^2=.49) and Internalizing with 36% (F=38.13; p<.01, η^2=.36).

As indicated in Table:11, the post-hoc comparisons showed the significant difference between groups on self-esteem that orphan girls had a significant difference with non-orphan girls(-4.76; p< .01), and non-orphan boys at (-7.26; p< .01) on self-esteem. In the current study orphan boys had a significant difference with non-orphan girls at (-3.18; p<.01) and non-orphan boys at (-5.60; p<.01) on self-esteem. Similar difference among non-orphans and orphans was revealed in study by Asif(2017). Non-orphan girls group had significant difference with non-orphan boys group at (-2.50; p<.01) on Self Esteem.

Similarly, for Depression significant difference between groups was found wherein orphan girls had a significant difference with orphan boys (2.64; p< .01), non-orphan girls (4.16; p< .01), and non-orphan boys at (6.06; p< .01). Safdar,S (2018) study also showed that there is significant difference in childhood depression among orphan boys and girls. Orphan boys had a significant difference with non-orphan girls at (1.52; p<.01) and non-orphan boys at (3.42; p<.01) on Depression. Non-orphan girls group had significant difference with non-orphan boys group at (1.90; p<.01) on Depression. Contradictory results were seen in study done by Thabet and colleagues (2007) found no significant gender differences on any of the mental health measures like depression, anxiety, PTSD.

From Table -11, on the subscale of Emotional Instability, Orphan girls had a significant difference with orphan boys (2.24; p<.01), non-orphan girls at (4.32; p<.01) and non-orphan boys at(-7.18; p<.01). Orphan boys had a significant difference with

non-orphan girls at (2.08; p<.01) and non-orphan boys at (-4.94; p<.01) on Emotional Instability. Non-orphan girls group had significant difference with non-orphan boys' group at (-2.86; p<.01) on Emotional Instability as well. On Emotional Regression, Orphan girls had a significant difference with non-orphan boys at (4.16; p<.01). Orphan boys had a significant difference with non-orphan boys at (4.24; p<.01). Non-orphan girls group also had significant difference with non-orphan boys' group at (-3.16; p<.01). Orphan boys did not have any significant difference from orphan girls and non-orphan girls in emotional regression.

Orphan girls on Social Maladjustment had a significant difference with orphan boys (2.24; p<.01), non-orphan girls at (4.32; p<.01) and non-orphan boys at(7.18; p<.01). Orphan boys had a significant difference with non-orphan girls at (2.08; p<.01) and non-orphan boys at (4.94; p<.01). Non-orphan girls group had significant difference with non-orphan boys' group at (2.86; p<.01) as well. On the subscale Personality Disintegration orphan girls had a significant difference with orphan boys (7.20; p<.01), non-orphan girls at (4.06; p<.01) and non-orphan boys at(5.44; p<.01). Orphan boys had a significant difference with non-orphan boys at (3.12; p<.01). Non-orphan girls didn't have any significant difference with non-orphan boys on Personality Disintegration.

Table-12 highlights the post-hoc comparisons between the four groups. The results showed the significant difference between groups on Physiological Anxiety and in that orphan girls had a significant difference with non-orphan boys at (-1.70; p< .01). No significant difference was found between orphan girls and boys and also between non-orphan girls and boys in the experience of physiological anxiety. But Orphan boys had a significant difference with non-orphan boys at (-1.78; p<.01).

Similarly, on Oversensitivity /worry significant difference between groups was found wherein orphan girls had a significant difference with non-orphan girls(1.98; p< .01), and non-orphan boys at (3.82; p< .01). Orphan boys had a significant difference with non-orphan boys at (2.92; p<.01). Non-orphan girls group had significant difference with non-orphan boys group at (-1.84; p<.01).

On Social concerns/concentration anxiety, significant difference between groups was found wherein orphan girls had a significant difference with non-orphan girls (0.96; p< .01), and non-orphan boys at (2.68; p< .01). Orphan boys had a significant difference

with non-orphan boys at (2.30; p<.01). Non-orphan girls group had significant difference with non-orphan boys group at (-1.72; p<.01). Atwine and colleagues (2005) also found similar significant difference among the orphans and the non-orphans on the level of anxiety. Hosseini andKhazali, H(2013) also found significant difference among the boys and girls on the level of anxiety.

Similarly results from Strengths and Difficulties Questionnaire showed that on Emotional Problems subscale, Orphan girls had a significant difference with orphan boys (-1.48; p<.01), non-orphan girls at (2.72; p<.01) and non-orphan boys at (3.74; p<.01). Orphan boys had a significant difference with non-orphan girls at (1.24; p<.01) and non-orphan boys at (2.26; p<.01). Non-orphan girls group did not have any significant difference with non-orphan boys group. On Conduct problems, Orphan girls had a significant difference with orphan boys(-1.48; p<.01)non-orphan girls at (3.38; p<.01) and non-orphan boys at (4.12; p<.01). Orphan boys had a significant difference with non-orphan girls at (1.90; p<.01) and non-orphan boys at (2.64; p<.01). Non-orphan girls group also had significant difference with non-orphan boys group at (3.16; p<.01). In Conduct problem non-orphan girls group did not have any significant difference with non-orphan boys group.

On Hyperactivity, orphan girls had a significant difference with orphan boys (-1.96; p<.01) non-orphan girls at (3.38; p<.01) and non-orphan boys at(4.12;p<.01) . Orphan boys had a significant difference with non-orphan girls at (1.42 p<.01) and non-orphan boys at (2.16; p<.01). Likewise, on Peer Problem orphan girls had a significant difference with orphan boys (-2.32; p<.01) non-orphan girls at (3.38; p<.01) and non-orphan boys at (4.20;p<.01) . Orphan boys had a significant difference with non-orphan girls at (1.88 p<.01).

Orphan girls had a significant difference with orphan boys (-0.62; p<.01) on Prosocial subscale. Similar difference was observed with non-orphan boys group at non-orphan girls at (0.62; p<.01). Difference was found to be insignificant between other groups.

