

Print ISSN No. 2349-3003

Online ISSN No. 2349-3011



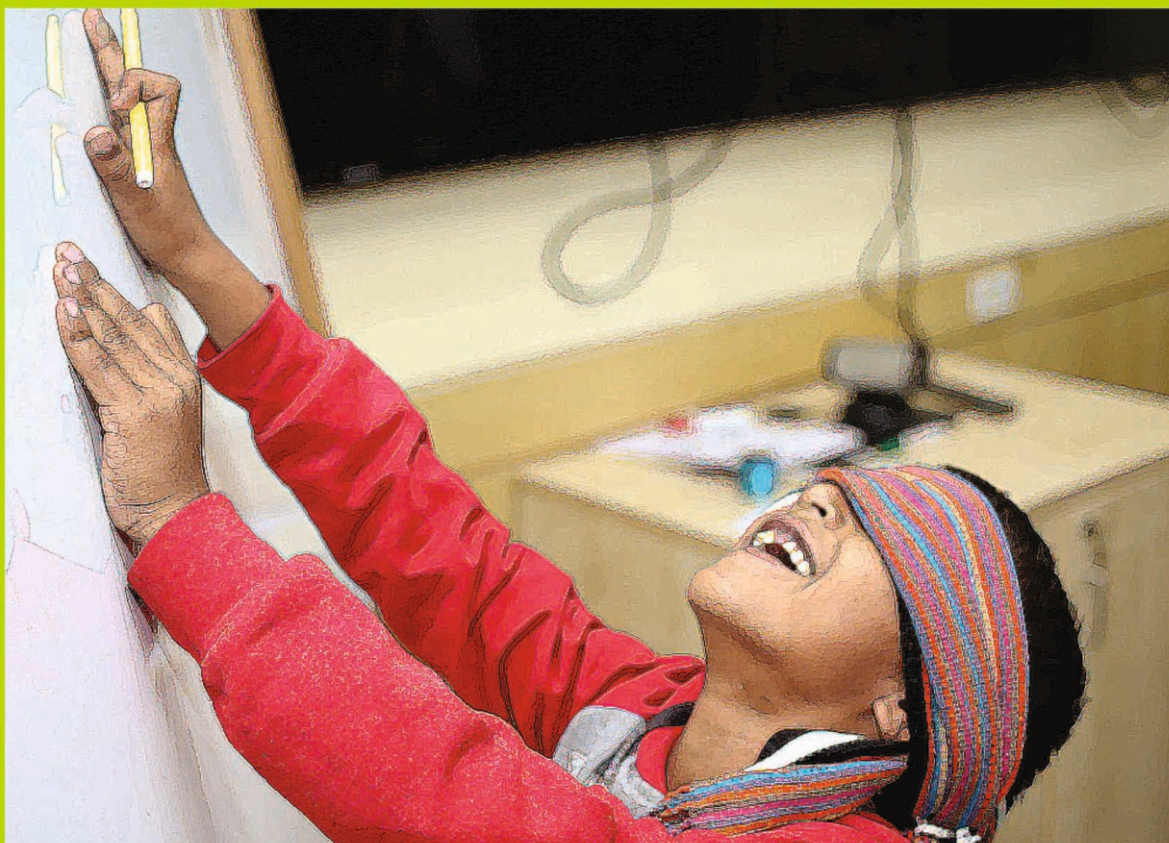
Institutionalised Children Explorations and Beyond

An International Journal on Alternative Care

Volume 4

September 2017

Number 2



**Special Edition on Depression in Children and Young Persons Living
in Alternative Care**

Focused on the South Asian Region



Institutionalised Children Explorations and Beyond

An International Journal on Alternative Care

EDITORIAL BOARD

The Board has currently been constituted as follows:

- **Editor-in-Chief** : Monisha C. Nayar-Akhtar, Ph.D.
- **International Liaison Editor** : Kiran Modi, Ph.D.
- **Associate Editor** : Deepak Gupta, M.D.
- **Associate Editor** : Luis Aguilar Esponda, L.L.M.
- **Movie Editor** : Sonia Parikh, M.D.
- **Book Editor** : Kakul Hai, Ph.D.

COUNTRY EDITORS

- **Bangladesh:** Md. Tuhinul Islam, MA, Ph.D., Senior Research Fellow, Centre for Management and Development Research (CMDR), Northern University Bangladesh
- **Pakistan:** Rukhsana Chaudhry, Psy.D. Assistant Professor of Clinical Psychology, George Washington University, United States
- **Sri Lanka:** Mallika R. Samaranayake, Technical Lead, Child Protection in Crisis (CPC) Learning Network and Founder Member / President - Community of Evaluators (CoE) South Asia

ADVISORY BOARD

- **Alexandra M. Harrison, M.D.**, Assistant Clinical Professor in Psychiatry, Harvard Medical School (USA)
- **Christine Keiffer**, Clinical Psychologist and Psychoanalyst (USA)
- **Hiranthi Wijemanne, M.D.**, Member, U.N. Committee Rights of the Child (Sri Lanka)
- **Jed Yalof, PsyD.** Chair, Department of Clinical Psychology, Immaculata University (USA)
- **Rudy A. Gonzalez, M.A.**, Executive Director, Lighthouse Institute (Australia)
- **Shamim Ferdous, Ph.D.**, Executive Director, Bangladesh Protibondhi Foundation (BPF), (Bangladesh)
- **Shekhar P. Sheshadri, M.B.B.S., D.P.M., M.D.**, Professor, National Institute of Mental Health and Neurosciences (India)
- **Sima Samar, Ph.D.**, Former Minister for Women and Child (Afghanistan)
- **Sumedha Gupta Ariely, Ph.D.**, Psychology, Duke Global Health Institute (USA)
- **Sushama Sharma, Ph.D.**, Professor of Special Education (India)
- **Vikram Dutt, Ph.D.**

We are deeply indebted to WHO SEARO for making possible the publication of this issue.

Volume 4, Number 2, September 2017

The Journal Institutional Children: Explorations and Beyond (ICEB), is an initiative of Udayan Care. Articles published reflect the views of the author alone and not necessarily those of Udayan Care or of the ICEB.

Cover designed by: Shalini Verma

Cover Photo: © Udayan Care

Typeset by: Indian Journals

Indexed/Abstracted with

- Index Copernicus (2016, ICV - 78.03)
- INFOBASE INDEX (IB Factor 2017 - 2.7)
- Primo and Primo Central
- J-Gate
- Google Scholar
- Summon Proquest
- Indian Science
- ISRA-JIF
- EBSCO Discovery
- CNKI Scholar
- Cite Factor
- DRJI ● IIJIF

For More Information on Udayan Care click here: www.udayancare.org



Editorial

Monisha C. Nayar-Akhtar 105-108

Foreword to the Special Edition

Depression: The Black Hole of Despair 109-114
Monisha C. Nayar-Akhtar

Interview

Interview with Leon Fulcher, Child and Youth Care Consultant 115-127
Leena Prasad

Research Articles

Depression within an OSC Environment: Children, Young Adults and
Caregivers in Delhi, India 128-139
*Anna Bensley, Chaarushi Ahuja, Kiran Modi, Riti Chandrashekhar
and Sumedha Gupta-Ariely*

Depression among Children of Tibetans in Exile: A Socio-cultural
Perspective 140-146
Pradeep Nair and Manisha Pandit

A Sequential-Narrative Psychodynamic Approach to TAT Interpretation 147-159
Jed Yalof

Depression Effects among Vulnerable Children 160-164
Liranso G. Selamu and Mohan S. Singhe

Are We Caring Enough for the Children of Lanka? Exploring the
Emotional Well-being of Children in Institutions in Sri Lanka 165-175
Esther John and Roshan Mendis

Externalising and Internalising Behaviour among Institutionalised
Street Children 176-181
Shefali Mishra, Mazhar Khan, Amit Sen and Parvati C. Patani

Depression in Children Living in Alternative Care 182-187
Roma Debabrata and Smritikana Ghosh

International Perspective

'Future Global Goals and Challenges in Alternative Care' – A Discussion
on Interventions and Solutions for Children without Parental Care 188-198
Niels Peter Rygaard

Good Practices and Models of Alternative Care

- What are the factors associated with depressive symptoms among orphans and vulnerable children in Cambodia? 199-213
Ken Ing Cherng Ong, Siyan Yi, Sovannary Tuot, Pheak Chhoun, Akira Shibamura, Junko Yasuoka and Masamine Jimba

Movie Review

- Philomena 214-215
Sonia Parikh

Book Review

- My Heart and Other Black Holes - Jasmine Warga 216-218
Kakul Hai

Brief Communications

219-230

- One-day Consultation on 'Trauma-informed Care: Concepts & Practices for Children in Alternative Care', New Delhi, India 219
- 'Depression: Let's Talk' Says WHO, as Depression Tops List of Causes of Ill Health, Geneva 220
- Supporting Institutional Caregivers in a Children's Home in Rural South India 221
- Two-day Workshop on Alternative Care for Children, New Delhi 225
- Orphanages can be a Child's Best Hope 226
- India's Supreme Court Endorses Family-based Care and Institutions as a Last Resort – National and Global Implications 227

Upcoming Events

231-235

- The Third Biennial International Conference on Alternative Care for Children: with Special Focus on South Asia 231
- 10th International Conference of the International Society for Health and Human Rights (ISHHR) 233
- Eurochild Partnering with IFCO 2017 World Conference 233
- Nurturing Hope 2018: fourth Biennial California Community Services & third Child and Youth Care World Conference 234
- Youth and Justice Congress 2017, 25th to 27th October 2017 in Toronto, Ontario, Canada 234
- AVLIC 2018, Little Hands, Big Message: Working with Deaf Children and Youth 235
- CDPECY 2018: 20th International Conference on Developmental Physical Education for Children and Youth 235

Editorial

The September 2017 issue of this journal marks a turning point in our publication history. Our combined efforts to make this a journal that gradually gains a stellar reputation in the region and beyond has finally culminated in the journal's move to a peer-reviewed platform. This ensures our steadfast commitment to publishing clinical and research papers that address issues related to mental health, policy, care and management of children who have been institutionalised or are otherwise in need of care and protection. While our format remains essentially unchanged, we do take the liberty to publish special journal issues when relevant. The current issue is an example of this trend. We stand with the World Health Organization's recognition and resulting global campaign against depression for this year and are therefore devoting the current journal issue to research and clinical papers that focus on various aspects of this debilitating disease in the population we represent. I am extremely thankful to my editorial committee for the guidance and hard work that they put in behind the scenes and of course to our esteemed reviewers who assisted us in the review and ultimate selection of the papers presented in this issue. I hope that as you peruse through this issue, you will feel encouraged and motivated to be part of our growing team of contributors and reviewers.

This topic of depression is of growing concern nationally and globally. I have therefore chosen to write a short foreword to introduce this topic and shed light on emerging trends and concerns. Writing as a psychoanalyst, my perspective is informed by how an individual's internal world and psyche is shaped by both internal and external factors. I hope this foreword along with the following articles in this issue will inform the reader to the imperative need to address the problem of depression aggressively and with sensitivity.

My foreword examines the psychodynamic underpinnings of depression. Freud highlighted the process of depression in his paper "Mourning and Melancholia" and the profound impact of the loss of a loved one. From an initial denial to the gradual resolution of grief, the process is complex and takes time. Since then, the impact of trauma and compromised attachment has shed further light on this, process as has the understanding of neurobiological underpinnings of this disorder. This along with contemporary psychoanalytic speculations on the dynamics and clinical treatment of depression is further examined.

The issue then follows a well-established format. We begin with our customary interview of an individual whose contributions in this field have been exemplary. We are honored to present an interview of Dr. Leon Fulcher, who has spent over forty years working with maladjusted and delinquent adolescents in residential settings. He has a distinguished academic record, serving as the assistant provost and dean

of students at the UAEU University and as a foster carer in different parts of the world. He is superbly qualified in discussing matters of culture and geographical concerns that impact team working, caring for caregivers and advancing the well being of them. His interview conducted by Ms Leena Prasad is informative, enlightening and provides inspiration and highlights the depth of his work and experience.

I am happy to include a paper from our research students from Duke University. Under the tutelage of Dr. Sumedha Gupta and with the support of Dr. Kiran Modi, these students provide us with another stellar contribution. In their paper, they examine the connection between depression and other mental health indicators and provide support for alternative care programs and mental health professionals in combating this potentially debilitating disease. In addition, their study provides evidence to attend to the mental health needs of the care taker populations who are also identified as being significantly depressed and in need of care. The care giving after all is only as good as the caregiver.

Pradeep Nair and Manisha Pandit expand on this topic by providing a socio-cultural perspective on depression among children of Tibetans in exile. Using semi-structured interviews they explore this further in the care centers of the Tibetan community-in-exile in Dharamshala. By broadening the scope of their investigation they shed light on the complex interplay of factors: social, cultural, religious and political that impact the mental health of a child and particularly as it pertains to the notion of shared memories and the intergenerational transmission of narratives. Following this is a paper from Jed Yalof, who is known for his extensive research and analysis on subjective and objective assessment instruments for understanding personality functioning and assisting in diagnosis and treatment. He explores the use of the Thematic Apperception Test, a structured assessment tool to organize information that can enhance our understanding of ego functioning and intrapsychic conflict. Dr. Yalof references a case that highlights multicultural concerns and depression. Broadening the scope of our discussion and drawing attention to the global imperative for understanding depression, Drs. Liranso Selamu and Singhe's paper on working with orphaned children in Ethiopia inform us that these children are more likely to experience depression. Their findings are consistent with other research findings in this population. They along with others, emphasize the provision of appropriate psychosocial support, education and developmentally appropriate care in addition to skills training and counseling programs.

From the SAARC region, we have a paper by Esther John and Roshan Mendis in which they examine external factors and relationships that impact the emotional well being of institutionalized children. Using case studies from LEADS, a NGO based in Sri Lanka, they obtained information on over 200 children and followed this with expert interviews. The relationship between several factors and the

adjustment of these children is explored. The authors stress that institutionalised children always yearn to go home and be part of a family and their research appears to support government policies to move in that direction.

A research paper from Shefali Mishra, Drs. Khan and Sen and Parvati Patni, examine the existence of mental disorders in street institutionalised children. The propensity for mental illness in this population is high and the authors discuss the various disorders that exist in this population. Using a variety of measures, the authors explore the high risk for these children for a variety of disorders and alert us to the prevalent abuse and neglect that exists in these children and the ramifications of this as they transition to adolescence.

Smritikana Ghosh and Roma Debabrata, drawing from their experience with the STOP Trafficking and Oppression of Women and Children program, present a sensitive analysis of the mental health status of individuals who have a history of trauma. The sense of rootlessness often manifesting as depression is acute and not always visible. They are mindful of how the face of depression is different in childhood and emphasize how it is important to address this for the optimal psychosocial development of the child.

For our international paper, we have a contribution from Dr. Niels Peter Rygaard, who drawing from the global online-based training programs examines the global forces, that drive research, policies and intervention programs. Dr. Rygaard's international perspective and the depth and breadth of his knowledge is immediately evident as the paper weaves in and out of policy, intervention and global trends. We are very fortunate to have an ongoing association with Dr. Rygaard. His clear and concise analysis of global trends, especially as the move towards foster care and adoption gains steam internationally, is helpful to the SAARC region as they begin their own transition to these alternative forms of care. Dr. Rygaard analyzes beliefs, ideology and other factors that contribute to the well being of the child and his paper is a rich contribution to this issue.

To complete the research section of our journal, we have a paper examining the factors associated with depressive symptoms among orphans and vulnerable children in Cambodia. The authors conclude that several factors such as physical health and exposure to violence have an impact on mental health in this population and suggest that since health plays a crucial role, early intervention possibly through schools can act as a buffer against the development of these symptoms. The expanding role of schools in the treatment of this disorder and in increasing ego-resiliency cannot be overemphasized.

The movie "Philomena" is showcased for the movie review and Dr. Sonia Parikh provides a succinct yet enlightening description of this 2013 movie that explores a mother bond's with her child. Set in the 1950's, the movie is a true story of Philomena

Lee who, having grown up in an orphanage, is coerced to give up her little boy. The abrupt rupture leaves her and her son (as we later learn) feeling like a part of them is missing and each seeks to find the other. For those longing to see a happy outcome, the ending is tragic as Philomena in search of her son, some fifty odd years after his adoption, learns that he died, though not without making attempts to find his biological mother. This beautiful movie resonates with many Bollywood movies that portray the powerful connection between mother and child and the inevitable sorrow and 'melancholia' that exists when one loses the other prematurely.

For our book review, Dr. Kakul Hai takes a look at "My Heart and Other Black Holes" a book by Jasmine Warga. The book explores the inner mind of a young sixteen-year-old girl who is grapples with feelings of sadness and is perplexed by the possibility of depression. Family history and the intergenerational transmission of depression are beautifully portrayed in the young girl's relationship with her depressed father along with thoughts of suicide and the desire to end it all. For many clinicians the idea of a 'black hole' aptly describes the painful feelings or rather the numbness that accompanies this debilitating mental condition. It also highlights how prevalent this is among teenagers along with the potential for peer and group support that exists among them. It is the ability to draw upon such support and carry each other through that marks a life that is lived versus one that drowns in abject sorrow. Dr. Hai once again does not disappoint us with her sensitive exploration of these issues in her review.

The journal concludes with a section on brief communications and upcoming events to inform the reader and keep research efforts and us abreast of the enormous clinical work that are underway in the region.

It is my sincere hope that you will become a member of our growing family and join us as a contributor, subscribers, reviewer and perhaps even more.

Monisha C. Nayar-Akhtar
Editor-in-Chief

Foreword to the Special Edition

DEPRESSION: THE BLACK HOLE OF DESPAIR

Monisha C. Nayar-Akhtar

*'Depression isn't just being a bit sad. It's feeling nothing.
It's not wanting to be alive anymore'. – J.K. Rowling*

J.K. Rowling, the author of the internationally renowned Harry Potter book series suffered from depression for years and often had suicidal thoughts. Her story of survival is inspirational and perhaps sometimes it takes someone like J.K. Rowling to alert us to the fact that depression is universal, and spares no one, irrespective of race, colour, creed, gender or age.

In the overwhelming and ever increasing population, globally, of orphans and children and adolescents who are institutionalised as well as those in need of care and protection, the World Health Organization serves a similar function. Their global campaign for the year 2017 is defined by a singular motive. To increase awareness of depression, its debilitating and devastating impact on children and adolescents and the imperative need for interventions and treatment that will aid in the amelioration of this tragic illness. Their efforts are to be applauded, and it is in recognition of this that I submit my foreword to this journal issue on depression and what I call the Black Hole of Despair.

As a psychoanalyst and psychologist, both my academic training and discipline and clinical practice inform me. Psychoanalytic theories of the origin and mechanisms of depression began with Freud's (1917) Mourning and Melancholia in which Freud advanced several ideas about depression. These continue to be widely accepted. According to Freud, pathological depression has a normal analogue: grief and mourning for a loved one or for someone or thing that has been lost through death or separation. The loss can be real or imagined (alluding here to the role of fantasy), and the person maybe believed to be either, consciously or unconsciously, dead and gone. The experience of loss is usually restricted in duration, and after a period of mourning, the person is able to return to a pre-mourning state. When a person is unable to return to their premorbid functioning, depression is the clinical condition that ensues. In this seminal paper, Freud identified the symptoms of pathological

Psychoanalyst and Psychotherapist, Clinical Assistant Professor University of Pennsylvania, Faculty,
Psychoanalytic Center of Philadelphia, Philadelphia, Pennsylvania, USA
Email id: monisha_akhtar@hotmail.com

depression from loss of interest, feelings of helpless and hopelessness, loss of self-esteem and the retreat into an internal world. In addition, he identified the complex interplay of psychic structures that get ruptured in the process. The compromise formations that result are often attempts to stave off despair and are adaptive especially when the person is young. However, during the course of one's life, unresolved issues pertinent to these earlier stages can reappear as one encounters normal and/or unusual losses. These can then trigger profound feelings of sadness that does not abate. Freud also added that for the depressed individual, identification with the loss person and aggression become conflated, that is, one tends to become like the person who has been lost. The role of identification becomes more nuanced when one considers the prevalence of ambivalence in one's psychic discourse. Unable to resolve these feelings, the individual turns their aggression inwards and becomes depressed. Freud's initial documentation of this pathological process was later expanded upon by Blatt (1998) and Brenner (1991) who further identified the role of guilt and judgments towards oneself as a precursor to suicidal tendencies often seen in depressed individuals.