In Externalizing score which was computed, it was found that, orphan girls had a significant difference with orphan boys (-3.30; p<.01), non-orphan girls at (2.56 p<.01) and non-orphan boys at (7.54;p<.01) . Orphan boys had a significant difference with non-orphan boys at (4.24; p<.01) on the Externalizing behaviours. Significant

difference was found between non- orphan girls and non-orphan boys at(-4.98;p<.01) on this subscale.

Lastly on the internalizing behaviours, Orphan girls had a significant difference with,non-orphan girls at (4.28; p<.01) and non-orphan boys at(4.84; p<.01) . Orphan boys had a significant difference with non-orphan girls at (3.10; p<.01) and non-orphan boys at (3.66; p<.01). Supporting findings were seen in study by Makame and colleagues (2002) wherein orphans had markedly increased internalizing problems compared with non-orphans (p < 0.01) and 34% reported they had contemplated suicide in the past year and multiple regression analysis indicated that the independent predictors of internalizing problem scores were sex (females higher than males).

Based on the objectives of the study, the following hypotheses were set forth for the study. Results of the study confirmed those hypotheses and can be summarized as follow:

Hypothesis -1*: It is expected that the selected Psychological measures would find applicability in the selected population as it is going to be one of the few endeavors in the selected population.*

The psychological test used in the present study were standardized but constructed for other culture. The preliminary analyses of the psychometric properties of the behavioural measures were computed as it was felt necessary that scale constructed and validated for measurement of the theoretical construct in a given population when taken to another cultural milieu may not be treated as reliable and valid unless specific checks are made (Witkin& Berry, 1975). The reliability and predictive validity of the scales and sub-scales were ascertained to ensure the psychometric adequacy of the scales used for the study. Internal consistency reliability was estimated for each of the scales used in the study using Cronbach's coefficient alpha (Cronbach, 1951). As per the results in Table- 1, it revealed the reliability of Self-Esteem (α=.79), Depression (α=.58) and subscales of Emotional Maturity Scale that Emotional Instability (α=.71); Emotional Regression (α=.65); Social Maladjustment(α= .72); Personality Disintegration (α=.64) and Lack of Independence (α= .78). Similarly, the results in Table- 2 revealed that the reliability of subscales of Revised Children Manifest Anxiety Scale (Physiological Anxiety - α=.51; Oversensitivity/Worry- α=.73; Social Concerns/Concentration -α=.63) and subscales of Strengths and Difficulties

Questionnaire (Emotional Problems- α=.74; Conduct Problems-α=.79; Hyperactivity - α= .78; Peer Problem - α=.77, Prosocial - α= .57; Externalizing - α= .78 and Internalizing - α= .67). The total coefficient of correlation of the subjects emerged to be satisfactory over the levels of analysis for the whole sample, which indicating the trustworthiness of the scales such as Self Esteem, Children Depression and emotional Maturity. The Reliability test of Cronbach Alpha shows reliability scores all falling above .50 showing the reliability and the validly proved the trustworthiness of the selected psychological scale for the present population under study. Brown-Forsythe Test of Homogeneity of Variances and Levene's Test were used. From the test it was ascertained that there is homogeneity of the variance within the whole sample. Thus, we accept hypthesis1of the current study.

Hypothesis -2*: It is expected that there will be significant differences between the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems(externalizing and internalizing) of the selected sample.*

Descriptive statistics post hoc means comparisionswere computed to excavate any significant difference present in dependent variables in relation to the groups. Results confirmed the hypothesis-2 by showing the significant mean difference between the groups:orphan girls, orphan boys, non-orphan girls and non-orphan boys in almost on all dependent variables as provided by the mean tables, Tables- 3, 4 & 5 and the post hoc comparision table.

Hypothesis-3:*It is expected there will be significant relationship between the sub-scales/scales of Self-Esteem, Emotional Maturity and Behavioural problems (externalizing and internalizing) in the selected population.*

The correlation matrix of the psychological variables of Self Esteem, Depression and subscales of Revised Children Manifest Anxiety Scale and Emotional Maturity Scale and the strengths and difficulties questionnaire are presented in Table-6, 7 & 8. The results. Results confirmed the hypothesis-3 by showing the significant correlation between almost all the variables. The results in Table - 6 revealed that Self-esteem had significant negative correlation with Depression. It was also revealed that Self-esteem had significant negative correlation with Emotional Instability, Emotional Regression, Social Maladjustment. Personality Disintegration, Lack of Independence. Overall it means that Increase in Self Esteem will increase Emotional Maturity among the

children. Self Esteem is also found to have significant negative correlation with Anxiety subscales viz; Physiological Anxiety, Oversensitivity/Worry and Social Concerns/ Concentration. Depression was found to have positive correlation with Emotional Maturity subscales. It also had significant correlation with the anxiety factors/subscales. Results in Table -7 indicates the correlation between the measures of Self-Esteem, Depression and subscales of Revised Children Manifest Anxiety and Strengths and Difficulties Questionnaire. And it was revealed that all the variables had significant correlation with each other except for the prosocial subscale with self-esteem and physiological anxiety. Results from Table - 8 depicted significant correlation between almost all the subscales of emotional maturity and the strengths and difficulties questionnaire except for the Prosocial subscale of the strengths and difficulties questionnaire which did not have any significant relationship with any other subscales of Emotional Maturity among orphans and non-orphans.

Hypothesis-4:*It is expected that there will be independent effect of 'gender' and 'orphanage' on the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems (externalizing and internalizing) among sample.*

The ANOVA results in Table-9 showed significant independent effect of Orphanage on Self-Esteem, Depression, and subscales of Emotional Maturity viz; Emotional Instability, Emotional Regression, Social Maladjustment, Personality Disintegration and Lack of Independence. Independent effect of Orphanage was also found with the subscales of Anxiety: Physiological Anxiety, Oversensitivity/Worry Social Concerns/ Concentration and with the subscales of strengths and difficulties questionnaire: emotional problem, conduct problem, hyperactivity, peer problem, externalizing and internalizing behaviours. Results also depicted the significant independent effect of Gender on Self-Esteem with, Depression, Emotional Maturity and Anxiety and with subscales of strengths and difficulties questionnaire except internalizing behaviour. Results confirmed the Hypothesis-4 that significant independent effect of Gender and orphanage will be observed on the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems (externalizing and internalizing)among orphans and non-orphans.

Hypothesis-5:*It is expected that there will be interaction effect of 'gender' and 'orphanage' on the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems (externalizing and internalizing) among sample.*

The ANOVA results in Table-9 showed significant interaction effect of Orphanage on Self-Esteem, Depression, and subscales of Emotional Maturity viz; Emotional Instability, Emotional Regression, Social Maladjustment, Personality Disintegration and Lack of Independence, with the subscales of Anxiety: Physiological Anxiety, Oversensitivity/Worry Social Concerns/ Concentration and with the subscales of strengths and difficulties questionnaire: emotional problem, conduct problem, hyperactivity, peer problem, externalizing and internalizing behaviours. Thus, the results confirmed the Hypothesis-5 that significant interaction effect of Gender and orphanage will be observed on the sub-scales/scales of the Self Esteem, Emotional Maturity and Behavioural problems (externalizing and internalizing) among orphans and non-orphans.

Limitations of The Study:

The study although has most of the variables that will capture behavioural problems using self-report questionnaires it is not free of limitations. First, the sample size of the study can be increased for better representation. Inclusion of children from orphanages from all the districts of Manipur would have been a better representation.
Another limitation of this study is the lack of sufficient data from the caregivers. It would have been informative if the study had included questionnaires which can be administered to the caregivers so that they can respond about the behaviours about the orphan children based on their observations.The researcher felt that qualitative method such as open interview with the children from orphanages and from the caregivers would strengthen the finding of the results. Because the caregivers would have yielded more information about the children based on their observations.

And all the questionnaire was self -report questionnaire, inclusion of at least a caregiver version of a checklist/questionnaire which can be given to the caregiver so that the responses can be crossed checked, would have improved the findings of the study considerably.

Suggestions:

Based on the limitations of the present study, it was suggested that further studies are needed to have a bigger sample size which will include orphanages from other districts as well which will be better representation of the cultural diversities within the state. Including qualitative method such as open interview with the children from orphanages and from the caregivers would strengthen the finding of the results. Inclusion of at least a caregiver version of a checklist/questionnaire which can be given to the caregiver so that the responses can be crossed checked, would have improved the findings of the study considerably. The data collected from the caregivers and the Orphan children can be corelated and analyzed.

Conducting cross-sectional study and longitudinal study is very much needed for better understanding for the onset and progression of behavioural problems over the years of stay in the orphanage, its consequences and antecedents.

Implications:

From the findings of the study, awareness programs be organized in orphanages for psychoeducation about the behavioural problems which will help the caregivers identifying and consulting mental health professional if needed. And this study recommends employing a mental health professional who can cater to the psychological issues of the children in orphanages on a regular basis. It also suggests importance of routine check up to ensure psychological well-being of the children.

Planning intervention programs in orphanages based on the findings of the study to boost their self-esteem and for overall personality development.

APPENDIX-I

SEMI STRUCTURED PROFORMA

Please indicate your responses to the following against each question.

Name :

Age :

Gender :

Address :

Educational Qualification :

Religion :

Number of siblings :

Family History of mental illness : Yes/ No.

If Yes please indicate : ……

Any history of prior psychiatric consultation sought:Yes/No.

If Yes please indicate

thereason:……

……

APPENDIX-II

A) <u>Self Esteem:</u>

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

1. On the whole, I am satisfied with myself.
    a. **Strongly Agree**
    b. **Agree**
    c. **Disagree**
    d. **Strongly Disagree**
2. At times I think I am no good at all.
    a. **Strongly Agree**
    b. **Agree**
    c. **Disagree**
    d. **Strongly Disagree**
3. I feel that I have a number of good qualities.
    a. **Strongly Agree**
    b. **Agree**
    c. **Disagree**
    d. **Strongly Disagree**
4. I am able to do things as well as most other people.
    a. Strongly Agree
    b. Agree
    c. Disagree
    d. Strongly Disagree
5. I feel I do not have much to be proud of.
    a. Strongly Agree
    b. Agree
    c. Disagree
    d. Strongly Disagree
6. I certainly feel useless at times.
    a. Strongly Agree
    b. Agree
    c. Disagree
    d. Strongly Disagree
7. I feel that I'm a person of worth, at least on an equal plane with others.
    a. Strongly Agree
    b. Agree
    c. Disagree
    d. Strongly Disagree
8. I wish I could have more respect for myself.
    a. Strongly Agree
    b. Agree
    c. Disagree
    d. Strongly Disagree
9. All in all, I am inclined to feel that I am a failure.

a. **Strongly Agree**
b. **Agree**
c. **Disagree**
d. **Strongly Disagree**

10. I take a positive attitude toward myself.

a. **Strongly Agree**
b. **Agree**
c. **Disagree**
d. **Strongly Disagree**

APPENDIX-III

B.<u>The Revised Children's Manifest Anxiety Scale (RCMAS)</u>

"What I Think and Feel"

Read each question carefully. Put a circle around the word YES if you think it is true about you. Put a circle around the word NO if you think it is not true about you.