The implicit role of trauma in this discourse was not ignored by Sigmund Freud who identified the mind's internal capacity to deflect traumatic experiences as acting as a protective shield (or the stimulus barrier). When the mind is flooded with stimuli (Freud referred to this as the breakdown of the stimulus barrier) from external and internal sources, the child experiences trauma. The impact of external/internal factors is of course dependent on the child's developmental stage and the coping mechanisms that have developed including ego-resiliency and the capacity for language and affect modulation. Since then, the literature on trauma and its impact on the mind, body and developing child have exploded. Implicit in the literature is the role of the maternal figure (or caretaker) and their capacity to mitigate the impact of unavoidable events that would otherwise render a child helpless and subsequently impaired. Early childhood trauma is now known to impact the development of the mind and later contribute to interpersonal difficulties, to cognitive impairment and increases the risk for depression and suicide. I cannot do justice to this literature in this foreword but would remind the reader to bear in mind the myriad of environmental and constitutional factors that are precursors to the development of a healthy social, cognitive and emotional life in a child.

Recognising the complex world of a child who is developing and growing within the context of a social and familiar environment, Erna Furman (1986, 1982) elaborated on these distinctions in her seminal book on this topic. In 'A Child's Parent Dies' (Furman, 1981), she used a psychoanalytic lens to elaborate on her clinical work with young children. She stressed the age and maturity of the child as a factor in combating susceptibility to trauma. While recognising that the mother compensates for the infant's and young child's initial immaturity, she also recognised that this

auxiliary function contributes to child's vulnerability as well. If the mother does not function well or suffers from illness and traumatic history of her own, the task of protecting her child can be jeopardised. According to Furman, 'in assessing the developmental factor we therefore have to take into account the interaction of two variables, the developmental status of the child's personality and the nature and availability of the auxiliary ego of the mothering person'. Children will always turn to the mother, regardless of whether she is available or not, looking for her even when she does not exist as if to magically procure her from the unseen and unknown to once again be the reparative ego in charge.

According to Furman, these traumatic or immediately post-traumatic states may last for minutes, hours, days, months or years. They may recur, even recur repeatedly under certain conditions. The French movie 'Ponette' (1996) by director Jacques Boillon captures the wide array of symptoms that a child displays when they lose a mother. It centres on a 4-year-old Ponette who loses her mother in a car crash. Boillon captures beautifully the young girl's struggle to come to terms with the loss of her mother, the process of identification and finally the acceptance of things as they are. Moreover, who can forget the 1954 Bollywood film 'Bootpolish' where brother and sister find themselves separated after their mother dies and their poignant reunion years later. In more contemporary times, the film 'Lion' has gained international fame as a young Indian child, separated from his mother and raised in another country, finds himself searching for his mother in his adult years.

The power of films to ignite feelings as we identify with characters or find ourselves on a desperate journey to reclaim a lost one reminds us of the significant role of observation and participation in understanding human behaviour and development. The work of Bowlby (1980) and Rene Spitz (1945) comes to mind as both focused on infant observations to understand the impact of maternal deprivation on the developing infant. Their combined contributions resulting in the theory of attachment and the role of maternal deprivation and its impact on the child's social and emotional development is well-documented. Bowlby identified the parameters of healthy attachment and its impact on the child and their capacity to form healthy relationships later in life. The significant body of research emanating from their initial findings is of particular relevance when working with orphans and institutionalised children. While Bowlby's findings enhanced our understanding of how one could inoculate a child against adversity and contribute to a healthy adaptation, it was Rene Spitz's investigation of maternal deprivation in an infant population confined to institutions that furthered the discussion of depression in young children. Spitz noted the abject misery and retreat from the external world in young infants who were institutionalised and lacked the normal day-to-day contact with maternal figures. He coined the term "anaclitic" depression to describe this phenomenon and later introduced the term "hospitalism" to describe infants who face severe maternal deprivation. His clinical

observations and subsequent theoretical contributions significantly impacted the care of children in orphanages and perhaps in conjunction with Bowlby's understanding of attachment theory contributed to contemporary guidelines for alternative care for orphaned.

Maternal loss is however, as Freud pointed out, not always real. Shengold (2000), a psychoanalyst, whose early work on trauma is well known, emphasised the consequences of maternal child abuse and deprivation on a young child and referred to what happens to the child as a form of 'soul murder'. This term was famously defined by Ibsen (1896, p. 269) as the 'killing of the joy in life-or of the capacity for love-in another human being. It is not a diagnosis, but a crime with a perpetrator and a victim. The perpetrator may be, or at least can come to play the role of, a parent; the victim is either a child or as helpless and powerless as a child', (quoted by Shengold, 2000) In a similar vein, Green (1986), a French psychoanalyst defined the 'dead mother complex', which results from an early and destructive identification with a mother who is emotionally unavailable and depressed. The child's early identification leads to a failure to thrive and later to the onset of depression and depressive symptoms.

The relationship between a mother and child served as the crux of Winnicott's (1965, 1960) literary contributions as he emerged as an outspoken voice on the role of the mother and the developing child. Known for his observation that there is no 'baby without a mother', Winnicott went on to postulate on this dyadic relationship and coined the phrase 'a good enough mother' which allowed for maternal frustrations and other emotions to be present without the fear of irreversible damage on the child. Winnicott's (1975) theoretical contributions along with those of others gave some hope to many who worked with juveniles and young children. The unique array of symptoms that mask depression is highlighted in Winnicott's explication of the anti-social personality where juveniles in trouble with the law could now be viewed and understood through a psychoanalytically informed lens. Contemporary psychoanalytic thinkers recognise that normal depression is a feature of the life cycle. There are losses and gains at each step of development (Rustin, 2009) and the ability to navigate through each step is marked by one's initial ability to negotiate losses with parental figures and other important relationships.

The complex and disturbing world of depression continues to intrigue us. As clinicians and professionals, we see not only its devastating impact as through suicide and loss of life but also the remarkable ability in some children and adolescents who survive despite having grown up in neighbourhoods that would induce despair in many of us. In 'Behind the Beautiful Forevers', the author, Boo (2012) writes about such life, death and hope. Set in the slums of Mumbai, the book portrays the lives of families and orphaned children as they contend with the daily struggles and challenges. This is a non-fiction book and Boo's personal 3-year journey of getting

to know the inhabitants of the Annawadi slums is poignant, riveting and transforming in its message of how one wrenches hope from the jaws of death and despair. Moving to a fictional realm but one that provokes deep feelings in many of us is the award winning movie 'SlumDog Millionaire'. Who can forget little Jamal as his journey from a young child to a young man captures the essence of survival, hope and reparation in life? Many of life's lessons are learned in little encounters that disappear in the deep recesses of our mind. Yet, years later, they reappear and foster adaptive functioning in complex situations.

While Jamal's story may not resonate with many orphaned children, his journey nevertheless reminds us of the imperative need to investigate the factors that make the difference. From despair that spirals downwards to the abyss of sorrow and ultimate suicide to despair that finds expression in recovery, reparation and resolve.

The treatment of depression and its sequelae is informed with our initial understanding gleaned from Freud's initial contributions regarding the psychic apparatus at play. Since then, contributions from the field of neurobiology, psychiatry and neuropsychology have added to our understanding of the neurological underpinnings of depression and its devastating impact. Recognising the genetic predisposition to depression does not negate the impact of environmental factors that can either mitigate its expression or accelerate it beyond repair. Advances in early mother-child-infant research which stresses the importance of the early maternal attunement to the child enhances our understanding of this debilitating condition and contributes to our early intervention efforts. That children and adolescents suffer from depression can no longer be ignored or refuted. It is not enough today to believe only in the power of love. Early diagnosis and intervention remains the key to hope and survival and for many that is their only hope to escaping the Black Hole of despair. The constellation of symptoms that define the depressive disorder also occur in conjunction with other disorders and the treatment therefore is complex and nuanced. From individual short and long term therapy, from insight oriented to cognitive approaches, to working with family systems and addressing institutional systemic functioning, to developing ego strengths, and to the use of medication, the diagnosis and treatment of depression continues to evolve. Perhaps by incorporating ideas from several disciplines we will eventually find ways to combat this disease and reverse its alarming increasing global trend.

I end with a quote from David Foster Wallace, a brilliant award-winning writer, who also suffered from depression for years. According to Wallace, 'we all suffer alone in the real world. True empathy's impossible. But if a piece of fiction can allow us imaginatively to identify with a character's pain, we might then also more easily conceive of others identifying with their own. This is nourishing, redemptive; we become less alone inside. It might just be that simple'.

David Foster Wallace was 46 years old when he died. He hanged himself in 2012 having suffered from depression for years.

REFERENCES

- Blatt SJ, 1998. Contributions of psychoanalysis to the understanding and treatment of depression. *Journal of the American Psychoanalytic Association*, Vol. 46, pp. 723–752.
- Boo K, 2012. Behind the beautiful forevers. New York: Random House Inc.
- Bowlby J, 1980. Attachment and loss. *Loss Sadness and Depression*. Volume III. A member of the Perseus Books Group. New York.
- Brenner C, 1991. A psychoanalytic perspective on depression. *Journal of the American Psychoanalytic Association*, Vol. 39, pp. 25–43.
- Freud S, 1917. Mourning and Melancholia Standard Edition Volume XIV, London, The Hogarth Press and the Institute of Psychoanalysis
- Furman E, 1981. A child's parent dies. Yale University Press. New Haven.
- Furman E, 1982. Mothers have to be there to be left. *Psychoanalytic Study of the Child*, Vol. 37, pp. 15–28.
- Furman E, 1986. On trauma – when is the death of a parent traumatic? *Psychoanalytic Study of the Child*, Vol. 41, pp. 191–208.
- Green A, 1986. 'The dead mother' in on private madness. London: Hogarth Press, pp. 142–173.
- Ibsen H, 1896. John Gabriel Borkmann, trans. M. Meyer. In *When We Dead Awaken and Other Plays*. Garden City, NY: Anchor-Doubleday, 1960.
- Rustin M, 2009. The psychology of depression in young adolescents: A Psychoanalytic view of origins, inner workings and implications. *Psychoanalytic Quarterly*, Vol. 23, No. 3, pp. 213-224
- Shengold L, 2000. Is there life without mother? *Psychoanalytic Quarterly*, Vol. 69, No. 3, pp. 445–464.
- Spitz R, 1945. Hospitalism; an inquiry into the genesis of psychiatric conditions in early childhood! By Rene A. Spitz, M.D. New York.
- Winnicott DW, 1960. The theory of the parent–infant relationship. *International Journal of Psychoanalysis*, Vol. 41, pp. 585-595.
- Winnicott DW, 1965. A clinical study of the effect of a failure of the average expectable environment on a child's mental functioning. *International Journal of Psychoanalysis*, Vol. 46, pp. 81–87.
- Winnicott DW, 1975. Through paediatrics to psychoanalysis: the international psychoanalytic Library, Volume 100. London: The Hogarth Press and the Institute of Psychoanalysis. pp. 1–325.

Interview

INTERVIEW WITH¹, LEON FULCHER², CHILD AND YOUTH CARE CONSULTANT

Leena Prasad

INTRODUCTION

The International Liaison Editor of the Institutionalised Children: Explorations and Beyond (ICEB) Journal and also the Managing Trustee of Udayan Care, Dr. Kiran Modi, has had a long association with Dr. Leon Fulcher and colleagues at the CYC Net. Dr. Modi is also a Board member of the CYC Net.

The following interview was divided into four segments. Firstly, we take a stock of the general situation of children and get to know the views of Dr. Fulcher. In the second part, Dr Fulcher reflects on issues of depression in children living in alternative care: prevalence & interventions deinstitutionalization. In the third and fourth section, Dr. Fulcher shares his views on the way forward to improve overall care and protection for children without parental care in South Asia and as he rightly puts it: 'there are many pathways!', to improve care and protection for children without parental care in South Asia.

¹This interview was conducted on email in May 2017 by Ms Leena Prasad, Consultant at Udayan Care.

²Leon Fulcher, MSW, PhD, has more than 40 years of experience as a social worker with maladjusted and delinquent adolescents in residential child and youth care work, as a joint warden of a university residential college for 18 years, as assistant provost and Dean of students at the United Arab Emirates University and as a foster carer in different parts of the world. As a practitioner, supervisor, manager, researcher, scholar and author, Leon has given special consideration to working across cultures and geographies, how this impacts on what we notice with children and young people, on team working, supervision and caring for caregivers, as well as promoting learning with adult carers. Now in semi-retirement living near Lake Waikaremoana in New Zealand, Leon continues as an author published at The CYC-Net Press, and as a co-director of Transform Action International, a child and youth care consultancy group at www.transformaction.com. Since 1999, Leon has contributed a monthly Postcard from Leon at www.cyc-net.org/cyc-online where he has explored child and youth care themes from around the world. Biography with access to video interviews about Cross-Cultural Working and Outcomes that Matter at: <http://www.transformaction.com/index.html>. Those interested in exploring the ideas presented below further may find references to e-books or paperback copies and articles in the references section of assistance and most are available through The International Child and Youth Care Network at www.cyc-net.org is offering Amazon-supported search and translation options.

Chairperson of The International Child and Youth Care Board of Governors @ www.cyc-net.org, 44 Mountain Road, RD 5, Tuai, 4195 New Zealand

I. VIEWS ON THE GENERAL SITUATION OF CHILDREN

(1) You have over four decades of work experience and expertise on issues of child and youth care. Can you share with us what got you started working in this sector? What was the situation 40 years back on issues of child protection and what has changed in this sector now? Would you wish to share an anecdote with us from your journey so far?

*Looking back, I guess I started working in this sector through my involvement in scouting and voluntary youth work, first as a participant and then as a leader while undertaking concurrent university studies in Sociology and Social Work. I was fortunate to receive a National Institute of Mental Health (USA) scholarship to study and train as an MSW qualified Psychiatric Social Worker at the University of Washington in Seattle. During that time, and following graduation, the focus of my professional life was with emergency mental health and residential child and youth care practice with young women in secure care – many of whom suffered from depression. What has changed? The UN Convention on the Rights of the Child (2010) for a start! The USA has signed that Convention but sadly, along with the Cook Islands, Niue, the State of Palestine and the Holy See, the USA is not a party to it. I find the politics associated with children, young people and families suffering from pain, deeply distressing – especially when refugees of war zones are re-labelled economic migrants and walls are built to pen them in, or pen them out indefinitely. In my early work as a psychiatric social worker with maladjusted teenagers in Scotland and with young women in secure care, I learned about the personal and family stories behind depression, and of the importance of restorative practices. Such stories are highlighted in **Sisters of Pain – An Ethnography of Young Women Living in Secure Care** (Fulcher & Moran, 2013), written with Aliese Moran now grandmother, author and Native American activist but one of the young women back then who lived in that secure unit.*

(2) Why do child protection issues remain largely unaddressed in many parts of the world, even today?

As a generalisation, I would argue that the experts who write and publish about child protection are doing so from a mostly western perspective, or from what the post-modernists might claim as to be their location or place from which they speak. Gun crime remains unaddressed in many parts of the world. In America, more toddlers kill their parents while playing with a loaded revolver in their mother's handbag than the total number of Americans killed by so-called terrorists – in a country that has signed the UN Convention on the rights of the child but has so far failed to fully enact it. Guns are a central feature around war zones, along with missiles, barrel bombs, shrapnel and now suicide bombers. Trauma and post-traumatic stress syndrome continue to challenge restorative efforts with children, young people and

families the world over. The nature of trauma is heavily shaped by economic, social and cultural dynamics, and these require attention alongside any professional efforts to provide therapeutic remedy and support through crisis times into times of restorative equilibrium.

(3) What worries you most when you think of the various vulnerabilities of children globally, especially children in out-of-home-care?

I worry when children and young people have no real sense of belonging or present as someone without any personally rewarding relationships with another or others. Children and young people are vulnerable to exploitation – everywhere! Moreover, there are those who would exploit children for financial gain – everywhere! I worry that the people with money who are paying others to help them exploit children are becoming bolder and more aggressive in their activities! I worry that in many places in our world, local politicians and law enforcement agents help wealthy people exploit children on a scary scale. I can see why, for many child and youth care workers or policymakers, it just feels too hard! So the experts tell us what to do without ever having been there ‘doing Child Protection work’ on a Saturday night in any urban centre.

(4) Given your extensive work with so many individuals and organisations, could you list out the most important issues in child protection in the times to come?

In contemporary times, we already see survivors of war zones arriving at and crossing borders as refugee immigrants seeking new lives in places more peaceful than the places left behind. There and elsewhere, old socio-cultural practices confront new socio-cultural realities, with patriarchal family order maintained in the old country but severely challenged and undermined in the new. Establishing a sense of belonging whilst undergoing cultural adaptation, learning a new language and re-establishing a livelihood are themes that generate ripple effects in families through at least three generations. Throughout Africa and Asia, children and young people have been pressed into becoming child soldiers or sex slaves, now even suicide bombers with hopeful promises about how paradise will be better than present circumstances offer. Religious training and residential education continue to present important challenges, especially in places where private education may be the only options available. Western experts commonly assume that public education such as they received is available for the most part everywhere. Social class and the Hindu socio-cultural caste system cannot be simply intellectualised away through a mental health and psychiatric diagnostic process. How does one make sense of the symptoms of post-traumatic stress syndrome presented by an ‘untouchable child’ as compared with the physically and emotionally abused child of an aspiring ‘merchant-class’ family, or ‘mixed-religion’ family? Professional child protection practices will need to take

issues such as these into consideration from the very first contacts with children at risk and families at risk of endangering their child (ren).

(5) What has been the overall impact of your kind of writings and trainings you do and have you in any way been able to measure the impact of the work you do?

Who knows? I know Aliese Moran has formally published an evaluation of my care and protection work carried out with her and her mother. Then there are the young people with whom I worked during the past 40 years who are now Facebook friends, and our relationships continue in multiple ways. I guess that says something about impact. A Google Search would be the easiest way for somebody to 'check me out' quickly, or even <https://www.academia.edu/>.

(6) You have said that 'Child and Youth Care will not ever be recognised as a profession just because child and youth care workers and educators assert that it should be'. Can you elaborate on this and suggest ways of positioning the work done by this cadre of professionals more seriously?

Child and Youth Care Workers are the day-to-day keepers of stories fundamentally important to the lives of children and young people who spend time in out-of-home care. Those who are successful in this work are those to whom young people return as young adults to restore relationships, if only for brief moments, that remain important in young peoples' lives after leaving care. When young people leave care with their pain acknowledged, respected and with restorative efforts having assisted them to move on with comparative success, these are what make other professionals acknowledge child and youth care workers for their personal authority to act in the best interests of each child in their care. When young people leave care being angry, having experienced added pain in addition to that they suffered before entering care, then every incident like that undermines the professional recognition of child and youth care work. Child and youth care work, as best evidenced in Canada and South Africa where professional certification is required to practice, is most comparable to professional recognition of social pedagogues in Scandinavia and Western Europe as a distinctive professional occupation compared with social arbeiter.

II. REFLECTIONS ON DEPRESSION IN CHILDREN LIVING IN ALTERNATIVE CARE: PREVALENCE AND INTERVENTIONS

(1) Werner discovered that, at least during sensitive periods of their development, children have to be supported by an empathic and caring adult. Would you agree with this proposition and how far have we come on this aspect with children in out-of-home care?

*I totally agree with this proposition, and the sooner and more often such support is recurring, the greater the benefits. If you were to check out **The International Child***

and Youth Care Network at www.cyc-net.org, you will find both qualitative and quantitative evidence that supports Werner's proposition. How far have we come? Not far enough!

(2) Would you know of specific instances of how prevalent depression is amongst children in out-of-home care globally and whether there is literature available through evidence-based studies on this subject?

*In answer to this question, my answer is No. I am more interested in what happens in the daily life spaces of children's lives. My claim is that every child or young person admitted to out-of-home care has very good reason to feel afraid, sad and depressed, without hope about their present or future life circumstances. I do not need to confirm a psychiatric diagnosis of depression – regardless of professional typology being used in a particular clinic or service-delivery centre. As a professional, I need to connect with and work in relationship alongside others to make moments meaningful through the purposeful use of daily life events (see **Making Moments Meaningful in Child and Youth Care Practice** - Garfat et al. (2013).*

(3) Is it true that poor social support is the main cause leading to excessive depression in children living under alternative care globally?

When asked a question like this, I always answer 'It all depends'. It's a 'no brainer' that children, young people and families living in poor conditions without social supports available to others will live with depression or use alcohol or drugs to try and numb the pain. When someone is in pain, a child, a young person, or a young parent or grandparent, what support can they turn to? When 'naebudy cares', as might be heard in Scotland, why wouldn't somebody feel excessively depressed? Moreover, always lurking around depression is anger about what caused this present state of being for this young person. Experience has shown that there is always 'somebody' about whom a young person experiences a cocktail of emotions – including pain, anger, rationalisation as well as motivating episodes of acting out.

(4) What, in your opinion are the symptoms of post-traumatic stress disorder in children exposed to abuse, neglect and abandonment and what is the role of trauma informed care for such children?