1. I have trouble making up my mind.	Yes	No
2. I get nervous when things do not go the right way for me.	Yes	No
3. Others seem to do things easier than I can.	Yes	No
4. I like everyone I know.	Yes	No
5. Often I have trouble getting my breath.	Yes	No
6. I worry a lot of the time.	Yes	No
7. I am afraid of a lot of things.	Yes	No
8. I am always kind.	Yes	No
9. I get mad easily.	Yes	No
10. I worry about what my parents will say to me.	Yes	No
11. I feel that others do not like the way I do things.	Yes	No
12. I always have good manners.	Yes	No
13. It is hard for me to get to sleep at night.	Yes	No
14. I worry about what other people think about me.	Yes	No
15. I feel alone even when there are people with me.	Yes	No
16. I am always good.	Yes	No
17. Often I feel sick in the stomach.	Yes	No
18. My feelings get hurt easily.	Yes	No
19. My hands feel sweaty.	Yes	No
20. I am always nice to everyone.	Yes	No
21. I am tired a lot.	Yes	No
22. I worry about what is going to happen.	Yes	No
23. Other children are happier than I am.	Yes	No
24. I tell the truth every single time.	Yes	No
25. I have bad dreams.	Yes	No
26. My feelings get hurt easily when I am fussed at.	Yes	No
27. I feel someone will tell me I do things the wrong way.	Yes	No
28. I never get angry.	Yes	No
29. I wake up scared some of the time.	Yes	No
30. I worry when I go to bed at night.	Yes	No
31. It is hard for me to keep my mind on my schoolwork.	Yes	No
32. I never say things that I shouldn't.	Yes	No
33. I wriggle in my seat a lot.	Yes	No
34. I am nervous.	Yes	No
35. A lot of people are against me.	Yes	No
36. I never lie.	Yes	No
37. I often worry about something bad happening to me.	Yes	No

APPENDIX-IV

C. Children Depression Inventory

Pick out the sentences that describe you best in the **PAST TWO WEEKS**

Item 1:
1.I am sad once in a while.
2. I am sad many times.
3. I am sad all the time.

Item 2:
1Nothing will ever work out for me.
2.I am not sure if things will work out for me.
3.Things will work out for me O.K.

Item 3:
1.I do most things O.K.
2.I do many things wrong.
3.I do everything wrong.

Item 4:
1.I have fun in many things.
2.I have fun in some things.
3. Nothing is fun at all.

Item 5:
1.I am bad all the time.
2.I am bad many times.
3.I am bad once in a while.

Item 6:
1.I think about bad things happening to me once in a while.
2. I worry that bad things will happen to me.
3. I am sure that terrible things will happen to me.

Item 7:
1.I hate myself.
2.I do not like myself.
3.I like myself.

Item 8:
1.All bad things are my fault.
2.Many bad things are my fault.
3. Bad things are usually my fault.

Item 9:
1.I do not think about killing myself.
2.I think about killing myself nut I would not do it.I want to kill myself.

Item 10:
1.I feel like crying everyday.
2.I feel like crying many days.
3.I feel like crying once in a while.

Item 11:
1.Things bother me all the time.
2.Things bother me many times.
3.Things bother me once in a while.

Item 12:
1.I like being with people.
2.I do not like being with people many things.
3.I do not want to be with people at all.

Item 13:
1.I cannot make up my mind about things.
2.It is hard to make up my mind about things.
3.I make up my mind about things easily.

Item 14:
1.I look O.K.
2.There are some bad things about my looks.
3.I look ugly.

Item 15:
1.I have to push myself all the time to do my schoolwork.
2.I have to push myself many times to do my school work.
3. Doing schoolwork is not a big problem.

Item16:

1.I have trouble sleeping every night.
2. I have trouble sleeping many nights.
3. I sleep pretty well.

Item 17:

1.I am tired once in a while.
2. I am tired many days.
3. I am tired all the time.

Item18:

1.Most days I do not feel like eating.
2. Many days I do not feel like eating.
3. I eat pretty well.

Item 19:

1.I do not worry about aches and pains.
2.I worry about aches and pains many times.
3.I worry about aches and pains all the time.

Item 20:

1.I do not feel alone.
2. I feel alone many times.
3.I feel alone all the time.

Item21:

1.I never have fun at school.
2.I have fun at school only once in a while.
3.I have fun at school many times.

Item22:

1.I have plenty of friends.
2.I have some friends but wish I had more.
3.I do not have any friends.

Item 23:

1.My schoolwork is alright.
2.My schoolwork is not as good as before/
3. I do very badly in subjects I used to be good in.

Item 24:

1.I can never be as good as other kids.
2.I can be as good as other kids if I want to.
3.I am just as good as other kids.

Item 25:

1.Nobody really loves me.
2. I am not sure if anybody loves me.
3. I am sure that somebody loves me.

Item 26:

1.I usually do what I am told.
2.I do not do what I am told most times.
3.I never do what I am told.

Item 27:

1.I get along with people.
2.I get into fights many times.
3.I get into fights all the time.

APPENDIX-V

D.Emotional Maturity Scale:

In the following pages are given forty-eight questions about yourself. Five possible modes of responses re provided, such as Very Much, Much, Undecided, Probably and Never. Read each question carefully and mark tick in ANY ONE of the five alternative response modes to indicate your level of agreement with the particular content of the question. Do not think too much while answering, whatever you feel may indicate.

Very Much= 1 Much= 2 Undecided=3 Probably=4 Never=5

A		**1**	**2**	**3**	**4**	**5**
1	Do you get involved in mental botherations?					
2	Do you get frightened about the coming Situations?					
3	Do you stop in the middle of any work before reaching the goal?					
4	Do you take the help of other person/s to complete your personal work?					
5	Is there any difference between your desires and objectives?					
6	Do you feel within yourself that you are short-tempered?					
7	Do you feel that you are very stubborn?					
8	Do you feel jealous of other people?					
9	Do you get wild due to anger?					
10	Do you get lost in imagination and day-dream?					

B		**1**	**2**	**3**	**4**	**5**
11	If you fail to achieve your goal, do you feel inferior?					
12	Do you experience a sense of discomfort and lack ofpeace of mind?					
13	Do you tease against the others?					
14	Do you try to put blame on others for your lapses?					
15	When you do not agree with others, do you start quarreling with them?					
16	Do you feel yourself as exhausted?					

17	Is your behaviour more, aggressive than your friends and others?					
18	Do you get lost in wool gathering (in the world of imagination)?					
19	Do you feel that you are self-centered?					
20	Do you feel that you are dissatisfied with yourself?					

C		**1**	**2**	**3**	**4**	**5**
21	Do you have a strained companionship with your friendscolleagues?					
22	Do you hate others?					
23	Do you praise yourself?					
24	Do you avoid joining in social gatherings?					
25	Do you spend much of your time for your own sake?					
26	Do you lie?					
27	Do you bluff?					
28	Do you like very much to be alone?					
29	Are you proud by nature?					
30	Do you shirk from work?					

D		**1**	**2**	**3**	**4**	**5**
31	Even though you know some work, do you pretend as if you do not know it?					
32	Even if you do not know about some work, do you pose as if know it?					
33	Having known that you are at fault, instead of accepting it, do you try to establish that you are right?					
34	Do you suffer from any kind of fear?					
35	Do you lose your mental balance (poise)?					
36	Are you in the habit of stealing of any kind?					
37	Do you indulge freely without bothering about moral codes of conduct?					
38	Are you pessimistic towards life?					

39	Do you have a weak will?(Self-will or determination)					
40	Are you intolerant about the views of others?					

E		**1**	**2**	**3**	**4**	**5**
41	Do people consider you as undependable?					
42	Do people disagree with your views?					
43	Would you like to be a follower?					
44	Do you disagree with the opinions of your group?					
45	Do people think of you as an irresponsible person					
46	Do you evince interest in other's work?					
47	Do people hesitate to take your help in any work?					
48	Do you give more importance to your work than other's work?					

APPENDIX-VI

E. 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 not absolutely certain. Please give your answers on the basis of how things have been for you over the last six months.

1= Not True 2= Somewhat True 3= Certainly True

		1	**2**	**3**
1.	I try to be nice to other people. I care about their feelings	□	□	□
2.	I am restless, I cannot stay still for long	□	□	□
3.	I get a lot of headaches, stomach-aches or sickness	□	□	□
4.	I usually share with others, for example CD's, games, food	□	□	□
5.	I get very angry and often lose my temper	□	□	□
6.	I would rather be alone than with people of my age	□	□	□
7.	I usually do as I am told	□	□	□
8.	I worry a lot	□	□	□
9.	I am helpful if someone is hurt, upset or feeling ill	□	□	□
10.	I am constantly fidgeting or squirming	□	□	□
11.	I have one good friend or more	□	□	□
12.	I fight a lot. I can make other people do what I want	□	□	□
13.	I am often unhappy, depressed or tearful	□	□	□
14.	Other people my age generally like me	□	□	□
15.	I am easily distracted; I find it difficult to concentrate	□	□	□
16.	I am nervous in new situations. I easily lose confidence	□	□	□
17.	I am kind to younger children	□	□	□
18.	I am often accused of lying or cheating	□	□	□
19.	Other children or young people pick on me or bully me	□	□	□
20.	I often offer to help others (parents, teachers, children)	□	□	□
21.	I think before I do things	□	□	□
22.	I take things that are not mine from home, school or elsewhere	□	□	□
23.	I get along better with adults than with people my own age	□	□	□
24.	I have many fears; I am easily scared	□	□	□
25.	I finish the work I'm doing. My attention is good	□	□	□

Thank you very much for your help

APPENDIX-VII

SEMI STRUCTURED PROFORMA

Chaanbidunasomgipaokhumwahangkhudingmakkipibiyu

Ming :

Chahi :

Nupa/Nupi :

Leipham :

LairikkiThaak :

Dharma :

Echilenao mashing :

Emungdapukningwakhalgianabaleiba :Lei/Leite. Leiragadikeinohainataakpiyu:

…….…….

Mamaang da Pukningwakhalgianabalaiyengbayaobikhraba:Lei/ Leite.

Leiragadimaramkeiginohainataakpiyu:

……...

APPENDIX-VIII

SELF-ESTEEM

(Rosenberg, 1965)

Makhadapiribasingasiadomesanaesagimaramdamayampumnamakioinafaonabaethilsing siwarolsingni. Adomnapumnamakyaningbaoiragadi**TASENGNA YANING NGI** da tick toubiyu. Waroladudayaningbaoiragana**YANING NGI** da tick toubiyu. Yaningdabaoiragana**YANINGDEY** da tick toubiyu. Sukyayaningdabaoiragana**SUKYA YANINGDEY**da tick toubiyu.

1. Punnayengbadaeieshagifibamshidapenjei.
- TASENGNA YANING NGI.
- YANING NGI.
- YANINGDEY.
- SUKYA YANINGDEY

2. Marakmarak ta eshaetomtamatikchadreyhaibafaojei.
- TASENGNA YANING NGI.
- YANING NGI.
- YANINGDEY.
- SUKYA YANINGDEY

3. Eihak se afabagyanmayamamayaori/chelli.
- TASENGNA YANING NGI.
- YANING NGI.
- YANINGDEY.
- SUKYA YANINGDEY

4. Eihakpu mi ateigachangdamnabayabathabak kaya toubangami.
- TASENGNA YANING NGI.
- YANING NGI.
- YANINGDEY.
- SUKYA YANINGDEY

5. Esaetomtaeisechaothokchaningngai/lemjanafamamattaleiteyhainaphaojei.
- TASENGNA YANING NGI.
- YANING NGI.
- YANINGDEY.
- SUKYA YANINGDEY

6. Eisemarakmarak ta channafamleitreyhainakhalhalli.
- TASENGNA YANING NGI.
- YANING NGI.
- YANINGDEY.
- SUKYA YANINGDEY

7. Miyamgachangdamnabadaeisikarisuchopteyhainakhanjei.
- TASENGNA YANING NGI.
- YANING NGI.
- YANINGDEY.
- SUKYA YANINGDEY