*Anyone who has ever been around an animal that has been beaten or abused will know how it may cower or attack, depending on closeness. Vygotsky's notion of Zone of Proximal Development is worth considering. It emphasises the importance of entering a child's personal zone of influence if we are to have any capacity to nurture pro-active responses that are restorative after children have been exposed to abuse, neglect and abandonment. For further information about this, see 'Zoning In to Daily Life Events that Facilitate Therapeutic Change in Child and Youth Care Practice' in **Making Moments Meaningful in Child and Youth Care Practice** (Garfat*

et al. (2013). I'm less interested in the symptoms of post-traumatic stress disorder than I am in ensuring that this child feels safe now and has experienced personal connection with another or others from the first hour of contact, and for every hour thereafter – hence the importance of good child and youth care workers. After a good safe wash, a good feed, and a good sleep in this place that sort of feels safe, or at least a little bit safer than yesterday, I want each child to feel a little more hopeful about tomorrow. What is the role of trauma informed care? To advocate with and for each child or young person to become active participants in their own personal care plan, a plan that also includes for example urgent yet sensitive health and dental care wherever possible.

(5) How would you suggest developing the ability in caregivers to help the child make meaning of the negative events and be able to re-fashion their art of developing resiliency and coping skills in them? Particularly for children, the process of interpreting the negative experiences is characterised by a dynamic interaction whereby the child looks to the reaction of immediate caregivers as a means of interpreting the threat (Ainsworth *et al.*, 1978).

*I wouldn't start from that place. **Child and Youth Care in Practice** edited with Thom Garfat outlines a different starting place, a more holistic approach to working with children, young people and families in pain (Garfat and Fulcher, 2012). My psychiatric training has helped to inform my professional practice over the years and has been particularly helpful in guiding me through meaningful moments that matter with psychiatrists and clinical or developmental psychologists, and even traditional indigenous healers. However, it is best to remember that a diagnosis is always 'an informed guess', but the truth is only made known through a meaningful relationship that nurtures restorative opportunities for learning, personal achievement and happiness. I think of the 'dynamic interaction' referred to in this question as better explained as a 'mirroring dynamic' as a child or young person in pain reacts to prospective caregivers. We have to find our way into 'their zone', and spend less time requiring a young person in pain to enter 'our zone' so we can help them.*

(6) What is the role played by gender when it comes to depression and success in interventions? Do boys and girls have different responses to social support received?

Gender plays a central role, located – as gender is – within socio-cultural norms in any given society and family constellation. Family secrets and relational pain frequently underscore depression, sometimes over generations. Some children and young people experience trauma and internalise the pain, whereas others block off the pain and act out with aggressive or anti-social behaviour. Are there gender patterns? My experience tells me that generally speaking, boys are more socialised to act out their pain, whereas girls are socialised to internalise their pain. There are of course exceptions to this, where young men are at higher risk of suicide and

young women place themselves at higher risk through acting out behaviour. In a study with Professor Gale Burford from the University of Vermont called *Resident Group Influences on Team Functioning* published in **Group Care Practice with Children and Young People Revisited** (Burford and Fulcher (2006). It was shown how, for example, over a 3-year period, placing young people with internalised pain together in a residence prompted different staff teamwork responses than was found amongst care worker teams working most commonly alongside young people with histories of acting out behaviour. An interesting insight was that staff members working with young people with internalised pain are more prone to have feelings of tiredness, lethargy and mild depression. In short, to work effectively with young people with internalised pain, one must enter their zone or existential life space and share something of their load of pain. Meanwhile, staff working with acting out teenagers – whether young men or young women – were more prone to smoking and drinking more heavily, eating more and exercising less. This mirroring aspect of relationships between carers and those for whom they care remains a professional interest.

(7) Would you be able to elaborate upon your proposition of ‘youth care approach’ while working with children in out-of-home care with depression? Does it help if the child and youth care workers are involved with families as they live their lives; and if daily life events are used for therapeutic purposes, as they occur?

Anyone can read (for free!) the first half of Chapter 1 in **Child and Youth Care Practice with Families** edited with Thom Garfat where **Characteristics of a Child and Youth Care Approach** to practice are summarised in Figure 1 (Fulcher and Garfat, 2015).

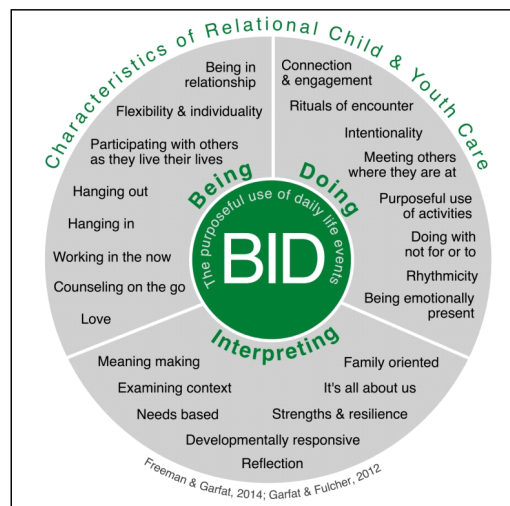


Figure 1: Characteristics of relational child and youth care

Each characteristic and grouping – being; interpreting; doing – is illustrated to show how it is enmeshed with characteristics in each of the groupings. Together, they help guide decision-making and planning by focusing on the following questions:

- *How does my or our way of **Being** with this child or young person and family members influence our working relationship?*
- *What am I noticing and how am I **Interpreting** what is happening with this young person and her or his family, at this particular time in their lives, and in the particular social and cultural context in which we are engaging together?*
- *What might I or we be **Doing** to keep this child safe and help nurture her or his voice about what they need to make their life better, helping to restore diplomatic relations between this young person and her or his family members, or others most important to them?*

IV. THE WAY FORWARD TO IMPROVE OVERALL CARE AND PROTECTION FOR CHILDREN WITHOUT PARENTAL CARE IN SOUTH ASIA

(1) What, in your opinion, are the key factors for child and youth care organisations to keep in mind while working in South Asia on issues of alternative care?

Key factors to which policy and practice attention will need to be addressed include (1) poverty and rural–urban migration; (2) acts of religious violence; (3) inequality of opportunity; (4) tribalism and ‘them and us’ warfare by political leaders who demonstrate little care for the children, young people and families killed and displaced by nationalist and sectarian acts of genocide; (5) restricted access to educational and employment opportunities for displaced children and young people, whether through rural–urban migration or as war refugees and (6) youthful disillusionment as highlighted in the youth suicide statistics in any given country and now includes youth suicide bombers. Children, young people and family members move daily from rural areas into the cities, seeking work even at below subsistence level, including scouring rubbish tips, cleaning sewage drains, begging, prostitution, drugs and human trafficking. As family structures weaken, so does religion challenges new behaviours amongst children, young people and re-constituted families. These challenges include a re-examination of Hindu socio-cultural traditions around social caste and prescriptions for children or young people in need of out-of-home alternative care. Fundamentalist Islam, whether Sunni or Shiite, requires nurturing from within local communities to negotiate safe places where each can become better shepherds of their own peoples instead of blaming others as perceived threats from other socio-cultural traditions like Buddhism or Christianity. Buddhism and Christianity also have their own fundamentalist zealots amongst those socio-cultural traditions, adults always ready to exploit children and young people in out-of-home

*care to gather a following, and in some cases, make money through donations from benevolent Westerners with little idea of how their money is really used. **Residential Child and Youth Care in a Developing World: Volume 1 – Global Perspectives**, edited with Tuhinul Islam (2016), offers several accounts of how alternative care is being developed and is operating across eight South Asia and Middle Eastern countries, including India, Bangladesh, Saudi Arabia, Palestine, Jordan, Cambodia, Malaysia and Japan. Volume 2 – *European Perspectives* (Islam and Fulcher, 2017a) may be of interest but **Volume 3 – Asian Perspectives** (Islam and Fulcher 2017b) in that series (September release) will include additional material from Hong Kong, five further states of India (including Telengana & Andhara Pradesh, West Bengal, Maharashtra, Rajasthan and Jammu & Kashmir), two states of Pakistan, Sri Lanka, Iran, Iraq, Turkey, Lebanon, Yemen, Thailand, Indonesia and the Philippines. Volume 4 in this series, *African Perspectives* will follow at the end of the year (Islam and Fulcher, 2017c).*

(2) What is the significance of developing skills in caregivers in South Asia on trauma informed care when working with children and young people? Would you know of any successful interventions in this regard?

Caring for the caregivers is fundamental to providing quality developmental care for children and young people. Across South Asia, there is no real tradition of training for child and youth care workers, as with European Social Pedagogues, at a comparable level. Instead, most care workers are recruited, mostly women, at low pay and with low expectations from those responsible for placing children in their out-of-home care. Ironically, the profession of Social Work has strong recognition across South Asia as the lead agent of the state with assigned authority to case manage a child or young person's case, even though they may rarely have face to face contact with that child or young person at different times of the day or week. Some efforts have been made to make education and training materials available for direct care workers, houseparents and foster carers during the past two decades, as with The International Child and Youth Care Network @ www.cyc-net.org to supply free internet-based training materials for use in local training initiatives carried out by local service organisations. With the Motto 'Help Children Save The World', the Danish-based Fairstart Foundation @ <http://fairstartfoundation.com/> now offers free online training in 17 languages for people taking care of abandoned and vulnerable children, whether as foster parents, kinship carers or staff in children's institutions.

(3) Can you share with us some experiences from your vast training work on child and youth care? What are the key happy moments and some challenges that you have had to counter in the process?

The important elements of Child and Youth Care education and training, as with Social Work and Nursing education and training, are not learned in a lecture theatre

or tutorial. The most important learning – about Praxis or theory into practice – comes through actively doing something in a child or young person's life space. That also means knowing when 'doing nothing but waiting and attending' are the most important elements of Praxis in this opportunity moment. This also highlights the importance of professional supervision for child and youth care workers as highlighted by Charles et al. (2016). My greatest challenges have come from professional social work specialists, psychologists and psychiatrists who are so expert that they no longer require being in daily life space encounters with children, young people or families. Diagnoses are all too often a power and control issue which give little regard for participation in decision-making by either young people themselves, or family members engaged in decision-making around expert opinions. Statistics for racial dis-proportionality across youth and adult prison populations for indigenous and lower class or caste young people are likely to confirm this assertion in almost any country. I am most interested in what are the key happy moments in young peoples' lives while living in out-of-home care.

(4) What would you suggest as the first key priorities in the area of child and youth care reform globally? What would the future decade be like for child protection and how is a network like CYC-Net contributing in this regard?

*Keeping children and young people safe, wherever they are, is a key priority and helping each one of these children and young people find pathways towards personal achievement and learning. Each young person seeks after a sense of belonging, can be nurtured and encouraged to master challenges and requires support as a care leaver as they grow towards independent and inter-dependent living. To the extent possible, young care leavers need support to enter a shared community that is enriched by generosity and celebrations of relationships. Through the CYC-net discussion list and discussion list threads, and also through the archive of materials published monthly since 1999 through e-Journal **Child and Youth Care Online** available at www.cyc-net.org, now the largest library holding of specialist child and youth care literature is available anywhere in the world. A search facility powered with Amazon helps to make this service very accessible and useable to all engaged in child and youth care work worldwide – at no cost to end users!*

IV. WAYS FORWARD IN SOUTH ASIA (THERE ARE MANY PATHWAYS!)

(1) How would you suggest the World Health Organisation campaign on depression can be taken forward in the context of children living in out-of-home care in South Asia?

*Instead of starting with the latest Diagnostic and Statistical Manual of Mental Disorders IV diagnostic criteria and then applying these criteria across cultures and with children under the age of 14 to 17, why not start from the notion that **All***

Children in Out-of-Home Care have Reason to be Depressed! *Those who act out their pain are likely to have somebody throw a diagnosis of behaviour or personality disorder at them, or even (Attention Deficit Hyperactivity Disorder) ADHD. Young people who internalise their pain and present symptoms of (Obsessive-Compulsive Disorder) OCD, bed wetting, tummy pains, along with suicidal rumination are more likely to achieve diagnoses of post-traumatic stress, adolescent adjustment crisis or neurotic disorders. If we start from this different place, then the challenge is to create and nurture living and learning environments where vulnerable children and young people can feel safe, find nurturing and encouragement to learn and find their special passion, experiencing meaningful moments in relational daily living opportunities. If South Asia is not careful, the only depression that mental health services may try to address – and often quite badly – would be clinical depression with a readiness to use regimes of psychotropic medication or cognitive behavioural therapy which doesn't cross socio-cultural boundaries terribly well.*

(2) What should be the role and responsibility be of Governments in tackling depression and push for stronger child protection systems that strengthen families and community-based care for children? Do you think this can help reduce depression at a scale that is appropriate?

How easy it is to forget that governments are run by people, albeit, most frequently people located on organisational charts where bureaucracy commonly takes over from personal relationships. Child health, education and welfare professionals – social workers, psychologists, paediatricians, psychiatrists, nurses, allied health professionals like audiologists and speech therapists, opticians and ophthalmologists, as well as teachers – may need to spend more time using their expertise towards enabling politicians and policy makers to see the opportunity cost-benefits that can be achieved through better child protection services that work in partnership with families to support community-based care for their children and young people. More training for front-line child and youth care workers is essential. When children, young people and family members start to feel as though somebody is actually listening to their stories, and offering to share some of the emotional burdens associated with such stories, it is quite often a new experience. Most often, the professionals have been telling them what to do. A central task involves attending to personal safety and shelter while nurturing realistic hope for the future. That is what helps to reduce depression, especially for young mothers with children, and with young people who have lost – for whatever reasons – parental and family contact.

(3) For countries in South Asia, what would you suggest as the best strategy to reduce depression amongst children living in alternative care settings in South Asia?

Along with national aspirations to enter the space race as a significant player on the world stage, India's strategic priorities might do well to extend its explorations

of space to a focus on the significant challenges faced through the rural–urban migration of children, young people and families. With few regional development strategies to create family opportunities in regional centres, rural–urban migration to the mega-cities in search of employment is a dynamic now prominent across all of South Asia. The opportunity cost-benefit strategy would seek to address concurrent housing, health and sanitation challenges – even before one thinks of depression rates in shanty town communities or the precise etymology of depression in any given state or region of South Asia. I would submit that concentrated efforts directed towards making moments meaningful for children, young people and family members living in, or with family members living in alternative care across South Asia would make a world of difference to WHO statistics on depression rates for children and young people – wherever they live. Many live in their own families, as do many live in out-of-care. More and more children – especially younger children – now have opportunities to live in foster care, with extended family members or kinship carers (Fulcher and Garfat, 2008). At the same time, more and more young war refugees and asylum seeking youths are to be found living in small, youth-centred residential group living communities.

REFERENCES

- Burford GE and Fulcher LC, 2006. Resident group influences on team functioning. In: Fulcher L.C, Ainsworth F, eds. *Group Care Practice with Children and Young People Revisited*. pp. 177–208, The Haworth Press, London.
- Charles G, Freeman J and Garfat T, (eds.), 2016. *Supervision in Child and Youth Care Practice*. The CYC-Net Press, Cape Town. Available in e-book or paperback format here at [<http://press.cyc-net.org/books/supervision.aspx>].
- Freeman J and Garfat T, 2014. Being, interpreting and doing: a framework for organising the characteristics of a relational child and youth care approach. *CYC-Online*, No. 179, pp. 23–27, accessed here 30 April 2017 at [<http://www.cyc-net.org/cyc-online/jan2014.pdf>].
- Fulcher LC and Garfat T (eds.), 2015. *Child and Youth Care Practice with Families*. The CYC-Net Press, Cape Town. Available in e-book or paperback format at [<http://press.cyc-net.org/books/CYCPFam.aspx>].
- Fulcher LC and Garfat T, 2008. *Quality care in a family setting: A practical guide for foster carers*. Cape Town: The CYC-Net Press. Available in e-book format at [<http://press.cyc-net.org/books/QCIFS.aspx>].
- Fulcher LC and Moran A, 2013. *Sisters of pain: An ethnography of young women living in secure care*. Cape Town: The CYC-Net Press. Available in e-book or paperback format at [<http://press.cyc-net.org/books/sisters-of-pain.aspx>].
- Garfat T and Fulcher LC (eds.), 2012. *Child and Youth Care in Practice*. The CYC-Net Press, Cape Town. Available in e-book or paperback format here at [<http://press.cyc-net.org/books/CYCiP.aspx>].
- Garfat T, Fulcher L C and Digney J (eds.), 2013. *Making Moments Meaningful in Child and Youth Care Practice*. The CYC-Net Press, Cape Town. Available in e-book or paperback format here at [<http://press.cyc-net.org/books/MMM.aspx>].

Interview with Leon Fulcher, Child and Youth Care Consultant

- Islam T and Fulcher LC (eds.), 2016. *Residential Child and Youth Care in a Developing World: Volume 1 – Global Perspectives*. The CYC-Net Press, Cape Town. Available in e-book or paperback format here at [<http://press.cyc-net.org/books/global%20perspectives.aspx>].
- Islam T and Fulcher LC (eds.), 2017a. *Residential Child and Youth Care in a Developing World: Volume 2 – European Perspectives*. The CYC-Net Press, Cape Town. May availability in e-book format here at [<http://press.cyc-net.org/books/global%20perspectives.aspx>].
- Islam T and Fulcher LC (eds.), December 2017c. *Residential Child and Youth Care in a Developing World: Volume 4 – African Perspectives*. The CYC-Net Press, Cape Town.
- Islam T and Fulcher LC (eds.), September 2017b. *Residential Child and Youth Care in a Developing World: Volume 3 – Asia and Middle Eastern Perspectives*. The CYC-Net Press, Cape Town.

Research Article

**DEPRESSION WITHIN AN OSC ENVIRONMENT:
CHILDREN, YOUNG ADULTS AND CAREGIVERS IN
DELHI, INDIA**

***Anna Bensley^{1*}, Chaarushi Ahuja¹, Kiran Modi²,
Riti Chandrashekhar³ and Sumedha Gupta-Ariely⁴***

ABSTRACT

Depression is a leading cause of disability globally, with an estimated prevalence of 350 million people (WHO, 2016). Persistent depression, which is often also co-morbid with physical health disorders, can impede daily functioning and lead to grave outcomes such as suicide, a leading cause of death among 15–29 year olds worldwide (WHO, 2016). Vulnerable populations, such as orphaned and separated children (OSC), who have experienced traumatic events are at an even greater risk of developing depression than their non-vulnerable counterparts (Cluver *et al.*, 2012; Overstreet *et al.*, 2017). This 2-year study describes the prevalence of depression among three distinct populations associated with Udayan Care, an organisation working on alternative care for OSC children in Delhi, India. A random sample of OSC (n = 67), a full sample of their caregivers (n = 29), and a convenience sample of recent graduates of the Udayan Care programme (aftercare and alumni; n = 25) were assessed on depressive symptomology during one-on-one interviews using the Center for Epidemiologic Studies-Depression Scale for Children (CES-DC) or the Center for Epidemiologic Studies-Depression Scale Revised, respectively. As a group in both 2015 and 2016, children living within Udayan homes and aftercare/alumni reported clinically significant levels of depression on the CES-DC scale. Average depression scores in both populations increased from 2015 to 2016 with 48% of aftercare/alumni (n = 12) and 70% of children (n = 47) scoring above the threshold for screening clinical depression in 2016. In addition, 1-year cross-sectional data of caregiver mental health suggests 30% of caregivers are also experiencing depression of clinical significance. Although not necessarily surprising, given the past histories and vulnerabilities of these populations, findings support the emphasis that alternative care programmes and mental health professionals have placed on the importance of depression-related care. This is especially pertinent for vulnerable OSC populations which include caregivers of OSC children and young adults transitioning out of residential care and/or alternative care homes. Future research continuing to follow this cohort longitudinally and investigating the connection between depression and other mental health risks as well as resilience in this population may help elucidate the best ways to support the specific needs of these vulnerable groups.

Keywords: Alternative care, Caregivers, Depression, Mental health, Orphaned and separated children, Vulnerable populations, Young adults

¹Duke Student Researcher, Duke Global Health Institute, Duke Univ., Durham, North Carolina, USA

²Founder and Managing Trustee, Udayan Care, New Delhi, India

³Student, Amity Institute of Psychology and Allied Sciences, Amity University, Noida, U.P., India

⁴Assistant Professor, Duke Global Health Institute, Duke University, Durham, North Carolina, USA

*Corresponding author email id: anna.d.bensley@gmail.com

INTRODUCTION

Depression, either major, clinical depression, subsyndromal depression, dysthymia or minor depression, encompasses a variety of symptoms and range of severity and is a leading contributor of the global burden of disease, affecting approximately 350 million people around the world each year (WHO, 2016). It is known, especially in its severer forms, to be co-morbid with other serious health problems, such as heart disease, as well as other psychological disorders, such as anxiety (WHO, 2016; Reddy, 2010). Depression and depressive disorders can often be caused by adverse life events and are exacerbated by traumatic occurrences. Orphaned and separated children (OSC), due to their severe trauma histories and complicated psychological, social and emotional pasts, thus, tend to be at a higher risk for mental health disorders, such as depression (Trout *et al.*, 2009; Koumi *et al.*, 2012). Unsurprisingly, rates of depression in OSC populations are higher than rates in their non-OSC counterparts (Sengendo and Nambi, 1997; Cluver *et al.*, 2012; Overstreet *et al.*, 2017). Even for OSC in institutionalised care, in which chances for mental health care are higher than for those living in more informal settings like the street, prevalence of depression is generally higher as compared with the overall population (Margoob *et al.*, 2006). If misunderstood, misdiagnosed, untreated or uncared for, depression can continue into adulthood, morph into major mood disorders and lead to an array of stress-related chronic conditions as well as psychologically debilitating ailments (Sigal *et al.*, 2003).