8. Eihakesa se etomtamamalkhajiktang henna loujarabadifagadabni.
- TASENGNA YANING NGI.

- YANING NGI.
- YANINGDEY.
- SUKYA YANINGDE

9. Khanbakheikhanjilluragaesaetomtapunshi da maithiraba mi oinihainakhalhalli.

- TASENGNA YANING NGI.
- YANING NGI.
- YANINGDEY.
- SUKYA YANINGDEY

10. Esanaesabuachumbawakhallonamadayengjei.

- TASENGNA YANING NGI.
- YANING NGI.
- YANINGDEY.
- SUKYA YANINGDEY

APPENDIX-IX

B. The Revised Children's Manifest Anxiety Scale (RCMAS)

"Eina Kari Khalliamasung Kari Phaowee"

Piribapaokum sing asimunnapabiyoo.
Somnapiribapaokumasieshagidamakchummephaobiradi "Yaaningi" ta circle toubiyoo, adugasomnalallekhalladi "Yaningde" da circle toubiyoo.

1. Eipukningkharachette..	Yaaningi	Yaningde
2. Einakhanbamawongdathabakoidabamatamda, eipakhatkalli	Yaaningi	Yaningde
3. Eigayengnabada, me ataisingidithabaksingselainathok-khibadaonaphaowe.	Yaaningi	Yaningde
4. Eieinakhangba mi ayambaadumnungsinei.	Yaaningi	Yaningde
5. Eitoinasorsudabadaonaphaowee.	Yaaningi	Yaningde
6. Eitoinapakhatkalli, mathasaganli.	Yaaningi	Yaningde
7. Einaakiba pot mayamaama lei	Yaaningi	Yaningde
8. Eimingondaadumpukchelchaowee.	Yaaningi	Yaningde
9. Eithunnasaogalli.	Yaaningi	Yaningde
10. Eieigi ema-pabungnacheirakkanihainakijei	Yaaningi	Yaningde
11. Ei mi ateinaeinaeigieetousepamammoihainakhalli	Yaaningi	Yaningde
12. Eithaksikhasinaina, vehabharnainachatli	Yaaningi	Yaningde
13. Einungdangtumbayagande	Yaaningi	Yaningde
14. Ei mina eigimaramdathinnangangnaramgadarahainapakhatli	Yaaningi	Yaningde
15. Eimigapullasu, etomda tong-ngannatabaphaowee	Yaaningi	Yaningde
16. Ei se adumaphabameeni	Yaaningi	Yaningde
17. Eisetoinapuknungaitabaphaowee	Yaaningi	Yaningde
18. Eiseerai-lainathamoisok-kalli	Yaaningi	Yaningde
19. Eigikhubak se humangtoinathok-kalli	Yaaningi	Yaningde
20. Ei mi-khudingmaktaphajannaadumtouwee	Yaaningi	Yaningde
21. Eiyamnawagalli.	Yaaningi	Yaningde
22. Eikarithok-lakkanihainayamnawagalli	Yaaningi	Yaningde
23. Angangeteidieingondagi henna haraowee	Yaaningi	Yaningde
24. Eiachumbaadumngangee	Yaaningi	Yaningde
25. Eimang phat-tabamang-galli	Yaaningi	Yaningde
26. Einakari-nommada henna khanjanluradi, eithamoihektakaigalli	Yaaningi	Yaningde
27. Einatoubathabakta mina lallehainahairakkadarahainakhalli.	Yaaningi	Yaningde
28. Ei sung-saosaogande	Yaaningi	Yaningde
29. Eitumbahougatlakpadakiragahougatlakpayaowee	Yaaningi	Yaningde
30. Eitummamdaidamathasaraga/thawainungaitragatummi	Yaaningi	Yaningde
31. Eise school githabaktapukningchangbangamde	Yaaningi	Yaningde
32. Ei, einahairoidabawahaide	Yaaningi	Yaningde
33. Eiphambadayamnaleng-ngi	Yaaningi	Yaningde
34. Ei yam pakhat-kalli	Yaaningi	Yaningde
35. Mi mayamamanaeiyaningde	Yaaningi	Yaningde
36. Eioidabasuk-ngangngande	Yaaningi	Yaningde
37. Einondaphatabaamathokkadarahaina, eitoinapakhatli.	Yaaningi	Yaningde

APPENDIX-X

C. Children Depression Inventory:

Houkhibahaptaanisida, Somgakhwaidagichaanabawaheiparengadukhanbiyu.

Item 1:

1. Eihaptaamada, amuraktisoidanathawainungaitabaphaowe.
2. Eithawaitoinanungaigande.
3. Eithawaiadumnungaitana lei.

Item 2:

1. Einakhanbathabakamataoigande.
2. Einakhanbathabaksingseoiganieithajade.
3. Einakhanbathabaksingseadumoiganihainaeithajai.

Item 3:

1. Eithabaktoubadasoigande.
2. Eithabaktoubadasoigalli.
3. Eithabakkudingmaksoinatougalli.

Item 4:

1. Ei pot ayambadaharaowe
2. Ei pot kharadaharaowe.
3. Ei pot kariamatadaharaode.

Item 5:

1. Eisematamkhudingmaktaphatkande.
2. Eiayambadaphatkande.
3. Eimarak-marak ta phatkande.

Item 6:

1. Eingonakudong-thibathokpagiwakalmarak-marak ta khalli.
2. Eingondakudong-thibathokanihainaeipakhalli.
3. Eingondakudong-thibathokanihainaeinathajai.

Item 7:

1. Einaeisenungshijade.
2. Einaeisepamjade.
3. Einaeisepamjai.

Item 8:

1. Fatabathoudokkhudingmakeigieraalni.
2. Fatabathoudokayambaeigieraalni.
3. Fatabathoudokayambaeigieraalni.

Item 9:

1. Eisijakhragehainakhande.
2. Eisijakhragehainakhalliadubueitoudi-touroi.
3. Eisijaningbaphaowe.

Item 10:

1. Einumitkhudinggikapningbafaowe.
2. Eitoinakapningbafaowe.
3. Eihaftaamadaamuktikapningbafaowe.

Item 11:

1. Pot khudingmakeinondakhoidousaohalli.
2. Pot ayambaeingondakhoidousaohalli.
3. Pot kharamarak-marak ta eingondakhoidousaohalli.

Item 12:

1. Eimigapunbapammi.
2. Eimigatoinapunbapamde.
3. Eimigapunbasuk-pam pamde

Item 13:

1. Eisepukningchette.
2. Eisemarak-marktapukningchette.
3. Eisepukningchetli.

Item 14:

1. Eisesakadumyengbayaihainakhalli.
2. Eisesak ka-henna fajadehainakhalli.
3. Eisesakthihainakhalli.

Item 15:

1. Ei school gi homework touningde.
2. Ei school gi homework marak-maraktatouningde.
3. Eischoolgi homework adumtouthok e.

Item 16:

1. Einungdangkhuding-gitumbayagande.
2. Eimarak-maraktanungdangtumbayagande.
3. Einungdantumbayadabatoude.

Item 17:

1. Eisemarak-marktahakchangwagalli.
2. Eiseayambamatamdahakchangwagalli
3. Eiseadumhakchangchoktagalliwagalli.

Item 18:

1. Eiadumchaningbapokande.

2. Eiayambamatamdachaningbapokande.
3. Eichabdakarisunungaitableite.

Item 19:

1. Einaba-chikpagimaramdapakhate.
2. Einaba-chikpagimaramdamarak-maraktapakhatli.
3. Einaba-chikpagimaramdatoinapakhatli.

Item 20:

1. Einaitomtaabaphaode.
2. Eitoinanaitomtaabaphaowe.
3. Eiadumnaitomtaabaphaowetli.

Item 21:

1. Ei school da suknu-nugaite.
2. Ei school da mark-marktaungai.
3. Ei school da yam nungai.

Item 22:

1. Eigiemanaba-emanabiyamlei.
2. Eigiemanaba-emanabikhara lei.
3. Eigiemanaba-emanabiamataleite.

Item 23:

1. Ei school da leiraikphajannaadumtouwe.
2. Ei school da leiriakhannadaonaphajanatoudare.
3. Ei school da leiriakphajannatoudare, hannaditourami.

Item 24:

1. Eiangangateidaonaphajanatoubasukngam-ngammaroi.
2. Einahotnaradieisuangangateidaonaphajanatoubangamni.
3. Eisuangangateidaonaadumphajannatouri.

Item 25:

1. Ei kana amatananungside.
2. Eise mina nungsibibarakhangde.
3. Eibunungsibiba mi leiramganihainakhalli.

Item 26:

1. Eitouwohaibathabakadumtouwe.
2. Eitouwohaibathabaktoinatougande.
3. Eitouwohaibathabak sung-taoutoude.

Item 27:

1. Eimigaadumtinnai.
2. Eimigamarak-maraktakhatnai.
3. Eimigaadumkhatnai.

APPENDIX-XI

D.Emotional Maturity Scale:

Laakadouriba chena lamaisingdanahaakkimaramdawahangniphuunipaanpiri. Oibayaabapaokhummangaapiri, khudam gum “yaamnatoina”, “toina”, haiphamkhangde”, oirambayaai” amadi “sungtoutoude”. Waheipareng sing asimunnapaabiyuadugasomnayaaningbapaokhumadudakhotpiyu, wakhanggimatungenna. Paokhumpibibamatamdayaamnakhanthabiganu, somnaphaobaadudakhotpiyu.

Yaamnatoina = 1 Toina = 2 Haiphamkhangde =3 Oirambayaai =4Sungtoutoude =5

A		**1**	**2**	**3**	**4**	**5**
1	Somsimathasaragatoinaleibibra?					
2	Thoklakkadabathodok sing gimaramdakhallaga, sompakhatpapokpibara?					
3	Sompanthungyouramdaida, tabakhek-hekthadokpatoubibara?					
4	Somesagithabaktoubada, mi atoppagimatengloubibara?					
5	Somgiapambagapanthunggakhetnabara?					
6	Somnasomsethunnasougallihainakhanjabara?					
7	Somnasomsemanungyamnakallihainakhanbibara?					
8	Somse mi ataiuragakalakpaphaobra?					
9	Somsaobanamaramoidunalaknaphanabanamdabayaobara?					
10	Sommondrangamasungwakhal da taodunaleibayoubra?					

B		**1**	**2**	**3**	**4**	**5**
11	Somnasomgithabak ta panthungyoubangamdrabadi, somnaeisabumayamdagihanthanaloubra?					
12	Somsepukningcharangbaamasungleitadabaphaobibara					
13	Somna mi atopadalaknaba, usitabatoubibara?					
14	Somnawakhalphadabangamdabadagitourubaaaranbasindo, mi atopadaoinatainabibara?					
15	Somnaatoppagayanningdradi, somhek-hekmidugakhatnabibara?					

16	Somsetoinawaba, hakchangchokthabaphaobibara?					
17	Somnasomgimataosemarupataidagi henna phingngihainakhanbibara?					
18	Somsemondrang da hek-hektaobibara?					
19	Somnaeshaseeshagidangkhallehainakhanbibra?					
20	Somna, esadagipendabaphaobibara?					

C		**1**	**2**	**3**	**4**	**5**
21	Somna mi tinabaseyamnayaiyehainakhanbibara?					
22	Som mi ateisenungsidabaphaobra?					
23	Somse, esabuthagatchabara?					
24	Somsemayampunbadathawoinayaodanabahotnabara?					
25	Somse, somgiayambamtameesagithabaktounabadaloisanbara?					
26	Somseoidabangangbara?					
27	Somsenamtaktoubara?					
28	Somseeethandaleibana henna pamjabara?					
29	Somsechouthokkanba /pongba mi amara?					
30	Somthabaktagileithokkanbara?					