A primary source of potential support for OSC is their caregivers. However, residential caregivers in low- and middle-income countries (LMICs), like OSC, can also have experienced fair levels of trauma throughout their lives. A history of traumatic events increases an individual's risk for developing depression later in life (Schilling *et al.*, 2014). In addition, providing care for vulnerable populations in any setting, home or institution, can be stressful and emotionally straining with subsequent impact on mental health outcomes (Pinquart and Sörensen, 2003, 2004). Caregivers for OSC populations may be at an even greater risk for developing mental health problems than caregivers for other populations (Lv *et al.*, 2010) and thus are an important subgroup in their own right necessitating attention and support.

Developmental transitions into young adulthood and associated responsibilities also present on-going challenges. Institutional care programmes in India are only permitted to care for children until the age of 18 [Juvenile Justice (Care and Protection of Children) Act, 2015]. At this time, children are required to leave residential homes and begin the transition into adulthood, a process that can be emotionally and physically taxing for all young adults and even more for OSCs. As discussed earlier, adverse events during childhood, such as trauma experienced by OSC, can exacerbate this transition and lead to poor mental health such as increased rates of depression (Schilling *et al.*, 2014). Furthermore, OSC are more likely to experience

‘mental problems and loneliness’ than their non-OSC counterparts of the same age (Stein, 2006).

Despite the global burden of disease that depression contributes to, the growing body of literature on the high risk of depression in OSC populations, and the necessity for treatment, relatively little is still known about the extent of depressive disorders within OSC environments. Given this, recently more global attention is being paid to depression, and the World Health Organisation has declared the 2017 World Health Day campaign to be on depression (WHO, 2016). It is understood that OSC as well as young adults are disproportionately affected by depression. However, the prevalence of depression among children and caregivers living within an OSC environment and how depression among these groups affects the efficacy and quality of institutionalised care, especially in LMICs, is still relatively unknown. In India, specifically, more studies are needed to examine the varying levels of depression among different populations in the OSC context. The current study, which takes place at an alternative care programme operated by Udayan Care in New Delhi, aims to elucidate the presence as well as trends in depression and depressive symptoms in three diverse subgroups: children, young adults and caregivers.

METHODS

Objective

To better understand the presence of depression within an OSC residential context by assessing the trends of depressive symptoms within three important and distinct groups: (1) children, (2) young adults and (3) caregivers.

Study Details

The study was conducted over the course of 2 years, 2015 and 2016, with teams of four Duke students each year conducting individual interviews. Depression was assessed within three groups within Udayan Care: group (1) children (ages 6–18), group (2) young adults (ages 18–30) and group (3) adult caregivers. Institutional Review Board (IRB) approval was obtained through Duke and the Udayan Care board, and assent and consent was obtained from all individuals and their represented guardians prior to participation.

Setting

The study is conducted within Udayan Care, an alternative care programme primarily located in the greater Delhi area. Udayan Care bases its care model on the living in a family environment strategy, which emphasises small social networks of professional staff, long-term volunteers and other children. Udayan Care strives to promote positive mental health outcomes through an alternative care model that provides opportunities for children and young adults to flourish through a multi-

tiered care structure. Within the Udayan ghars, children are overseen and cared for by caregivers, social workers, volunteers and mentor parents. Once the children reach the age of 18, they are admitted into the 2-year Udayan aftercare programme which strives to help young adults navigate the transition into adulthood by providing financial, educational, psychosocial and vocational support. Alumni typically begin a life outside of Udayan, and many start families of their own.

Participants

Group 1: Children

Sixty-seven children were randomly selected from 11 of Udayan Care's small group care homes and interviewed both in 2015 and 2016. All participants were of ages 6–18 during the time of the one-on-one interview. A sampling frame of all children within the homes was obtained, and stratified random sampling was used to select proportional groups of participants by gender and age. Children were stratified into three age groups prior to randomisation (group 1 = ages 4–8, group 2 = ages 9–14, group 3 = ages 15+). To ensure roughly equal distribution of ages among the sample, all Udayan children in the youngest group, ages 4 to 8, were included in the study. Given the overall gender proportions within Udayan, more females ($n = 41$) participated in the study than males ($n = 26$). Depression among children was assessed using the Center for Epidemiological Studies Depression Scale for Children (CES-DC), a diagnostic screening tool selected for its previous use within cross-cultural contexts. Children were asked to respond to statements about their experiences with symptoms of depression over the past 2 weeks (response options were 0 = 'not at all', 1 = 'a little', 2 = 'some' and 3 = 'a lot'). A total score of 15 (range 0–60) or more indicates the prevalence of depressive symptoms of clinical significance, and it is suggested that these participants get more screening and additional mental health support as appropriate. The CES-DC was translated and back translated into Hindi, and the final translated version was used for children who did not feel comfortable responding to the questionnaire in English.

Group 2: Young Adults

In 2015, a convenience sample of 23 Udayan aftercare members and 9 Udayan alumni was recruited to participate in the study by Udayan Care administrative staff. Subsequently, in 2016, 16 aftercare and 9 alumni were re-recruited. An additional 8 aftercare and 11 alumni were interviewed for the first time in 2016. All aftercare and alumni participants were in some level of contact with Udayan Care prior to the study and lived within the greater Delhi area. For the purposes of this study, the primary focus will be on the 2-year longitudinal sample (total aftercare and alumni = 25). The Center for Epidemiological Studies Depression Scale Revised (CESD-R) was used to evaluate the prevalence of depressive symptoms among aftercare and alumni. On a possible range of 0–60, any total score above 16 on the CESD-R

indicates depressive symptoms of clinical significance, and it is suggested that the interviewee seek care from a mental health professional. The CESD-R was translated and back translated into Hindi for reliability purposes; however, most adults were comfortable speaking English, and the Hindi version of the measure was used infrequently.

Group 3: Caregivers

In 2016, for the first time, caregiver mental health was also assessed. All caregivers ($n = 29$) within the same 11 homes were assessed. Two to three caregivers in each of Udayan's small group homes are responsible for daily maintenance of the home and childcare. Similar to the young adult population, one-on-one interview depressive symptoms were measured using the CESD-R. A total score above 16 on the CESD-R denotes significant risk for depression. Interviews were primarily conducted by an Udayan Care intern in Hindi using a version of the CESD-R that underwent extensive translation and back translation. It was the same version that was used for the few young adult participants who preferred answering the interview in Hindi.

Data Analysis

Data analysis for each population was conducted using SPSS Statistics software and Microsoft Excel. In the case of longitudinal data, mixed method analyses of variance (ANOVAs) for repeated measures (factorial within-subject and between-subject analysis) were used to test for significance ($p < 0.05$). For children, the between-subject variable was gender (male and female), and for young adults, the between-subject variable was level of Udayan programme (aftercare or alumni). Furthermore, individual-paired t-test analyses were conducted for alumni and aftercare analysis.

RESULTS

Presence of Depression in Group 1(OSC Residents, 2015–2016)

When interviewed using the CES-DC, descriptive analysis indicated that children, on average, reported greater depression symptoms in 2016 ($M = 21.39$) than in 2015 ($M = 20.07$). However, as can be seen by the averages, this increase was quite slight and a within-subject ANOVA for repeated measures confirmed this difference was not significant ($p = 0.496$). More specifically, in 2016, 70% of children ($n = 47/67$) scored above the clinical threshold for depression on the CES-DC. Thirty-seven of those children had scored at least a 15 on the CES-DC (the threshold for depression risk) in 2015 as well. Thus, it is important to note that 55% of children in our sample showed clinically significant levels of depression across 2 years on this measure. A liberal patient care approach to this data could be used to imply that 55% of our sample *stayed* at a clinically significant threshold across 2 years,

highlighting the importance of longitudinal research and of advocating for importance of long-term mental health support.

The 2-year longitudinal sample was also analysed by gender. On average, females ($n = 41$) had higher CES-DC scores (denoting higher depressive symptoms) than males ($n = 26$) in both 2015 and 2016 [males (2015: $M = 19.12$, $SD = 13.79$; 2016: $M = 18.65$, $SD = 9.20$), females (2015: $M = 20.68$, $SD = 10.81$; 2016: $M = 23.13$, $SD = 11.07$)], but there was no statistically significant main effect of gender across the 2 years ($p = 0.216$). Moreover, although the scores appear to diverge in 2016 (i.e. females' scores increased from 2015 to 2016 while males' scores decreased slightly), there is no significant time by gender interaction (Figure 1).

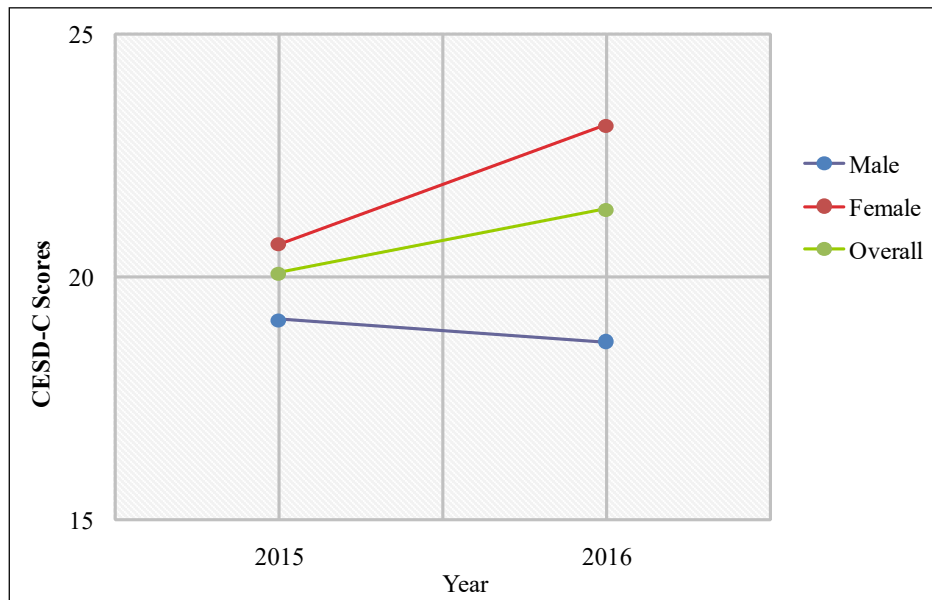


Figure 1: Longitudinal children sample (ages 6–18) CES-DC scores by gender

Across both years, on average females ($n = 41$; green) and males ($n = 26$; orange) in the longitudinal sample showed depressive symptoms of clinical significance (CES-DC scores > 15). Gender scores tend towards divergence, but gender differences are not significant ($p = 0.216$).

Presence of Depression in Group 2 (Transitioning Young Adults, 2015–2016)

For the longitudinal sample ($n = 25$), depression symptomology as scored by the CESD-R was analysed using a simple paired t -test. Depression scores significantly increased from 2015 to 2016 among the total longitudinal sample of aftercare and alumni [$n = 25$; $t(24) = -3.187$, $p = 0.004$]. In 2015, the mean score for young adult

depression was 16.08, and in 2016, for the same participants, the mean score was 21.64. Both yearly averages are above the clinical threshold for significant depressive symptoms (score > 16). In addition, the range of CESD-R scores increased from 2015 (range = 2–48) to 2016 (range = 1–52).

There was not a significant between-subject main effect when comparing aftercare and alumni ($p = 0.579$). However, as stated above, there was a significant within-subject effect for time ($p < 0.05$). Furthermore, when looking at change across time within each subsample of alumni and aftercare, the changes in reported depression symptomology over time were significant. Repeated measures simple t -tests showed that on average aftercare ($n = 16$) scores increased from 17.5 in 2015 to 22.5 in 2016 [$t(15) = -2.137, p = 0.049$]. Alumni ($n = 9$) also reported greater levels of depression in 2016 ($M = 20.11$) than in 2015 [$M = 13.55; t(8) = -2.492, p = 0.037$]. Although the sample sizes are small, this time effect for each subgroup is an important trend to monitor. Furthermore, more alumni ($n = 3$) than aftercare ($n = 1$) in 2016 reported increased depression symptoms above the clinical threshold. Longitudinal trends across 2015–2016 are shown in Table 1.

Table 1: Young adult longitudinal depression trends, 2015–2016

	Young Adult Longitudinal Depression Trends			
	Remained Low Depression	Decreased to Low Depression	Increased to High Depression	Remained High Depression
Alumni	2	2	3	2
Aftercare	7	2	1	6

Depression was measured using the CESD-R. ‘Low’ scores are interpreted as below the threshold for clinical significance (score < 16). ‘High’ denotes any participant who reported a total CESD-R score above clinical significance (Figure 2).

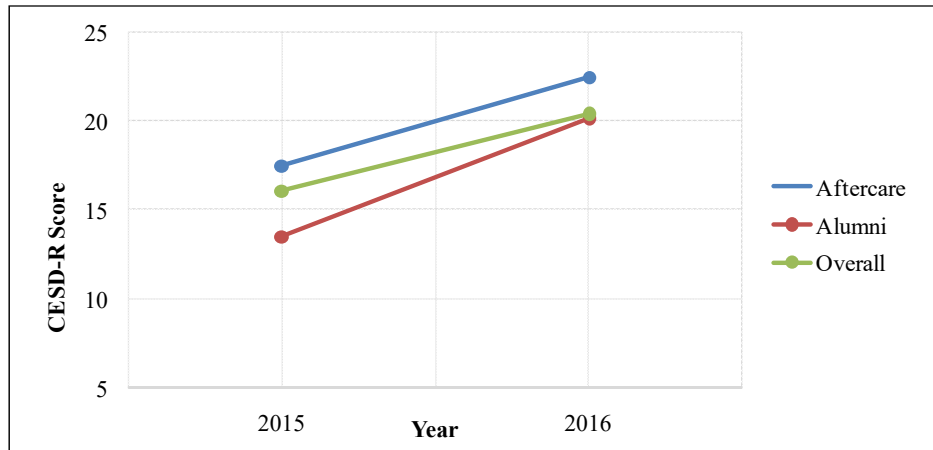


Figure 2: Longitudinal young adult average depression scores

Aftercare ($n = 16$) CESD-R scores were consistently higher than alumni ($n = 9$) CESD-R scores. Overall, young adult depression scores increased significantly between 2015 and 2016 [$n = 25$; $t(24) = -3.187$, $p = 0.004$].

Presence of Depression in Group 3 (Caregivers, 2016)

The mean depression score for the 29 caregivers who were assessed via the CESD-R in 2016 was 11.58, with scores ranging from 0 to 35 (highest possible score is 60), and with a standard deviation of 9.75. Although almost a third of the group, 31% ($n = 9$), reported scores above the threshold for clinical significance (score > 16), the majority reported subclinical indications for depressive symptomology (Figure 3).

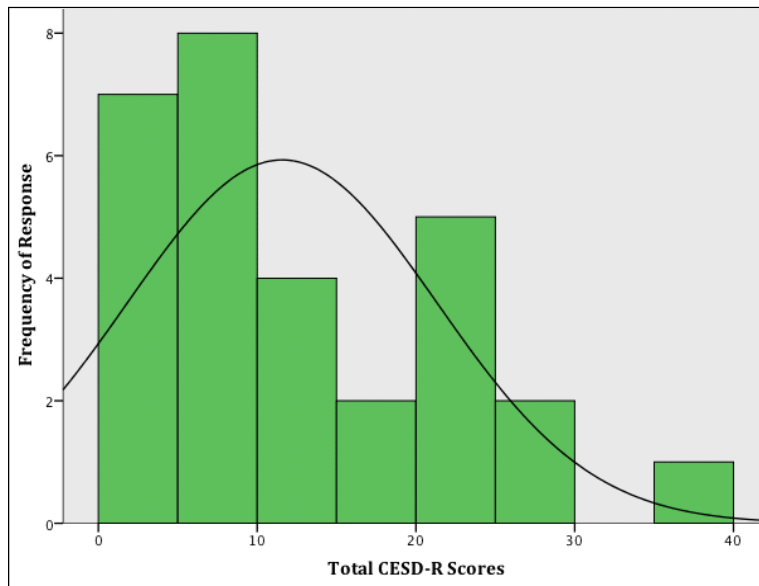


Figure 3: 2016 Cross-sectional caregiver depression

Caregivers reported depression scores ranging from 0 to 35 ($M = 11.58$; $SD = 9.75$). Curve for normal distribution is shown.

DISCUSSION

Within an OSC environment, there are many distinct vulnerable populations at risk for developing depression or depressive symptomology. Depression, whether major or minor, can inhibit proper development, restrict well-being and limit the ability for one to care for him- or her-self as well as others. Depression and other associated mental health conditions within vulnerable populations are not surprising outcomes. Within alternative care settings, depression can encumber an organisation's efforts

in supporting and fostering positive developmental growth and can be detrimental to the care each unit tries to provide in cultivating a healthy environment for children and caregivers. Recognising the importance mental health plays in development and the connections between physical and mental well-being, academics and policymakers are emphasising the need for increased study, research and clinical support (WHO, 2016; Miranda *et al.*, 2017; Rice *et al.*, 2017). The first critical step is to determine the presence of depression for vulnerable populations within the environments that support them. This study, undertaken as part of Udayan's mission of care, found that, on average, children and young adults experience some clinically significant levels of depression symptoms, and that about one-third of caregivers also display similar depression levels.

The rates of depression found between 2015 and 2016 among children (group 1) may be attributable to a multitude of factors including, but not limited to, past traumatic events, co-morbidity of mental illnesses and anxiety and stress. However, it is worth noting that female and male rates of depression symptoms over the 2 years were comparable. This finding supports other research findings from LMICs showing female and male mental health trends to be similar (Gray *et al.*, 2015). Regardless of gender, support and treatment for OSC children who are experiencing depression needs to be increased. Continuing to conduct research within this population and investigating possible risk factors for depression among this, especially vulnerable group will further inform best standards of care.

Similar to child results, on average, individuals in group 2 (young adults) exhibited clinically significant depressive symptoms in both 2015 and 2016. Unlike the children, however, depression among young adults significantly increased across the 2 years ($p = 0.005$). Depression may be attributable to a variety of factors, ranging from intensified stress during transition to adult and independent living, and possibly new adverse life events (Stein, 2006), or more vulnerable mental status due to co-morbidity with other mental health problems. A previous study found a correlation between depression, anxiety and social adjustment among orphaned and separated young adults transitioning out of small group home-based care (Ahuja *et al.*, 2017). Depression rarely exists in isolation and is not uncommon even among non-OSC young adults transitioning into independent living from upper and middle-income families. It is probable that OSC young adults face many additional difficulties as they become more independent and that depression is just one single indicator among possible others. As the young adults interviewed were once in group home care, it is important to note that prevalence of depression among this group may be predictive of future mental outcomes for current residential care children.

Udayan Care is a relatively unique model in the alternative care environment as it recognises the need for and actively tries to support transitioning young people through the aftercare programme. Institutions and programmes that assist

adolescents transitioning into adulthood, financially, emotionally and academically, provide some of the natural support that non-OSC young adults often find through their networks of immediate and extended family. The extensive efforts to support OSCs that alternative care models try and provide, however, is just one critical lifeline in mental health needs that OSCs and other vulnerable groups require. Further steps to incorporate depression awareness and foster mental health care across many OSC children globally, and in India, is an important step in helping lower the presence of depression among populations that often have a deep history of trauma.

When compared with the other two groups within this study, caregiver depression (group 3) can seem relatively and optimistically low. On average, caregivers reported depression symptom levels below the threshold for clinical significance. Nevertheless, it is noteworthy that almost one-third of the caregivers reported clinical levels of depression symptoms. If caregiver's health is indeed predictive of child health (Thielman *et al.*, 2012), any amount of depression among caregivers could be a risk factor for increasing rates of child depression. However, the relationship between children and caregivers is likely also bidirectional. Caring for children who are exhibiting depressive symptoms may be more tolling for the caregivers as well. These are important relationships that need to be supported and further investigated.

This study has a few limitations worth addressing. Both the caregiver and longitudinal young adult populations were relatively small ($n = 29$ and $n = 25$, respectively). Ideally, more young adults will be interviewed in the following years. Recruitment incentives and accommodating travel expenses may encourage more transitioning young adults to participate in the study. In addition, the young adult population encompasses many different phases in life, and therefore, individuals may be facing very different stressors that could impact the likelihood of developing depression symptoms such as pursuing secondary education, looking for and starting a career, finding marriage partners and starting a family. A larger sample size would allow for a more robust analysis and comparison of aftercare and alumni as separate populations with unique and transitionally informative experiences.