D		**1**	**2**	**3**	**4**	**5**
31	Somsethabakheirasu, heitaba sabra?					
32	Somsethabakheitrasu, heiba sabra?					
33	Somnalaalekhangnasu, somnachummehainamayamdautnabahotnabibara?					
34	Somkarigumbakharageaakibaleibara?					
35	Somsesomgiwakhalleitabatoinakeibara?					
36	Somse pot huranba, migi pot matpagiheinabileibara?					
37	Toubhamthokpa-thoktabayendana, somsesomnaappambadatouba oibara?					
38	Somse, punsigimaramdaphatabangaktana henna uganbakhanganba oibara?					
39	Somseakhaangkanbaoidabra?					

	(eshagiakhaangkanbaamaditougekhanba)					
40	Som me atoppagiwakhalsingdatoinayaningdabaphaobara?					

E		**1**	**2**	**3**	**4**	**5**
41	Somsethabakheirasu, heitaba sabra?					
42	Somsethabakheitrasu, heiba sabra?					
43	Somnalaalekhangnasu, somnachummehainamayamdautnabahotnabibara?					
44	Somkarigumbakharageaakibaleibara?					
45	Somsesomgiwakhalleitabatoinakeibara?					
46	Somse pot huranba, migi pot matpagiheinabileibara?					
47	Toubhamthokpa-thoktabayendana, somsesomnaappambadatouba oibara?					
48	Somse, punsigimaramdaphatabangaktana henna uganbakhanganba oibara?					

APPENDIX-XII

E. Strengths and Difficulties Questionnaire

WaheiParengkhudingichaanbiduna “Chumde”, “KharaChummi” nutraga “TasengnaChummi” haina box ta khotpiyu.

Somnaloinamakkipaokhumasitasengnachummekhanbidrasu,yaramakheiloinamakkipaok humpibirabadiakkhoigiyaamnamatengoigani.Houkhibathaataruk ta somgikamainatoukhibagehaibadugimatunginnapaokhumpibiyu.

1= Chumde 2= KharaChummi 3= TasengnaChummi

	Items	**1**	**2**	**3**
1	Eimipumkhudingmaktafajanatounabahotnei. Mina Kari phaokhinihaibakhanthei.			
2	Eipothaphamkhangde, kuinatuminnaleibangamde.			
3	Eitoinakokchikpa, pukyekpa, naabatouganli.			
4	Eianambanamigapotcheiyengnei, khudamoina CD’s, sanapot, achapot.			
5	Eiyaamnasaoganli, toinasaogatkanli			
6	Eigilonggagimigapundoimahutta, ethandaleibanaphei			
7	Eingodatouhaibaduanambanatouganli.			
8	Eiyaamnamipaiganli			
9	Kananomasok aba, thawainungaitaba or naaraba, migimatengpaanganli			
10	Eitoinakhoilenglenganli			
11	Eigiluunatinabamarupamanutragaamadagi henna lei			
12	Ei mi yaamnakhatnaganli, eigiapaambamingondatouhanbangammi.			
13	Eitoinathawainungaitaba, waaganba and kapkanli			
14	Eigilonggagi mi ateisingnaeibuadumpaammi			
15	Eitoinawakhalchoiganli, pukningchangnatoubawaanathok e			
16	Eianoubaphipham/jagah da mipaiganli, eshadanthaajabamaanganli			
17	Eigimakhagiangangsingdaeipukchelchaowi			
18	Eihakpuoidabangangbaamadinamthaaktouwihainatoinamaraalsibi			
19	Ateianagngsingnaeibulaaknabiba and tuhatpibatouwi			
20	Eieshanamigimatengpaanganli (ema-epa, ojasing, angang sing)			
21	Thabakamatoudringeidaeikhantharagatouwi			
22	Eiginuttabapotcheiei school dagi, yum dagi and atoppajagahdagilouwi			
23	Eigilonggasingapunbabudi, ahansinggana henna chashannei			
24	Eigiakeebamayam lei, eiyaamnalaainakiganli			
25	Einatoubathabakloishanli, pukningchangbagipaangalphei.			

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BRIEF BIO-DATA OF THE CANDIDATE

NAME OF THE CANDIDATE	: Ningthoujam Debala Chanu
FATHER'S NAME	: N.Nabakumar Singh
MOTHER"S NAME	: N. Ongbi Mani Devi
DATE OF BIRTH	: 28/02/1989
ADDRESS	: Nongmeibung Academy Road Imphal, Manipur-795001
CONTACT NO	: 9402732888
EDUCATIONAL QUALIFICATION	:**M.Phil in Clinical Psychology** from Regional Institute of Medical Sciences (RIMS) Imphal, Manipur
	:Masters in Psychology from Maharaja Sayajirao University of Baroda, Gujarat
	: Bachelor in Arts with Honors in Psychology from Maharaja Sayajirao University of Baroda, Gujarat

PARTICULARS OF THE CANDIDATE

Name of Candidate	:Ms. Ningthoujam Debala Chanu
Degree	: Doctor of Philosophy
Department	: PSYCHOLOGY
Title of Thesis	:"Self-Esteem, Emotional Maturity and Behavioral Problems among Orphans: A Study in Manipur"
Date of admission	: 21.07.2014

APPROVAL OF RESEARCH PROPOSAL

1. Board of Studies	: 13.04.2015
2. School Board	: 01.05.2015
3.Registration No. and Date	: MZU/Ph.D/724 of 01.5.2015
5. Extension if any	: Nil

(PROF.H.K LALDINPUII FENTE)

Head,
Department of Psychology
School of Social Sciences
Mizoram University
Aizawl-796004.