In conclusion, studying depression among an OSC environment is critical for prevention of negative mental health outcomes and appropriate care for vulnerable populations. In this study, three populations, children ($n = 67$), young adults ($n = 25$) and caregivers ($n = 29$), were screened for depression. The presence of clinically significant levels of depression among all groups denotes the need for further mental health support and continuing research to elucidate the association of depression among and between populations within OSC environments.

ACKNOWLEDGEMENTS

This research was supported by the Duke Global Health Institute Student Research Training Program. We would like to acknowledge all the Udayan staff for their

passion and determination to provide a better future for the Udayan children. The extent of our data collection in 2016 was made possible only through the support of Udayan Care interns: Anshita Jinal and Kashni Channa. Lastly, we are grateful to our 2015 and 2016 Duke Student Research Training Program (SRTP) India teammates for being part of and helping collect the 2 years of data that were used in these analyses.

REFERENCES

- Ahuja C, Bensley A, Huh J, Levy J, Nayar-Akhtar M and Gupta-Ariely S, 2017. Transitioning OSC mental health profiles: a 2-year longitudinal study of aftercare and alumni from Udayan Care. *Institutionalised Children Explorations and Beyond*, Vol. 4, No. 1, pp. 40–51.
- Cluver LD, Orkin M, Gardner F and Boyes ME, 2012. Persisting mental health problems among AIDS-orphaned children in South Africa. *Journal of Child Psychology and Psychiatry*, Vol. 53, No. 4, pp. 363–370.
- Gray CL, Pence BW, Ostermann J, Whetten RA, O'Donnell K, Thielman NM and Whetten K, 2015. Gender (in) differences in prevalence and incidence of traumatic experiences among orphaned and separated children living in five low- and middle-income countries. *Global Mental Health*, Vol. 2. DOI: 10.1017/gmh.2015.1
- Juvenile Justice (Care and Protection of Children) Act, Chapter VI, Stat. 36 (3). Pub. 31 December 2015. New Delhi, India.
- Koumi EL, Mohamed A, Ali YF, El Banna EA, Youssef UM, Raya YM and Ismail AA, 2012. Psychiatric morbidity among a sample of orphanage children in Cairo. *International Journal of Pediatrics*, Vol. 2012. DOI:10.1155/2012/141854
- Lv Y, Zhao Q, Li X, Stanton B, Fang X, Lin X and Zhao J, 2010. Depression symptoms among caregivers of children in HIV-affected families in rural China. *AIDS Care*, Vol. 22, No. 6, pp. 669–676.
- Margoob MA, Rather YH, Khan AY, Singh GP, Malik YA, Firdosi MM and Ahmad SA, 2006. Psychiatric disorders among children living in orphanages – experience from Kashmir. *JK-Practitioner*, Vol. 13, No. 11, pp. S53–S55.
- Miranda JJ, Diez-Canseco F, Araya R, Cutipe Y, Castillo H, Herrera V and Cavero V, 2017. Transitioning mental health into primary care. *The Lancet Psychiatry*, Vol. 4, No. 2, pp. 90–92.
- Overstreet C, Berenz EC, Kendler KS, Dick DM and Amstadter AB, 2017. Predictors and mental health outcomes of potentially traumatic event exposure. *Psychiatry Research*, Vol. 247, pp. 296–304.
- Pinquart M and Sörensen S, 2003. Differences between caregivers and non-caregivers in psychological health and physical health: a meta-analysis. *Psychology and Aging*, Vol. 18, No. 2, pp. 250–267.
- Pinquart M and Sörensen S, 2004. Associations of caregiver stressors and uplifts with subjective well-being and depressive mood: a meta-analytic comparison. *Aging & Mental Health*, Vol. 8, No. 5, pp. 438–449.
- Reddy MS, 2010. Depression: the disorder and the burden. *Indian Journal of Psychological Medicine*, Vol. 32, No. 1, pp. 1–2. DOI: 10.4103/0253-7176.70510.
- Rice F, Eyre O, Riglin L and Potter R, 2017. Adolescent depression and the treatment gap. *The Lancet Psychiatry*, Vol. 4, No. 2, pp. 86–87.

Depression within an OSC Environment: Children, Young Adults and Caregivers in Delhi

- Schilling C, Weidner K, Schellong J, Joraschky P and Pöhlmann K, 2014. Patterns of childhood abuse and neglect as predictors of treatment outcome in inpatient psychotherapy: a typological approach. *Psychopathology*, Vol. 48, No. 2, pp. 91-100.
- Sengendo J and Nambi J, 1997. The psychological effect of orphanhood: a study of orphans in Rakai district. *Health Transition Review*, Vol. 7, pp. 105–124.
- Sigal JJ, Perry JC, Rossignol M and Ouimet MC, 2003. Unwanted infants: psychological and physical consequences of inadequate orphanage care 50 years later. *American Journal of Orthopsychiatry*, Vol. 73, No.1, pp. 3.
- Stein M, 2006. Research review: young people leaving care. *Child & Family Social Work*, Vol. 11, No. 3, pp. 273–279.
- Thielman N, Ostermann J, Whetten K, Whetten R, O'Donnell K and The Positive Outcomes for Orphans (POFO) Research Team, 2012. Correlates of poor health among orphans and abandoned children in less wealthy countries: the importance of caregiver health. *PLoS ONE*, Vol. 7, No. 6, pp. e38109.
- Trout AL, Casey K, Chmelka MB, DeSalvo C, Reid R and Epstein MH, 2009. Overlooked: children with disabilities in residential care. *Child Welfare*, Vol. 88, No. 2, pp. 111.
- WHO, 2016. *Depression (Fact Sheet)*. World Health Organization. Online: <http://www.who.int/mediacentre/factsheets/fs369/en/>.

Research Article

**DEPRESSION AMONG CHILDREN OF TIBETANS IN
EXILE: A SOCIO-CULTURAL PERSPECTIVE**

Pradeep Nair^{1} and Manisha Pandit²*

ABSTRACT

The Tibetan exile community located in India provides refuge to thousands of children living in different care centres located at the small mountainside town known as McLeodganj, Dharamshala – a homeland for them. The primary focus of this study is to explore and analyse the mental health issues, especially depression, among the children of an exiled community from a socio-cultural perspective. Mental health is defined variously from different socio-cultural perspectives. The concept includes, *inter alia*, subjective well-being, perceived self-efficacy, autonomy, competence, inter-generational dependence and self-actualisation of one's intellectual and emotional potential. From a socio-cultural perspective, it is very difficult to define mental health issues comprehensively, especially when it is intimately linked to the social, cultural, religious and political factors of a community which is outside Tibet and is only in the imagination of the children in the form of shared memories and experiences that they have heard from their elder ones. This study is based on semi-structured interviews conducted in the care centres of the Tibetan community-in-exile in Dharamshala. The inputs explore the status of mental illness and distress among the children living in these care centres and the interventions and strategies currently in practice to cope with them. The analyses also focus on the socio-cultural perceptions of mental illness and distress.

Keywords: Care centres, Children, Coping strategies, Culture, Depression, Interventions, Mental health, Tibetans-in-exile

The problem of depression among the children living in care centres of the exiled Tibetan community is quite different from other children. Although the care centres are socialising these children in Tibetan culture and values through narrated history (Yankey and Biswas, 2012), the failed efforts of the community fighting for its country's independence as well as for recognition, dignity and social justice often distort the picture and create a kind of hopeless feelings for the children living in an imagined community. The efforts of the care centres to involve the children in political, cultural and social gatherings are helping them to adapt an exiled environment, but lack of engagement in an elaborate network of mutual support is finally making them prone to adopt the image of helpless, homeless and uprooted refugees. The long-distance nationalism of the community inevitably contains a strong element of

¹Associate Professor & Head, ²Research Scholar, Department of Mass Communication and Electronic Media Central, University of Himachal Pradesh, Dharamshala, Himachal Pradesh, India

*Corresponding author email id: nairdevcom@yahoo.co.in

exclusiveness, thus putting its children in the danger of getting 'lost' in the distant culture of the host country (i.e. India) and creating an identity crisis among them. This mental distress is fundamentally different from others and needs to be understood within the context of the exiled community's cultural and social system.

There are a number of studies which argue that being a refugee is commonly associated with psychological distress (Baker, 2008). But Tibetans are different from others as they have an advantage of a functional government-in-exile and also have a social and cultural support system. This is somehow effective in dealing with the stresses of a life-in-exile, especially in the case of adults. But the growing number of mental health issues among children living in exile due to the doubt of their self-identity and future creates an urge to explore the different social and cultural constructions of mental illness and distress, and the strategies required to deal with the emerging coping challenges.

DECONSTRUCTING THE CHILDHOOD IN EXILE

The French social historian Philippe Aries in his work *Centuries of Childhood* explicated that childhood is a term socially constructed and has different meanings in different historical periods and cultures. He observed that the concept of child and childhood has varied across centuries and the notion of child and childhood is both historically and culturally conditioned (Aries, 1962). The Tibetan children living in a foreign land, in a distinct socio-political environment and struggling for maintaining their own socio-cultural identity out of an established image of a refugee community have different economic, political, social and cultural ethos and structures. The identity and idea of Tibetan children living in exile are shaped by multiple social, political and cultural factors.

The Tibetan exile community located in Dharamshala, India was established in 1959 following the military occupation and subsequent annexation of Tibet by the People's Republic of China. His Holiness the Dalai Lama and thousands of Tibetans were forced to leave Tibet and took political asylum in India. Due to violence, turmoil, political repression and persecution, nearly thousands of children and adults seek refuge in India every year. The small mountainside town, known as Dharamshala, presently provides refuge to more than 30,000 children. These children living in alternative care centres are growing up in a different socio-cultural set-up than their other counterparts. Their dream and hope of going back to their homeland one day is shattering day by day while witnessing the political reality of the Tibetan struggle for freedom. The community is trying every means and method to preserve its social and cultural identity, but it is becoming hard to develop a sense of loyalty among the children of new generation for Tibetan nationalism, as their upbringing is influenced by a socio-political environment which is quite different from their own. These young children living in exile are finding it difficult to preserve their identity,

as the language and culture of their surrounding is non-Tibetan, thus making them feel alone and self-conscious (Fazel and Stein, 2002). Every day, these children have to face harsh questions from their neighbouring communities about their family status and political affiliations. The young and immature mind of these children often fails to understand the cause of their exile and the extent of their transnational contacts, thus making it very difficult for them to keep their emotional and mental status in balance.

MENTAL HEALTH PROBLEMS IN TIBETAN-EXILED COMMUNITY

Mental health is basically known as a state of psychological and emotional well-being, but the concept is not so easy in the case of Tibetan community living in exile. Here, the understanding is multifaceted and complicated. It is not just about the psychological state of mind but about the manifestation of behaviour. Leaving their country and settling down in a different geographical, social, cultural and political land is in itself very traumatic and should be perceived from a psycho-social point of view rather than simply as mental disorders (Marsella, 1979). Depression and anxiety among the children of Tibetan exiles are severe and closer to behaviour disorder. Due to their poor social and economic status, the community lacks help-seeking behaviour and awareness and is more prone to depression and post-traumatic stress. The migrated children are facing difficulties in adjusting to the new culture of alternative care centres, and the stress of leaving their family behind is forcing them to the risk of developing common mental disorders. Studies conducted on the Tibetan-exiled community have shown that these children are four to five times more likely to develop depression, anxiety and post-traumatic stress in comparison to other migrated population (Fazel and Stein, 2002). But due to limited mental health resources and services in Dharamshala, it is difficult to gauge the extent of mental health issues prevailing in the community (Sachs and Rosenfeld, 2008).

In many parts of the world, mental health problems are identified on the basis of psychological diagnosis and therapy; whereas in a migrated community like the Tibetans-in-exile, the problem is more close to behavioural changes associated with religious beliefs, cultural values, customs and local ideas about mental illness and counselling (Marsella, 1979). The counselling services offered to children-in-exile are not very extensive and are suffering due to paucity of trained psychotherapists and counsellors (Sachs and Rosenfeld, 2008). Due to acute shortage of financial support and funding, the community lacks proper diagnostic set-ups to diagnose mental illness and psychological disorders, especially the psychosomatic symptoms of children suffering from psychological disturbances caused due to migration and resettlement. Many cases are generally referred to the nearby Indian hospitals. However, the psychiatrists of the Indian hospitals do not always understand the depressive or anxiety disorder among the children caused by increased stress and

anxiety that they experience due to problems in adjusting with the life in exile, resuming studies in new schools and escaping from their homeland. As a result, psychiatrists of the Indian hospitals may not be able to counsel the children in a right perspective. It is very difficult to understand the socio-psychological problems of the children in exile from outside (Ahearn *et al.*, 1999).

THE CULTURAL AND SOCIAL CONSTRUCTIONS OF MENTAL DISTRESS

Understanding the mental health issues of children living in exile is a complex task as it requires consideration of a multidisciplinary perspective – philosophical, psychological, physiological, biological, sociological, political, economic and cultural. The socio-cultural constructions of mental distress among children are important as it helps identify and explore the ability of children to understand their own world and to act upon it. In comparison to the children of developed communities where they actively participate and co-construct social and cultural meaning and knowledge, the children of an exiled community are mostly viewed in a paternalistic way – as being passive, helpless and incapable of making decisions for them. They act simply as passive recipients of an adult culture, which is based on shared memories and experiences. Thus, the mental distress of the children of Tibetan exiles needs to be understood from a socio-cultural perspective. The diagnosis of mental illness and psychological disorders varies according to the different roles and different experiences of children based on class, gender, ethnicity, religion and cultural background. The distress is constructed by various social, political and religious institutions, structures and cultures – schools, families or physical geographies. They influence the mental status of children by setting the boundaries of what is possible, appropriate and expected (Nair, 2016).

Depression and anxiety are visible among the Tibetan children due to the pressure on them to adapt and adjust themselves in an exiled environment (Sachs and Rosenfeld, 2008). Lack of culturally sensitive psychological support to fill the emotional gap created due to limited family support and access also makes the mental health problems more peculiar. Different society and cultures have different ways of understanding mental health problems. According to Kleinman (1978), mental health and illness need to be understood within the context of a society's or community's cultural and social system. A psychotherapy or counselling intervention may not work if it does not understand the local cultural belief systems and their association with the coping strategies.

THE COPING MECHANISMS AND INTERVENTIONS IN PRACTICE

To deal with the mental health issues of the Tibetan children-in-exile, coping strategies are practiced through pedagogical approaches in institutionalised care centres. The primary information obtained through interviews with the counsellors working with

the care centres reveals that the mental health issues of these children are different as they are part of a community that is geographically and physically outside Tibet, and the only idea of the homeland is the imagination often created on the basis of the stories and narrations the children hear from their elder ones. The challenge for the care centres is to acquaint these children with Tibetan culture and tradition. As the children go through the process of socialisation in a different land with a different belief system, culture and social practices, it ultimately makes them lost in between two different cultures – one of their homeland and the other of the host country. With a different socio-cultural atmosphere inside and outside the institutional care centre, these children go through various psycho-emotional outbreaks. To address these psycho-emotional outbreaks, the care centres appoint counsellors to take care of the mental problems directly or through other stakeholders. The problem that generally occurs at the institutional level is the diagnosis of the mental health issues. For this, life skills programme have been incorporated into the curriculum of the residential schools-cum-care centres which help in identifying the stress created due to identity crisis among the children. The life skills programmes prescribed by World Health Organization are integrated with the Buddhism's Ten Commandments to address the issues concerning mental health. One hour on every Saturday is dedicated to the life skills programmes. These programmes help the children know about their inner self and learn the ways to manage themselves in the socio-political surroundings. Brainstorming sessions are conducted with the students on specific life skills. Separate taskforce teams sensitise the students, teachers and care providers on the methods to deal with mental health problems. The indicators that are routinely monitored among the children are excessive sleeping, quarrelsome/argumentative, inattentive/poor concentration, disruptive, late comer, excessive bullying, bunking academic sessions, excessive anxiety, very depressive, incomplete assignment, short tempered and schizophrenia. The teachers and caretakers observe each student on a daily basis as per the monitoring sheet and later on correlate the behaviour of the child in various situations. If a particular behaviour is repeatedly observed in a child in a particular situation, based on the gravity of the case, it is further referred to the counsellors. The counsellors then investigate the reason behind the particular behaviour of the child. The other way adopted to bring forward the mental health problem is by putting up notice boards in each classrooms indicating about signs and symptoms of various unpleasant emotions. If a child experiences any one of the signs or symptoms in other child for more than a week, he/she can approach the counsellor directly. The unpleasant emotions may include oppositional behaviour, poor peer relationship, tendencies to harm self or others, bereavement and loss, abuse and neglect, substance abuse, school refusal and low self-esteem. The illustrations carrying various moods are also displayed in every classrooms and care centres, thus helping the children to identify their temperament and feelings of the day and to know when and how they are exhausted, confused, ecstatic, guilty,

suspicious, angry, hysterical, frustrated, sad, confident, embarrassed, happy, mischievous, disgusted and frightened. Being in their growth stage, the children want a state of autonomy, and this autonomy sometime takes the shape of excessive freedom which generally clashes with the discipline of the school and care centre. The uprooted children refugees socialising in a set-up different from their homeland often have conflicts with the values of the host society, which is more open and quite different from their own, leading to psycho-emotional outbreaks.

Mental health problems of the children are also addressed through religious practices. In Tibetan religious practices, the children are taught to control their mind from where all the problems arise. The four mindfulness training programmes are conducted for the children in which they become aware of self-consciousness, physical consciousness, emotional consciousness and soul consciousness. The mind is trained to remain free from all delusions and problems of day-to-day life. The training methods used in these programmes include classroom discussions and brainstorming sessions. Role plays, small/buzz groups, games/simulations and situational analysis/case studies are designed as pedagogical tools to track and monitor the psycho-social reasons of mental health problems among the children. Depending upon the reason and severity of the problem, the case is referred for medical treatment or counselling. In counselling, correctional and therapy methods are used to aware and sensitise the children about mental stress and anxiety. Meditation, which has a special place in Tibetan Buddhism, is also practiced to teach the children the ways to control their brain.

CONCLUSION

Even though the exile community has a well-established social and cultural support system, there is a lack of diagnostic and monitoring system in the care centres to track and monitor the extent of mental health issues among the children. Children growing into adolescents go through a lot of physical changes which further lead to mood disorders. The need of the situation is to sensitise the children about pleasant and unpleasant emotions, which, if unaddressed, turn into mental problems. The problems of anger, frustration, sadness, depression, excessive worrying, loneliness, uncertainty and excessive stress sometimes arise genetically, but mostly arise due to absence of family environment and parenting. Also, there is no professional monitoring mechanism that can effectively address these issues. As a result, the issues are addressed by the counsellor through observation or referral system which is too conventional and often fails to diagnose the problem at an early stage.

Further, lack of a gender sensitive approach to deal with the mental health problems also makes the cases worse for young girls. A number of cases of physical and emotional bullying of girl children are observed in the care centres, although the counsellors at the care centres make the children aware of good touch and bad

touch so that they can know when they are being bullied. But since the children living in the refugee set-ups are mostly introvert, they often do not come forward by themselves. Although a system of diary entry is practised, in the absence of proper coping mechanism, the whole responsibilities lie with the counsellors to deal with the mental health problems of the children. Counsellors have their own limitations. Coping strategies like computer-mediated learning, mood management devices and digital games are not followed to cope with the problems of stress and anxiety. Here, the community requires increased social and economic support from other communities, international donor organisations and healthcare providers so that the mental health programmes can be expanded to effectively address the challenges faced by the children.

REFERENCES

- Ahearn F, Loughry M and Ager A, 1999. The experience of refugee children. In: Ager A, ed. *Refugees: Perspectives on the Experience of Forced Migration*. Pinter, London.
- Aries, P. 1962. *Centuries of childhood*, New York: Random House.
- Baker K, 2008. Study shows depression, anxiety widespread in Tibetan Refugees. *Emory Report*, Vol. 60, No. 27. Retrieved from [www.emory.edu/EMORY_REPORT/erarchive/2008/April/April14/DisTibetanrefugees.htm].
- Fazel M and Stein A, 2002. The mental health of refugee children. *Archives of Disease in Childhood*, Vol. 87, pp. 366–370. DOI: 10.1136/adc.87.5.366 Retrieved from [http://adc.bmj.com/] on 23 March 2017.
- Kleinman A, 1978. Concepts and a model for the comparison of medical systems as cultural systems. *Social Science and Medicine*, Vol. 12, No. 2B, pp. 85–93.
- Marsella A, 1979. Cross cultural studies of mental disorders. In: Marsella A, Tharp R, Cibrowski T, eds. *Perspectives on Cross-Cultural Psychology*. Academic Press, London.
- Nair P, 2016. Children in India: growing young, urbane and liberal with digital games. *Indian Anthropologist*, Vol. 46, No. 1, pp. 79–92.
- Sachs E and Rosenfeld B, 2008. Entering exile: trauma, mental health and coping among Tibetan refugees arriving in Dharamshala, India. *Journal of Traumatic Stress*, Vol. 21, No. 2, pp. 199–208.
- Yankey T and Biswas UN, 2012. Life Skills Training as an effective intervention strategy to reduce stress among Tibetan refugee adolescents. *Journal of Refugee Studies*, Vol. 25, No. 4, pp. 514–536.

Research Article

**A SEQUENTIAL-NARRATIVE PSYCHODYNAMIC
APPROACH TO TAT INTERPRETATION**

Jed Yalof

ABSTRACT

As a story telling measure, the Thematic apperception test (TAT; Murray, 1943. Thematic apperception test manual. Cambridge, MA: Harvard University Press) has been an integral part of psychological assessment batteries dating back to the pioneering work of Rapaport *et al.* (Diagnostic psychological testing (rev. Edition). New York, NY: International Universities Press). Approaches to analyse TAT stories include, for clinical purposes: (a) organising information into discrete categories of ego functioning (e.g. Bellak, 1986. The T.A.T., C.A.T., and S.A.T. in clinical use (4th Edition), Larchmont, NY: Grune & Stratton), (b) content analysis of intrapsychic conflict (e.g. Arnold, 1949. *Journal of Abnormal and Social Psychology*, Vol. 44, No. 1, pp. 97; Arnold, 1951. Magda Arnold. In: Shneidman ES, ed. *Thematic Test Analysis*. pp. 31, Routledge, New York, NY; Arnold, 1962. Story sequence analysis: A new method of measuring motivation and predicting achievement. New York, NY: Columbia University Press; Sarason, 1948. *Journal of Consulting Psychology*, Vol. 12, No. 5, pp. 285; Schafer, 1958. *Journal of Projective Techniques*, Vol. 22, pp. 181), (c) subjective experience of client vulnerability (e.g. Hilsenroth, 1998. Using metaphor to understand projective test data: A training heuristic. In: Hilsenroth MJ, and Handler L, eds. *Teaching and Learning Personality Assessment*. pp. 391–412, Erlbaum, Mahwah, NJ; Silverstein, 1999. Self psychology and diagnostic assessment: Identifying selfobject functions through psychological testing. Mahwah, NJ: Erlbaum) and, typically for research purposes, (d) utilisation of formal scoring systems (e.g. Jenkins, 2008. A handbook of clinical scoring systems for thematic apperceptive techniques. New York, NY: Routledge). This article presents a psychodynamic interpretive approach to TAT sequence analysis that draws from TAT (Arnold, 1949. *Journal of Abnormal and Social Psychology*, Vol. 44, No. 1, pp. 97; Arnold, 1951. Magda Arnold. In: Shneidman ES, ed. *Thematic Test Analysis*. pp. 31, Routledge, New York, NY; Arnold, 1962. Story sequence analysis: A new method of measuring motivation and predicting achievement. New York, NY: Columbia University Press) methods for developing inferences across cards. TAT stories are read as an evolving narrative, not focused on a specific theme but more on the unfolding of a complex story, with TAT stimulus cards providing reality based ‘residue’ akin to Freud’s dream model [Freud S, 1981. The interpretation of dreams. In: Strachey J, (Ed. & Trans.). *The Standard Edition of the Complete Psychological Works of Sigmund Freud*. Vol. 4–5, pp. 1. (Original work published in 1900)]. A brief illustration of the method’s application is presented and integrated with a case of an adolescent male born of Asian parents, adopted by a US family at an early age. The case addresses multiculturalism and depression as well as other issues associated with the referral.

Keywords: Thematic apperception test, TAT interpretation, Rorschach sequence analysis

Department of Graduate Psychology and Counseling, Immaculate University, King Road, Nazareth #30, Immaculate, PA 19345, USA
Email id: jyalof@immaculata.edu

In this article, I present a psychodynamically informed clinical approach to thematic apperception test (TAT; Murray, 1943) interpretation that draws on the ideas of Arnold (1949, 1951, 1962) in particular, by analysing TAT stories as a narrative sequence. A sequential analysis of TAT responses, illustrated beautifully by Arnold (1949, see p. 109–110) assessing the ‘consistent development of the central theme’ (p. 109), was but one part of Arnold’s psychodynamically driven TAT content analysis. TAT sequence analysis proceeds by reviewing the entire protocol of stories as an unfolding of the client’s self narrative(s) (e.g. Schafer, 1992). My approach differs from Tompkins and Tompkins (1947) analysis of content sequencing of various ‘wishes’ evidenced in TAT stories. Instead, the approach in this article studies TAT responses in order of card presentation, noting shifts in content and structure across stories. It is less concerned with discerning a central theme and story ‘import’ (Arnold, 1962, p. 13), which, when sequenced, ‘... gives us a connected statement of the storyteller’s principles of action, his motivational pattern’ (p. 51). The ‘import’, in Arnold’s model, reflects the most important story moral, which provides ‘meaning or significance’ (p. 51) to the story. In Arnold’s model, each story is simplified around an objective theme, not presented in the first-person, ‘I’, narrative. According to Arnold (1962, p.64), ‘The import is objective in the sense that it is abstracted as accurately as possible without adding any kind of interpretation’. Story imports are embedded in sequences. Arnold (1962, p. 80) stated ‘The sequence provides the thread that links the imports together and reveals the various alternatives of action available to the storyteller’.

In my approach to TAT sequence analysis, I use the first-person narrative and integrate the cards in the order in which they were administered. This, too, differs from Arnold’s approach, in which story themes were grouped together based on whether they appear to start what Arnold described as a ‘new train of thought’ (p. 63; p. 88–89), rather than in successive order. As such, the use of first-person, the presentation of the storyteller’s narrative as a sequence of successive responses and the absence of a scoring system are what differentiate the approach that I describe from Arnold’s main ideas. I begin with a review of the psychodynamic implications of the TAT task and then present a sequence analysis strategy for understanding client TAT stories, followed by a case illustration that focuses that weaves culture with psychosocial issues associated with the referral.

PSYCHODYNAMIC IMPLICATIONS OF THE TAT TASK

The TAT has been an integral part of psychoanalytically informed, psychological assessment batteries dating back to the pioneering work of Rapaport *et al.* (1968). The TAT procedure is straightforward: the client is instructed to respond to a series of picture cards of people in alone or in relation to each other, with the pictures also including background scenes (e.g. Card 3BM depicts a person on the floor with a gun to the side, Card 4 depicts a man and woman with a picture of a woman in the

background). Instructions are to make up a story about the picture by describing the thoughts, feelings and actions of the characters, what led up to the situation and how it ends. The assessor prompts for clarification or elaboration at the completion of each story as needed. The TAT includes 30 cards (Bellak, 1986), with assessors using their judgement to determine which and how many cards to administer in any given situation. Multicultural applications and implications of thematic measures have been described (e.g. Abraham, 2003; Dana, 2005; Ephraim 2008; Hoy-Watkins and Jenkins-Monroe, 2008; Verdon *et al.*, 2014; also see Jenkins, 2008, p.3).

A psychodynamically informed interpretive approach builds on Murray's need vs. press binary. Standard psychodynamic interpretation of the TAT begins by evaluating client stories relative to response expectations for each card (Bellak, 1986). Inferences derived from stories lend to thematic grouping around particular domains (e.g. core conflicts, self-image, relationships, feelings, thoughts, defences, superego and endings/outcomes). Different psychodynamic strategies for reporting TAT findings might highlight (a) discrete ego functions (Bellak, 1986, p. 117), (b) a content analysis of the client's intra-psychic conflicts (e.g. Arnold, 1949, 1951, 1962; Cramer, 1996; Sarason, 1948; Schafer, 1958), (c) an emphasis on the first-person narrative (Arnold, 1949, 1951, 1962; Hilsenroth, 1998), (d) threats to the integrity of the self as a unitary structure (e.g. Silverstein, 1999) and (e) quantitative scoring (see Arnold, 1962; Jenkins, 2008) of such characteristics as primary process (e.g. Holt, 2008), defences (Cramer, 1996), oral dependency (e.g. Huprich, 2008) and object relations (e.g. Bram, 2014; Stein *et al.*, 2015; Westen *et al.*, 1985).

The first four approaches provide data for inclusion in assessment reports, whereas the latter approaches might be a better fit for research purposes, but they can also be integrated with each other (e.g. Cramer, 1996). For example, an assessor might utilise Schafer's (1958) content-process analysis to each story, highlighting the way the client tells the story, defensive operations and intra-psychic conflict. These findings can then be summarised under different ego functions (Bellak, 1986) and described subjectively from the client's viewpoint (Arnold, 1949, 1951, 1962; Hilsenroth, 1998), in a manner keeping with Silverstein's (1999) empathic understanding of threats to self-integrity. The assessor might also choose to score responses for such dimensions as affect (Thomas, 2008), empathy (Teglasi *et al.*, 2008), primary process (Holt, 2008) and/or defences (Cramer, 1996) or utilise Fine's (Ornduff, 2008) psychodynamic TAT scoring system for the entire protocol. The two main takeaway points are that the TAT provides a trove of rich clinical data, and that the psychodynamically oriented assessor has available several interpretive methods when developing inferences.

Story-telling methods are particularly sensitive to mood and other feelings that may be present, but subtle and not easy to describe, especially when working with children and youth. For example the astute observer can identify depression in children

through behavioural markers and shifts from prior levels of adjustment; however, children are not always able to articulate the relationship between depression or other mood disorders and the observations that signal the possible presence of a mood disorder, including somatic distress, sleep disturbance, appetite shifts, guilt, irritability, anger, moodiness, sadness, separation fears and decreased motivation for school or social involvements. Further, ages 13–18 appear to be a vulnerable period for increases in depression (Hankin *et al.*, 2015), imposing considerable risk for mental health problems on the adolescent population. Application of story-telling tests might be especially useful, for example, in identifying sadness (or other feelings) in children or youth whose stories might provide insight into what they feel but have difficulty expressing in first-person language. Analysis of story sequence, using the method described below, describes underlying themes in experience-near language vis-a-vis the client's subconscious narrative.

TAT SEQUENCE ANALYSIS

When analysing TAT stories in sequence, the assessor reads the second TAT response as a continuation of the first TAT response. Likewise, the third TAT response would be read as extending the narrative from the first two cards and so on. The assessor uses the TAT as a clinical interview and treats the different cards as 'interventions' (e.g. 'Next, tell me a story to this picture ...'). TAT cards represent 'real' stimuli to which the client responds. Each card has stimulus features that trigger unconscious fantasy. Here, the TAT cards might be analogised to Freud's (1981) 'day residue' in which elements of reality entwine with unconscious conflict to trigger the elaboration of a dream narrative in which symbolisation, condensation, displacement and concern for representation protect consciousness from the minds' more disturbing aspects. The dream has both manifest and latent content, the latter of which is more conflictual and subjected to the ego's defensive elaborations as part of the dream process.

The manifest and latent content of TAT stories can be categorised and analysed along similar lines (see Verdon *et al.*, 2014 for a formal TAT method). For example assume that a depressed and seemingly passive young adult male client offers a response to TAT Card I (i.e. typically pulls for achievement-related theme) of an angry boy who protests parental insistence that he plays the violin. In telling this story, the client is not consciously aware that the story portrays a stubborn reaction to authority that may belie the depression. Next, this same client responds to TAT Card II (i.e. typically pulls for a story about family members) by describing a girl who wants to distance from her family by running away but feels guilty because while she wants to leave, her father toils in the field, and her mother is pregnant and probably needs her help. Again, the client might have no conscious awareness of what an assessor might infer as guilt over autonomy strivings. Taken together, these two stories might be interpreted sequentially as disguising the following

unconscious conflict: *Stop pressuring me to do what I don't want to do (Card 1), because it takes away from my own initiative, makes me feel badly about pursuing my own interests (Card 2)!* Thus, in this model of TAT sequence analysis, the assessor observes the unfolding of the client's narrative. In what follows, I apply this method to the content analysis of TAT stories.

CASE ILLUSTRATION

To further illustrate this approach to TAT analysis, I present and analyse the sequence of a series of TAT stories given by a very soft-spoken, deferential and cooperative 19-year-old male with multiple learning disabilities (reading, math). He has no prior history of psychotherapy and is in good health. This client had spent his first 5 months in an orphanage in Asia before being adopted into a loving Caucasian family. The extent to which the client was deprived of a stable attachment figure attentive to his emotional and physical needs was not known, leaving one to speculate about the timeliness, quality and consistency of neurocognitive and psychological stimulation pre-adoption.

The assessment was done primarily to update areas of educational and social-emotional strength and need. The client's interview and responses to self-report were indicative of considerable anxiety. I administered psychoeducational and social-emotional measures. In what follows, I offer a brief interpretation of what I identified as the main themes that emerged in his TAT stories to each card and link these interpretations together into an extended narrative. The aim of this interpretive approach is to demonstrate how sequence analysis can be of use to clinicians who are interested in reading TAT stories as the client's first-person narrative, or story, addressing conflict, feelings, fears, defences and self-other relations (TAT card descriptions are from Bellak, 1986).

Card 1. (Boy seated at a table contemplating a violin which rests on a table in front of him.)

Story. This boy is looking at his brand new violin. He's wondering how to play it because he doesn't know how to play a violin. He's not very excited to learn because he's never seen it before. Moreover, he doesn't know what it does. (End?) He asks his parents to teach him. They teach him how to play, and he enjoys it.

Reframing the interpretation in first-person language, the client might be communicating the following: *Let me tell you about myself. First, it's hard for me to learn something new. I don't have enthusiasm and I question whether or not I can do it. I need support, even though I might hesitate to ask for it. However, if you'll prompt me, I will tell you what I need.*

Card 2. (Country scene: In the foreground is a young woman with books in her hand; in the background a man is working in the fields, and an older woman is looking on.)

Story. There's a family working on the farm, two kids and a mother. The son is ploughing the fields, whereas the daughter reads books on how to take care of crops and the farm. They get up early every morning to start working on the farm. They work until the sun goes down. When the crops are grown, they harvest them. When they're done with harvesting, they sell them to make money. After they make money, the son and daughter go to school and learn. (How are they feeling?) Very tired and happy.

Sequence Analysis. Interpreting the second story in response to the first story, the client's narrative develops as follows: *I'd like to think that even though I hesitate to start something new, which I just told you about, I really feel that hard work will pay off, especially if my family supports me. I will grow, and it will pay dividends.*

Card 3BM. (On the floor against a couch is a huddled form of a boy with his head bowed on his right arm. Beside him on the floor is a revolver.)

Story. There's a homeless woman living on the dirty streets in the city. She sits outside begging every day for money and food. She feels sad and lonely. Some people walk by and give her money and some people walk by without doing anything. Some people leave her food, and some people don't. Finally, someone picks her up, takes her to a shelter and gives her food.

Sequence Analysis. *This card touches something in me; seeing the person as a boy was too difficult. Even though I'm willing to work hard and feel that people there for me, my deeper fear is that my needs will get lost in the shuffle, and I could wind up sad and lonely. I even could have been homeless had someone not come for me; this makes it harder for me to express my needs because I also feel grateful for what I have.*

Card 4. (A woman is clutching the shoulders of a man whose face and body are averted as if he were trying to pull away from her.)

Story. There's a man and woman in a relationship. The woman really wants the man to marry; the man is feeling not so sure about the marriage. So, she's hugging him and trying to get him to ask her to marry her. The man doesn't think it'll work out. He tried to run away. She still loves him. After that, the relationship is over. The man feels happy, the woman feels very sad and angry about it because she really loved him.

Sequence Analysis. *Can I really trust that things will work out? I was left once before and am not sure that it will not happen, again. A part of me wants to put the*

work in, but a part of me gets uncomfortable no matter how hard others encourage me. I hold something back, and it brings relief but may make others sad. In the end, as I told you just a while ago, this may be one way of defending against my feelings not being recognised fully.

Card 7BM. (A grey-haired man is looking at a younger man who is sullenly staring into space.)

Story. There's a father and a son. The son did something he shouldn't have done and the dad found out about it. He asked his son to sit down in the kitchen. They had a father-son talk. The father asked the son why he robbed the store. The son tells him because he didn't have any money, and it was hard on him. The father tells him he could've worked for money. He also tells him how upset he is with his son. He will be grounding him. The son feels ashamed and tells his dad, 'Please don't tell anyone'. His dad grounds him for the rest of the year.

Sequence Analysis. *Maybe one reason I hold back is because I'm not sure I'll succeed, but also, I have this sense of deficit. I see things for what they are, and this pains me. I don't know what to do to get what I need. There are times when I'd like to take what others have in the hope that it will boost me. I have support and people in my life who care about me, but there's a part of me that feels scared and different, and it leads me to think that I always need to keep something in reserve, fend for myself, even at the risk of disappointing. I wind up feeling ashamed.*

Card 8BM. (An adolescent boy looks straight out of the picture. The barrel of a rifle is visible at one side, and in the background is the dim scene of a surgical operation, like a revenge image.)

Story. There were four guys out in the woods, hunting. One guy was trying to shoot a deer, missed, and the bullet hit his friend. He heard him scream when he got shot. So they went over to where they heard him scream and saw he was bleeding. They carried him to a doctor to take care of the wound and to help him. When he visited the doctor, the doctor asked him to assist, so they had to take the bullet out of him to save his life, and then, after they took the bullet out, they gave him pain medicine, and he felt a lot better but was still in pain. (How did his friends feel?) Pretty upset.

Sequence Analysis. *Let me explain further. I feel like something happened to me over which I had no control. I was in a lot of pain, wounded, and needed a doctor's help. I know that others feel my hurt and have helped me feel better, but it still hurts and there's more going on than meets the eye.*

Card 10. (A young woman's head against a man's shoulder.)

Story. A mother and a daughter. The daughter is trying to fall asleep but is having a lot of trouble. The mother says she has to get up early the next morning. The daughter keeps saying she can't fall asleep. So, the mother sings her a song and tells a story, and the daughter begins to fall asleep. Finally, the mother feels glad that she got her daughter to sleep and leaves the room and falls asleep in her own bed.

Sequence Analysis: *My needs for maternal connection are intense, and nighttime is hard. I can't relax. Fortunately, I can have an image of my mother as caring and patient, which helps me, but self-soothing does not come easy.*

Card 14. (The silhouette of a man {or woman} against a bright window. The rest of the picture is totally black.)

Story. There's a boy who likes to hang out in his room. It's very dark in his room. So, every night before falling asleep, the boy likes to look out of his window at the stars from his room. He looks for the Milky Way and planets. He also likes the noises outside. It always makes him feel relaxed. After 10 min, he goes to his bed and sleeps.

Sequence Analysis: *I'm able to use fantasy as an escape from darkness and this helps me relax. I'm looking for something, maybe it's milky, comforting; I'm not sure, and I can't really locate it. I need time to settle at night.*

Card 17BM. (A naked man is clinging to a rope. He is in the act of climbing up or down.)

Story. A statue in a museum that an artist made is of a man climbing down a rope. It's a very famous statue. A lot of people pay to see and take pictures of it. So, one day, the artist goes to the museum himself to see his art work. He sees a huge line and realises it's to see his sculpture. He looks at the very long line and smiles and feels very happy with himself that he made the sculpture. Then after he sees the sculpture, he realises what a good job he did and goes back to his art studios to make more.

Sequence Analysis: *I want others to be proud of me and I want to accomplish something that will make them feel it. That's my goal. I'll work harder if my efforts are rewarded. Others make me feel that I have something to offer, but sometimes, I have to imagine being special as a way of reassuring myself that I matter.*

Card 12M: (A young man is lying on a couch with his eyes closed.)

Story. Leaning over him is the gaunt form of an elderly man, his hand stretched out above the face of the reclining figure. There's a sick kid lying in bed, kind of, about to die. The older man tries to help him, but the kid is asleep, and the old man doesn't know if he's awake or dead, yet. So, he tries poking him. He then realises he's just

really sick and sleeping, but after the old man pokes him, the kid wakes up and is scared, then falls back asleep. (Scared?) Didn't know the old man was there. (How does the old man feel?) Sad for the kid. (Why?) The kid is really sick, and he can't do anything right now, so the old man just lets the kid sleep and brings him hot soup for when he wakes up.

Sequence Analysis: *Deep down, I'm scared and it may be hard for others to know how to approach me about my feelings. It's also hard for me to express how I feel. Others try to comfort me, and they mean well, even if they poke around; I guess they're wondering what's going on with me.*

Sequence Analysis Summary. The following narrative integrates each card into a 'story' about the client. This story frames the client's deeper feelings as a first-person subjective account. The synthesis of stories at this point permits an easier flow of the client's narrative, in sequence.

Let me tell you about myself. First, it's hard for me to learn something new. I don't have enthusiasm, and I question whether or not I can do it. I need support, even though I might hesitate to ask for it. However, if you'll prompt me, I will tell you what I need. I'd like to think that even though I hesitate to start something new, which I just told you about, I really feel that hard work will pay off, especially if my family supports me. I will grow, and it will pay dividends. Even though I'm willing to work hard and feel that people are there for me, my deeper fear is that my needs will get lost in the shuffle, and I could wind up sad and lonely. I even could have been homeless had someone not come for me; this makes it harder for me to express my needs because I also feel grateful for what I have. But can I really trust that things will work out? I was left once before and am not sure that it will not happen again. A part of me wants to put the work in, but a part of me gets uncomfortable no matter how hard others encourage me. I hold something back, and it brings relief, but it may make others sad. In the end, as I told you just a while ago, this may be one way of defending against my feelings not being recognised fully. Maybe, one reason I hold back is because I'm not sure I'll succeed, but also, I have this sense of deficit. I see things for what they are, and this pains me. I don't know what to do to get what I need. There are times when I'd like to take what others have in the hope that it will boost me. I have support and people in my life who care about me, but there's a part of me that feels scared and different, and it leads me to think that I always need to keep something in reserve, fend for myself, even at the risk of disappointing. I wind up feeling ashamed.

Let me explain further. I feel like something happened to me over which I had no control. I was in a lot of pain, wounded and needed a doctor's help. I know that others feel my hurt and have helped me feel better, but it still hurts and there's more going on than meets the eye. My needs for maternal connection are intense, and

nighttime is hard. I can't relax. Fortunately, I can have an image of my mother as caring and patient, which helps me, but self-soothing does not come easy. I'm able to use fantasy as an escape from darkness and this helps me relax. I'm looking for something, maybe it's milky, comforting; I'm not sure, and I can't really locate it. I need time to settle at night. I want others to be proud of me and I want to accomplish something that will make them feel it. That's my goal. I'll work harder if my efforts are rewarded. Others make me feel that I have something to offer, but sometimes, I have to imagine being special as a way of reassuring myself that I matter. Deep down, I'm scared and it may be hard for others to know how to approach me about my feelings. It's also hard for me to express how I feel. Others try to comfort me, and they mean well, even if they poke around; I guess they're wondering what's going on with me.

DISCUSSION

Arnold stated the following when summarising the clinical utility of an in-depth TAT analysis: 'Perhaps the most important insight the clinician can gain from such a TAT analysis is the recognition that the patient himself is actively working on his problem ...' (p. 111). Arnold (1949, 1951, 1962) linked TAT stories around a central theme in which the client's core conflict was portrayed through the dynamic interplay of TAT story figures. Regarding the TAT-psychoanalytic connection, Arnold (1949), Cramer (1996) and Schafer (1958), notwithstanding their somewhat different approaches to TAT story analysis, were focused particularly on the role of narration in TAT stories. In this latter respect, Schafer (1958) conceived of the TAT as a process- and content-oriented storytelling method analytic and felt similarly about analytic treatment (1992). For Schafer, analytic treatment is a process by which each client tells and retells their story as a series of narratives. The TAT offers a method for listening to the client's narrative emerge in response to different stimulus cards.

In the case application, there were self-narratives associated, for example, with conflicts over achievement and efficacy, fear of disappointing, self-punishment, need for affirmation, difficulty with self-regulation and feeling supported, but anxious and with some markers of depression. There were also areas of self-agency, such as being able to acknowledge painful feelings, wrongdoing, guilt, a desire for affirmation, some pride in accomplishments and others who demonstrate a caring attitude. Sadness, longing and possibly guilt over being saved by adoption can also be inferred. Keeping in mind these points, there are no doubt other interpretations to be derived from the TAT stories. What I offered in my analysis were some basic interpretations that allowed me to illustrate the value of synthesising content with sequential narrative about dynamic themes underlying the client's overt struggles. When seen from the client's viewpoint (Arnold, 1949, 1951, 1962), TAT stories provide a glimpse at the

client's sense of agency and efficacy as well as the conditions under which such agency is met with obstacles.

This approach to TAT analysis also builds on the psychoanalytic appreciation of empathy (Kohut, 1971), affirmation (Schafer, 1982), respect for how a client's narrative evolves over time (Schafer, 1992) and the centrality of listening to the client's conscious associations and embedded resistances with respect to interpretive methods (Busch, 1995). It draws from the assessment work of Finn (2007), who underscored the importance of implementing an empathic approach to assessment, and Sugarman (1978), who described the humanistic aspects of psychological testing. Most importantly, it privileges the importance of storytelling, as described by Jenkins (2008, p. xi): 'Storytelling is a quintessentially integrative function, as shown by studies of narrative memory. Stories bring people, ideas, and feelings together around campfires and research groups. Folktales build cultures; bedtime stories raise children'.

In summary, I have attempted to illustrate how the assessor can generate empathic inferences that tell the client's story, and then think creatively about how to integrate this information into the assessment process. The client's narration reflected efforts to understand, communicate and, as Arnold (1949) noted, seek solutions to his problems. In this latter respect, the work of the ego as a synthesising and adaptational mental construct was clearly at play. In relation to the pragmatic aspects of a narrational TAT analysis as it relates to recommendations and feedback, there are a few points to consider. First, a formal test report offers only a few salient themes that inform the referral question (e.g. 'The client struggles with fear of disappointing others, despite efforts to do well ...'). There might be page limitations or referral issues that preclude extensive disclosure of the client's underlying personal narrative (e.g. a report filed for educational purposes), in which case the assessor carefully considers the incremental yield of supplemental personality measures *vis-à-vis* the immediate purpose of testing. Second, an empathically informed feedback session that builds on information derived from the TAT sequence analysis (e.g. 'I can see how hard it is for you to put the work in without knowing if it'll pay off...or to put some feelings into words...there are times when it feels painful...hard to know if others see it ...') might be affirming in ways that are difficult to express in the more technical assessment report. Third, insights generated inferentially from the assessment can be titrated selectively can validate the client's experience in a way that reading a test report cannot approximate.

AUTHOR NOTE

Earlier versions of this article were presented to the Society for Personality Assessment, Philadelphia Chapter, November 2015, Widener University, Chester, PA, and at the Annual Meeting of the Society for Personality Assessment, March 2016, Chicago, IL.

ACKNOWLEDGEMENT

The author would like to acknowledge Dr. Sharon Rae Jenkins for her insightful comments on a draft of this article.

REFERENCES

- Abraham P, 2003. Multicultural/diversity assessment: an evolving process. *Society for Personality Assessment Exchange*, Vol. 15, No. Summer (2), pp. 10–11, 22.
- Arnold MB, 1949. A demonstration analysis of the TAT in a clinical setting. *Journal of Abnormal and Social Psychology*, Vol. 44, No. 1, pp. 97–111.
- Arnold MB, 1951. Magda Arnold. In: Shneidman ES, ed. *Thematic Test Analysis*. pp. 31–39, Routledge, New York, NY.
- Arnold MB, 1962. Story sequence analysis: A new method of measuring motivation and predicting achievement. New York, NY: Columbia University Press.
- Bellak L, 1986. The T.A.T., C.A.T., and S.A.T. in clinical use (4th Edition). Larchmont, NY: Grune & Stratton.
- Bram AD, 2014. Object relations, interpersonal functioning, and health in a nonclinical sample: Construct validation and norms for the TAT SCORS-G. *Psychoanalytic (Psychology)*, Vol. 31, pp. 314–342. DOI: 10.1037/a00362826.
- Busch F, 1995. The ego at the center of clinical activity. New York, NY: Aronson.
- Cramer P, 1996. Storytelling, narrative, and the thematic apperception test. New York, NY: Guilford.
- Dana RH, 2005. Multicultural assessment: Principles, applications, and examples. Mahwah, NJ: Erlbaum.
- Ephraim D, 2008. Psychocultural system manual. In: Jenkins SR, ed. *A Handbook of Clinical Scoring Systems for Thematic Apperceptive Techniques*. pp. 739–760, Routledge (an Imprint of the Taylor & Francis Group), New York, NY.
- Finn SE, 2007. In our clients' shoes: Theory and techniques of therapeutic assessment. New York, NY: Psychology Press. pp. 45–54.
- Freud S, 1981. The interpretation of dreams. In: Strachey J, (Ed. & Trans.). *The Standard Edition of the Complete Psychological Works of Sigmund Freud*. Vol. 4–5, pp. 1–627. (Original work published in 1900). London, Hogarth Press.
- Hankin BL, Young JF, Abela JRZ, Smolen A, Jenness JL, Gulley LD and Openheimer CW, 2015. Depression from childhood into late adolescence; influence of gender, development, genetic susceptibility, and peer stress. *Journal of Abnormal Psychology*, Vol. 124, No. 4, pp. 803–816. [<http://dx.doi.org/10.1037/abn0000089>].
- Hilsenroth MJ, 1998. Using metaphor to understand projective test data: a training heuristic. In: Hilsenroth MJ, Handler L, eds. *Teaching and Learning Personality Assessment*. pp. 391–412, Erlbaum, Mahwah, NJ.
- Holt RR, 2008. Primary process scoring for the TAT. In: Jenkins SR, ed. *A Handbook of Clinical Scoring Systems for Thematic Apperceptive Techniques*. pp. 283–292, Routledge (an Imprint of the Taylor & Francis Group), New York, NY.
- Hoy-Watkins M and Jenkins-Monroe V, 2008. The contemporized-themes concerning blacks test (C-TCB). In: Jenkins SR, ed. *A Handbook of Clinical Scoring Systems for Thematic Apperceptive*

A Sequential-Narrative Psychodynamic Approach to TAT Interpretation

- Techniques*. pp. 659–684, Routledge (an Imprint of the Taylor & Francis Group), New York, NY.
- Huprich S, 2008. TAT oral dependency scale. In: Jenkins SR, ed. *A Handbook of Clinical Scoring Systems for Thematic Apperceptive Techniques*. pp. 385–398, Routledge (an Imprint of the Taylor & Francis Group), New York, NY.
- Jenkins SR, 2008. A handbook of clinical scoring systems for thematic apperceptive techniques. New York, NY: Routledge (an Imprint of the Taylor & Francis Group).
- Kohut H, 1971. *Analysis of the self*. New York, NY: International Universities Press.
- Murray H, 1943. *Thematic apperception test manual*. Cambridge, MA: Harvard University Press.
- Ornduff S, 2008. Reuben fine's scoring scheme for the TAT and other verbal projective techniques. In: Jenkins SR, ed. *A Handbook of Clinical Scoring Systems for Thematic Apperceptive Techniques*. pp. 261–270, Routledge (an Imprint of the Taylor & Francis Group), New York, NY.
- Rapaport D, Gill M and Schafer R, 1968. *Diagnostic psychological testing* (rev. Edition). New York: International Universities Press.
- Sarason SB, 1948. The TAT and subjective interpretation. *Journal of Consulting Psychology*, Vol. 12, No. 5, pp. 285–299.
- Schafer R, 1958. How was this story told?. *Journal of Projective Techniques*, Vol. 22, pp. 181–210. DOI: 0.1080/08853126.1858.10380840.
- Schafer R, 1982. *The analytic attitude*. New York, NY: Basic Books.
- Schafer R, 1992. *Retelling a life: Narration and dialogue in psychoanalysis*. New York, NY: Basic Books.
- Silverstein ML, 1999. *Self psychology and diagnostic assessment: Identifying selfobject functions through psychological testing*. Mahwah, NJ: Erlbaum.
- Stein MB, Slavin-Mulford J, Siefert CJ, Sinclair SJ, Smith, M, Chung W and Blais MA, 2015. External validity of SCORS-G ratings of thematic apperception test narratives in a sample of outpatients and inpatients. *Rorschachiana*, Vol. 36, No. 1, pp. 58–81. DOI: 10.1027/1192-5604/a000057.
- Sugarman A, 1978. Is psychodiagnostic testing humanistic?. *Journal of Personality Assessment*, Vol. 42, No. 1, pp. 11–21.
- Teglasi H, Locraft C and Felgenhauer K, 2008. Scoring manual for empathy. In: Jenkins SR, ed. *A Handbook of Clinical Scoring Systems for Thematic Apperceptive Techniques*. pp. 607–632, Routledge (an Imprint of the Taylor & Francis Group), New York, NY.
- Thomas AD, 2008. TAT affective scale manual. In: Jenkins SR, ed. *A Handbook of Clinical Scoring Systems for Thematic Apperceptive Techniques*. pp. 477–488. Routledge (an Imprint of the Taylor & Francis Group), New York, NY.
- Tompkins SS and Tompkins EJ, 1947. *The thematic apperception test: The theory and technique of interpretation*. New York, NY: Grune & Stratton.
- Verdon B, Chabert C, Azoulay C, Emmanuelli M, Neau F, Vibert S and Louët E, 2014. The dynamics of TAT process: psychoanalytical and psychopathological perspectives. *Rorschachiana*, Vol. 35, No. 2, pp. 103–133. DOI: 10.1027/1192-5604/a000056.
- Westen D, Lohr N, Silk K and Kerber K, 1985. *Measuring Object Relations and Social Cognition Using the TAT: Scoring Manual*. University of Michigan. USA.

Research Article

DEPRESSION EFFECTS AMONG VULNERABLE CHILDREN

Liranso G. Selamu^{1} and Mohan S. Singhe²*

ABSTRACT

The aim of the study was to explore the depression effects of orphan and vulnerable children. To achieve its objectives, the study utilized a qualitative method to gather relevant, direct and rich information from participants. The study was conducted in the two orphanage organizations of Hosanna Town, Ethiopia. The study covered interviews with 24 key informants, four focus group discussions (FGDs) with 42 orphan children. The participants were selected using purposive sampling technique. The collected data was analyzed thematically. From the results of the study, the majority of the respondents indicated that orphan children those who were living in the institutions are more vulnerable to depression. Likewise, the majority of the respondents indicated that a higher depression and a lower self-esteem symptom have been seen in many children. Most children lost hope when it became clear that their parents were sick. They also felt sad and helpless. Many were angry and depressed in their life functioning. Thus, the organizations have to work on providing appropriate psychosocial support, education, developmentally appropriate care and providing skills training and counseling programs.

Keywords: Children, Depression, Effects, Orphan, Psychosocial supports, Vulnerable

INTRODUCTION

The word orphan comes from Greek word Orfanos, meaning a child whose parents are dead or have abandoned them permanently. There are different understandings in defining an orphan, some define an orphan as a child that has lost one or both parents and that is below 18 years of age. The Declaration on the Rights of the Child indicates that those people below the age of 18 years are considered as a child and deserve all the privileges that are accorded to this group. In common usage, an orphan does not have any surviving parent to care for him or her (UNICEF, 2012).

In Ethiopian traditional context, once a child becomes vulnerable to the above circumstances, it is believed that this child is the child of the community and the assignment for the indigenous community to care in traditional communal living and the extended family system like their parents did before. Conversely, the growing

¹Ph.D. Scholar, Many World Class Books and Journals Author

²Assistant Professor & Many Research Journals Editor and Author, Mangalore University, India

*Corresponding author email id: liranso.2006@gmail.com

number of vulnerable children in Ethiopia has been facing trouble due to the capacity for the extended family to fulfill their needs as previous because of households decline income, the extended family more likely a higher fraction of elderly members and less educated heads and mostly household heads by women (Donahue, 1998). The Ethiopian policy definition of an orphan child states that an orphan is a child less than 18 years of age who has lost both parents regardless of how they died. This definition entails that children above the age of 18 years are not labeled as the orphan even their parents have deceased. The definition also seems to suggest that transition from orphanhood to the non-orphan hood at the attainment of age 18 years.

Besides, Sherr *et al.* (2008) noted that the current situation is one fraught with a lack of clarity over definitions of orphanhood within the context of HIV/AIDS. The definition of an orphan varies in the literature, basically with regard to age and parental loss. Generally, an orphan is defined as a child who has experienced the death of both parents. The UNAIDS defines an orphan as a child under 15 years of age who has lost a mother or both parents (UNICEF/UNAIDS, 1999). Most researchers used the UNAIDS definition. Others have increased the age to 18 years (Atwine *et al.*, 2005; Cluver *et al.*, 2009; Nyamukapa, 2008).

Furthermore, Germann (2001) found that orphans and vulnerable children experience multiple risk factors, vulnerabilities, and stressors that lead to self-pity, poor self-esteem and often with accompanying shattered hope concerning the future. Cluver *et al.* (2007) found that orphans have behavioral and conduct problems as well as suicide thoughts. Although externalizing behaviors have also been identified, Bray (2003) and Wild (2005) argued that children affected by HIV/AIDS are at greater risk of becoming depressed and anxious than of acting out their distress overtly. High levels of depression have been reported among orphans (Traube *et al.*, 2010).

Compared to other children, orphans were observed to be more depressed, anxious, and less optimistic and to display angry feelings and disruptive behaviors (Segendo and Nambi, 1997; Atwine *et al.*, 2005; Nyamukapa *et al.*, 2008). The depression that orphans and vulnerable children experience can interfere with all aspects of their lives and may lead to energy loss, sadness, weight changes, feeling of worthlessness, difficulty sleeping or oversleeping, loss of interest in social activities and suicidal thoughts or thoughts about death (Foster and Williamson, 2000).

On the other hand, depression is an extremely complex disease. It occurs for a variety of reasons. Some people experience depression during a serious medical illness. Others may have depression with life changes such as a move or the death of a loved one. Still, others have a family history of depression. Those who do may experience depression and feel overwhelmed with sadness and loneliness for no known reason. Depression is a state of low mood and aversion to activity that can

affect a person's thoughts, behavior, feelings, and sense of well-being. People with depressed mood can feel sad, anxious, empty, hopeless, helpless, worthless, guilty, irritable, ashamed or restless (Lindert, 2014). Therefore, the aim of the study was to explore the depression effects of orphan children in two caregiver organizations of Hosanna Town, Ethiopia.

METHOD

The aim of the research was to discover the depression problems among orphan and vulnerable children. To achieve this research objective, the study employed the qualitative method to gather relevant, direct and rich information from the participants. The strength of qualitative research is its ability to provide complex textual descriptions of how people experience a given research issue. It provides information about the human side of an issue, that is, the often contradictory beliefs, opinions, emotions, and relationships of individuals (Natasha, 2011).

Moreover, a qualitative approach is directly in line with the research aim for it's a deeper exploration of information needed in addressing the depression effects; exploring perceptions of depression among the participants. Qualitative research is a realistic and interpretative approach which aims to understand the meanings people attach to cultural phenomena such as actions, beliefs, values etc. found within social contexts. Furthermore, it gives a thorough understanding of the real situations of the participants by learning about their social circumstances, their experiences, and perspectives in the confidential manner (Lewis and Ritchie, 2003). The study covered interviews with 24 caregivers' key informants' and four focus group discussions (FGDs) with 42 orphan children. The participants were selected purposively. By keeping in mind that "there are no fixed rules for sample size in the qualitative inquiry the validity, meaningfulness, and insights have more to do with the information richness of the cases selected" (Patton, 2001). And the collected data was analyzed thematically. Thematic analysis assists in organizing and summarizing findings from a large diverse body of the research.

FINDINGS

According to many participants, children in foster care show higher rates of behavior problems and psychological disorders compared with children, not in care. The study indicates that majority of the studied orphans have depression. This high prevalence may be related to many factors. For instance, early childhood painful experience, parental conflict, trauma from separations from parents, emotional pain of being rejected or abused, and relocation from one relative home to the orphanage. Moreover, being in orphanages, separation from his/her family, psychological trauma, related to the environment of the orphanages itself like mistrust, insecurity, maltreatment by their foster family, and risk of neglect, abuse, and exploitation.

Also, children in organizational care were using denial as a coping mechanism to handle depression. Furthermore, orphan children may have had other psychological or behavioral disorders that are manifested as depression. Also, the depression effects may be related to the fact that depression-prone effects, anxiety about the future especially girls more anxious about the future than boys and effect of societal discrimination and stigma.

Other commonly reported disturbing experiences were injuries, severe illness and treatments gaps, and violence. The number of children who had witnessed or were harmed in serious road accidents is alarming. They recounted that they witnessed people dying in most of these accidents, often including the sight of distorted corpses. Major depressive disorders in the chronic form of depression and post-traumatic stress disorder were faced by the participants. The prevalence of these conditions among the groups of children indicated in the study. Dysthymia was more common among orphaned boys and children have lost a father.

CONCLUSION

Most children lost hope when it became clear that their parents were sick. They also felt sad and helpless. Many were angry and depressed in their life functioning. Furthermore, the children had many psychological or behavioral disorders that were manifested as depression. Also, the depression effects may be related to the fact that depression-prone effects, anxiety about the future especially girls more anxious about the future than boys and effect of societal discrimination and stigma towards with their future life partners. There is a need for the well-developed system of care for orphans to be implemented in the organizations. Regular psychological assessment of the children should be carried for early detection and proper management of any mental abnormalities, especially among girls. Such program should raise awareness among caregiver about the importance of mental health conditions of the children, and consequence of psychological problems like depression through training and therapy. Further empirical research is needed to substantiate these findings and to promote the mental health supports to the children, and planning possible interventions to help these children develop into more stable individuals. Therefore, the organizations have great responsibilities to play their role in supporting orphanage children especially, in terms of psychosocial support through giving counseling services on how to increase the self-esteem of the children and overcoming the problems of the depression.

REFERENCES

- Atwine B, 2005. Psychological Distress among AIDS orphans in rural Uganda. *Social Science and Medicine*, Vol. 61, No. 3, pp. 555-564.
- Bray S, 2003. Physical activity is associated with better health and psychological well-being during transition to university life. *Journal of American College Health*, Vol. 55, No. 2, pp. 77-82.

- Cluver L and Orkin M, 2009. Stigma, bullying, poverty and AIDS-orphanhood: Interactions mediating psychological problems for children in South Africa. *Social Science and Medicine*, Vol. 69, No. 8, pp. 1186-1193.
- Cluver L, Gardner F and Operario D, 2007. Psychological distress amongst AIDS-orphaned children in urban South Africa. *Journal of Child Psychology and Psychiatry*, Vol. 48, No. 8, pp. 755–763.
- Donahue J, 1998. Community-based Economic Support for Households Affected by HIV/AIDS discussion. *Journal of Social Aspects of HIV/AIDS*.
- Germann S, 2001. Impact of HIV/AIDS on Children in Southern Africa. Paper presented at Southern African Poverty Network Workshop on Children, HIV and poverty. University of Pretoria press.
- Lewis J and Ritchie J, 2003. *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. Sage Publications, London.
- Lindert J, 2014. Sexual and physical abuse in childhood is associated with depression and anxiety over the life course: Systematic review and meta-analysis. *Int. J. Public Health*, Vol. 59, No.2, pp. 359-372.
- Natasha M, Cynthia M, Macqueen G and Emily N, 2011. *Qualitative Research Methods: A data collector's field guide*. FHI, USA.
- Nyamukapa, 2008. HIV-associated orphanhood and children's psychological distress: Theoretical framework tested with data from Zimbabwe. *American Journal of Public Health*, Vol. 98, No. 1, pp. 133-141.
- Patton M, 2001. *Qualitative research and evaluation methods (2nd Edition)*. Thousand oaks, CA: Sage Publications.
- Segendo J and Nambi J, 1997. The psychological effect of orphanhood: a study of orphans in Rakai district. *Health Transition Review*, Vol. 7, pp. 105–124.
- Sherr L, Varrall R, Mueller J, Richter L, Wakhweya A and Adato M, 2008. A systematic review on the meaning of the concept 'AIDS Orphan': Confusion over definitions and implications for care. *AIDS Care*, Vol. 20, pp. 527–536.
- Traube, 2010. Cross-cultural adaptation of the Child Depression Inventory for use in Tanzania with children affected by HIV. *Vulnerable Child Youth Studies*, Vol. 5, No. 2, pp. 174-187. Retrieved from (<http://dx.doi.org/10.1080/17450121003668343>)
- UNICEF and UNAIDS, 1999. *Children Orphaned by AIDS: Frontline responses from Eastern and Southern Africa*. New York: UNICEF.
- UNICEF, 2012. *The state of world's children*. New York.
- Williamson J and Foster G, 2000. A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa. *Aids*, Vol. 14, No. 3, pp. S275-284.
- Wild L, 2001. The psychosocial adjustment of children orphaned by AIDS. *Journal of Child and Adolescent Mental Health*, Vol. 13, No. 1, pp. 3–25.

Research Article

**ARE WE CARING ENOUGH FOR THE CHILDREN OF
LANKA? EXPLORING THE EMOTIONAL WELL-BEING OF
CHILDREN IN INSTITUTIONS IN SRI LANKA**

Esther John^{1} and Roshan Mendis²*

ABSTRACT

According to a recent research on the status on child-care institutions and children in Sri Lanka, there has been a rapid increase of child-care institutions from 1998 to 2013, and in 2013, there are 414 child-care institutions in Sri Lanka, providing care for 14,179 children in such institutions. The causes for institutionalisation of children include abandonment, mothers who migrate for employment, abuse, living in an unsafe home environment, due to the prolong conflict situation following the tsunami disaster and poor economic status of the family. In addition to such factors, children are also referred to 'remand' homes and detention centres due to petty and/or major crimes committed by them and other situations of abuse. In Sri Lanka, there is a growing trend towards greater institutionalisation as a favourable option for parents and for child welfare officers, as it may be the most convenient option available for children in the absence of better alternative care options. Sri Lanka has not established a foster care scheme. The need for better logistics to improve the quality and coverage of supervision in such a scheme has further excluded this being made available as an option.

Although institutionalisation of children has both positives and negatives, within the context of the current child welfare system in Sri Lanka, institutions do have their own challenges and often resulting in causing poor quality care for children. The child welfare system in Sri Lanka does not clearly outline the procedures related to institutionalisation. Thus, children are referred into institutions without an adequate plan and procedure in place. Due to such challenges, children are vulnerable to become the victims. Children often feel that they have been institutionalised due to their own fault and are thus at risk of suffering from guilt and rejection. Due to the lack of quality care in many institutions, children also face health issues and are at higher risk of abuse. Such experiences contribute to both a short- and long-term effect on their emotional well-being. One such child – a 14-year-old girl describes her thoughts on institutionalisation as *I like this home. But I want to go to my mother. I am a girl who has suffered a lot in life. If I want to be happy, I think I need to study well and make my mother's dreams come true. I feel really sad here. I don't have anyone. I don't want to be here and I want to go home.*

¹Esther John Working at LEADS as a practitioner in the field of child protection. 8 years' experience in providing psychosocial interventions and aftercare services for survivors of abuse. Working with children in institutions, specifically with children in conflict with the law.

²Roshan Mendis Since 2000, Roshan Mendis has been with LEADS as the executive giving leadership to the organisation and is a member of the board. Within LEADS, he provides direction to a broad range of sectors in Child-Centered Community Development, Relief & Recovery, Child Protection, Social Harmony & Rehabilitative ministries.

*Corresponding author email id: esther.escape@leads.lk

Even if the best care services are provided, children yearn to belong to a family. If their yearnings are not fulfilled, it would in turn affect their emotional well-being. The United Nations convention on the Rights of a child (UNCRC) which Sri Lanka ratified in 1990 endorses the rights of children to be in a happy and secure environment.

This study explores external factors and relationships that affect the emotional well-being of institutionalised children. Information is gathered from existing studies, reports and case studies from LEADS work with children and expert interviews. In the consideration of the emotional well-being of children as a priority in building a healthy nation, the authors' debates whether institutionalised childcare is the best option.

This article is written based on the experience of LEADS – a local non-governmental organisation in Sri Lanka working on child-protection-related issues the organisation provides aftercare services for survivors of abuse including children in institutions. The article is based on information gathered from 200 children in institutions, who received therapeutic and psychosocial services from the organisation in 2016 and using existing theories, studies and expert views.

Keywords: Alternative care, Child abuse & child neglect, Child rights, Emotional well-being, Institutionalised children, Mental health

INTRODUCTION

Children in institutions have been a part of history since mid-nineteenth century. This indicates the existence of child protection issues for many decades. Due to many factors, there has been an increase in the number of children being institutionalised. Social and economic factors are root causes. In this context, Sri Lanka's effort has to progress towards achieving economic and social development; there is some indication that the state is attempting to address current child-care issues. These include policy revisions and amendments to laws, which is an indicator that the state is positive in its emphasis on improving child-rights-based approaches to childcare. Though progress is slow, the country is moving forward in a positive direction. This is evident as the state is more receptive to changes in policies and addressing issues related to children in Sri Lanka. It is currently a period of transition. The process of transition would be slow to minimise the existing damage, manage and prevent further damage due to institutionalisation. There has been a recent increase in the number of child-care institutions in Sri Lanka. In 2013, there have been 414 registered child-care institutions which include remand homes, safe houses, certified schools, receiving homes, detention centres counselling centres and other types of centres with 14,179 children in such institutions.

The reasons for institutionalisation of children include socio-economic reasons, legal and policy-related factors. Together with external factors, the current gaps in the child-care system of Sri Lanka include a lack of necessary resources for the institutions to function in a manner which is in the best interest of the child. With such external factors affecting a child in institutional care, the separation of the

child from parents and family has a negative impact on all children and their development. Although children's basic needs such as food, safe water, shelter and security are important, it is also essential that children receive sufficient love and protection from parents. At every stage of development, both physiological and psychological needs will have to be met for healthy development of a child. The emotional development and well-being of a child would impact not only on their childhood but will continue to affect the child in adulthood. Thus, timely interventions are essential.

DEVELOPMENT OF A CHILD

The development of a child begins from the time of conception and continues until the end of adolescence. This includes physical, psychological/emotional, social, intellectual and spiritual development. At every stage of childhood, it is imperative that each need of the child is met.

Erik Erikson's theory of development focuses on the psychosocial needs of children. It is notable that his theory was formed based on his own life experience of being separated from his biological parents. The theory considers the impact of external factors, parents and society on personality development from childhood to adulthood. He says that, it is important that as a person progresses through every stage and if as a child, those experiences are not positive, it would affect a person in adulthood.

ATTACHMENT

The theory on attachment by John Bowlby (see footnote 3) suggests that infants need to develop a relationship with at least one primary caregiver so that it would influence a child's social and emotional development. The absence of attachment, either from the beginning of childhood or in any part of childhood, would impact relationships in adulthood.

The National Institute for Health and Care Excellence described 'attachment' in this way in their November 2015 guidelines regarding children's attachment:

Children whose caregivers respond sensitively to the child's needs at times of distress and fear in infancy and early childhood develop secure attachments to their primary caregivers. These children can also use their caregivers as a secure base from which to explore their environment. They have better outcomes than non-securely attached children in social and emotional development, educational achievement and mental health. Early attachment relations are thought to be crucial for later social relationships and for the development of capacities for emotional and stress regulation, self-control and metallization.

Attachment can be defined as an affective bond of infant to care giver. Basically, 'attachment' is a theory developed by psychologists to explain how a child's interactions with the adults looking after him or her will affect their behaviour. This trust building relationship in the early years of life is indeed crucial in the regulation of stress, anxiety and illness. Human beings have an innate need to become attached to a protective caregiver. However, due to the different types of parenting and the infants develop different types of attachment relationships: Some become securely attached to their caregiver whilst others find themselves in insecure/confused attachment relationships.

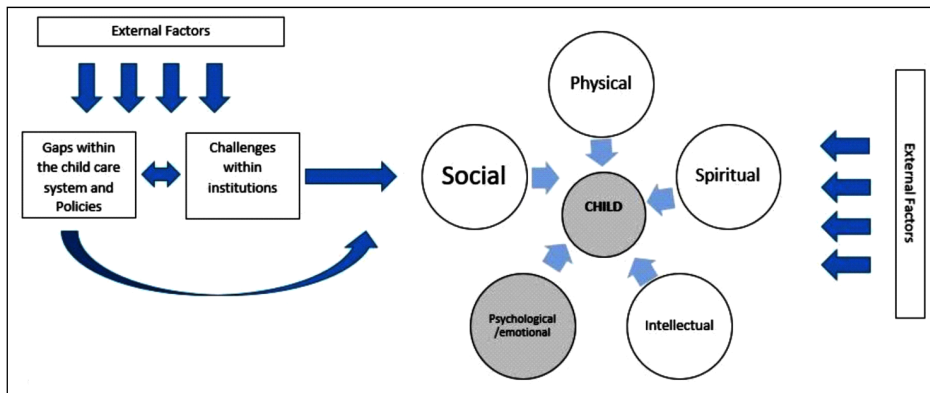
Secure attachment stems from a responsive caregiver, a child learning from the beginning that if he/she is hungry, frightened, uncomfortable etc the adults will understand, respond to the need and meet his need, reassuring him of their love, availability and care. This promotes confidence and self-esteem in a child and helps them to grow up to be happy, trusting, confident, functioning adults with a good sense of self-esteem. However, on the contrary, continuous, seriously inconsistent or unresponsive care giving towards a child, disregarding their needs can have damaging repercussions. Such attachments can lead to anxious children, self-doubting, unknowing how their caregiver will respond to them leading distrust and insecurity.

However, children who are institutionalised at an early age don't get the chance to form good attachments and run the risk of developing poor internal working models which can have very negative impacts on their view of themselves and their ability to form relationships with other people. John Bowlby's studies showed concerns about long-term impacts of these attachments including the increased aggression and even 'affectionless psychopathy' where a person cannot show affection or concern for others. Children who are in institutions display their lack of attachment in various forms. Low self-image, aggressive behaviour, attention seeking behaviour, inability to trust and form healthy relationships are some evident signs in such children.

*Expert view – Niluka Wickramasinghe
Child and adolescent mental health practitioner
Sri Lanka*

UNPACKING FACTORS INFLUENCING CHILDREN IN INSTITUTIONAL CARE

On the basis of the following framework, various factors influence children in institutional care, the ultimate recipient of these are the children, and this eventually influences the emotional well-being of the children.



EXTERNAL FACTORS INFLUENCING THE WELL-BEING OF A CHILD IN INSTITUTIONS

In spite of promises by ‘experts’ and rulers of the country that Sri Lanka will achieve phenomenal economic development after the war ended, we are seeing old and new challenges in the economy today, with deepening inequalities. One such challenge is the decline in rural incomes in the post-war years. Although the majority of Sri Lankan’s depend for their livelihoods in fisheries and agriculture, these sectors suffer from a lack of investments and years of neglect by the state. With increased market competition, selling their produce for a fair price is a challenge. Furthermore, scarcity of land for cultivation, access to water and depleting fish resources due to unsustainable fishing practices by large businessmen and Indian trawlers have reduced the harvests.

New job creation has been slow, giving no hope for people to earn in other sectors. Recent census statistics indicate that job growth was found only in the public sector. It means the macro-economic growth indicators only reflect a job-less growth. People survive these hard times by migrating to other places, including close to urban areas, in search of alternate forms of employment (as day-wage labourers, factory workers and migrant workers abroad) and via loans.

The entire household suffers when they are unable to earn enough to secure their basic resources. However, children are particularly affected, not just in terms of their present lives, but also in terms of their future prospects. They face mal-nutrition, unhygienic living conditions, lack access to health-care and general neglect, which affect their long-term growth and development. Further, their educational opportunities are affected badly. The local village system is no longer able to care for them, particularly if they are single-parent households. If there are opportunities to send children into homes, parents will opt for it, hoping for better care, protection and education in those homes. Without the burden of child-care, parents (particularly mothers) can go in search of much needed employment even to places far away or manage the precarious economic situation better, with less children to care for at home. Unfortunately, in many instances institutions for children are also found to be under-resourced or mis-managed, further stifling chances for the children to escape the cycle of poverty they were born into.

Expert view
Niyanthini Kadirgamar – Researcher

INSTITUTIONAL CARE

Thus, the economic circumstances affect children who are at the receiving end of such situations, being forced to bear the brunt of such adverse circumstances. When analysing the reasons for institutionalisation, it is evident that there are economic reasons which contribute to social factors. A recent study of the child-care institutions describes the reasons for institutionalisation even if both parents are alive. These include the level of their education, lack of care provided, low income, working parents, parent living abroad, domestic violence, dysfunctional family factors, disability/illness and sexual abuse. Further, children could also be institutionalised due to lack of protection at home, abandonment, if the parent has a psychiatric condition or a parent in prison.

GAPS WITHIN THE CHILD-CARE SYSTEM AND POLICIES INFLUENCING THE WELL-BEING OF A CHILD IN INSTITUTIONAL CARE

It is evident that there are challenges within the institutions which are due to policy and child-care-system-related gaps. Thus, it is a cycle that influences each other and the ultimate brunt is borne by the child. In the words of a child who described his plight as *'where ever it rains, it is us who gets wet'*, there is no doubt that at the end, it is children who are affected.

The definition of institutions, criteria for intake and period of admission is unclear when decisions are made regarding the child. There are situations in which the appointment and transfer of the child take place at times, without considering the best interest of the child. Thus, children who are not in conflict with the law are also treated the same way as those who are. In the words of a child who expressed her desire to return home, *'Just because I was sexually abused, I am treated like an offender and I have been put in this centre'*. Children who have been through abuse are also sent into detention centres, and the child feels that he or she is 'punished because of abuse'. The period of stay is not reviewed and thus children end up in centres for a long period of time. As a result, we have encountered certain cases where a child who did not have any behavioural problems due to being institutionalised develops new problems which he or she did not exhibit or had prior to admission.

Due to the lack of resources within the provinces, children are sometimes transferred out of one province to another. This has caused parents to travel many miles to meet their children. Due to the financial status of the family, at times, it has not been possible for a parent to forfeit their day's wage and travel to meet children. A child who as a result then has lost the attachment of their primary caregiver suffers further due to the loss in relationships which leaves the child with a sense of being unwanted. A 16-year-old boy describes his sense of loss of relationship as *I have not seen my family for almost a year. I am not sure if they have not visited me due to the distance or because I am not wanted anymore.*

Children who have been institutionalised for protection purposes due to a sexual abuse are compelled to wait for an extended period until the court proceeding is over. The delay in court hearings is often due to delays in providing reports and documentations on time. This in turn causes cases to backlog within the Attorney General's department, and then the procedure is delayed further. 'Of more than 1,450 cases reported in 2011, not a single conviction was reported by the end of 2011, and a backlog of 8,000 cases dates back 6 years. Officials at the UNICEF country office said that the justice system remains overwhelmed with backlogged cases and is in need of a complete overhaul'. -Inter Press Service News Agency

Although Sri Lanka does have laws related to child welfare, the challenge has been to implement such laws. In theory, institutionalisation of a child should be one of the options among many not the primary option. It is advisable that before such decision is made, alternative care options should be taken into consideration. Due to the lack of resources, however, it has not been possible to have a working system in place. Therefore, institutionalisation of a child has been the option considered the most and with perhaps the largest number. It is notable that this situation is not primarily due to the inefficiency of officials, but due to the lack of resources to set up an effective system for alternative care and monitoring.

CHALLENGES WITHIN INSTITUTIONS

Considering institutionalisation as the first option for alternative care, and at times, the only option available for a child, has led to a situation of overcrowding institutions and poor quality of care. The challenge that the department of probation and child-care services faces in such a situation is due to the limitation in human and financial resources.

It has been a challenge for institutions to meet even their basic requirements, sometimes they are dependent on donations and alms given from the community. In a case where there are sufficient resources, child-care institutions provide more than the minimum requirements. When considering the background of children in such institutions and if one of the primary causes for the child to live within such a care system is due to the economic difficulties, in such instances, children appreciate facilities provided and their opportunity to education. Yet, children invariably miss the parents and family even if all their basic physical needs are met. A 14-year-old child stated *'I like this place. I have food and I can go to school, but I want to go home'*.

Most institutions lack human resources and, therefore, children do not receive quality care. The existing staff are overworked and do not have access to regular breaks. Working in the field of child welfare and dealing with difficult children will lead to burnout, if staff are not provided with sufficient breaks. This could be one cause for an increase in abusive behaviour towards children by staff.

On a study of the status of child-care institutions in Sri Lanka, during interviews with probation officers, they mentioned that the salary scales of caregivers in the institutions are low and which is also a reason for inability to attract suitably qualified staff, resulting in poor services being rendered by them.

CHILDREN'S VIEWS ON INSTITUTIONALISATION

On the basis of the experience and case studies of LEADS, below are some of the views shared by children in institutions which capture the pros and cons of child-care institutions.

I am very happy in this home. I receive love and compassion from wardens, mothers and sisters of this home which I have never received from anyone else before, even though there are small arguments between us we forget those immediately. I have love, happiness, compassion, safety facilities and everything I need. Even if I must be here forever I like it. There is nothing in this home that I think that needs to be changed.

16-year-old girl

I like to be here. But I want to go to my mother. I am a girl who has suffered a lot in life. If I want to be happy, I think I need to study well and make my mother's dreams come true. I feel sad here. I don't have anyone. I don't want to be here and I want to go home.

14-year-old girl

At least in the future, do not allow little babies to live in places like this. I am in grade 7 and been in this home for 7 years.

12-year-old girl

We have facilities to study, happiness, freedom, good food and protection. I am 14 years and I have been in this home for a year.

14-year-old boy

I've been in homes from a very young age. But while those times are wonderful. I want to go home quickly. I can remember the days we used to play and have fun but those days are no more there. When will those times come back?

19-year-old girl

I have made many mistakes in my life and now I am in this institution. I know I am here to become a better person. I get food and clothes, which I don't get at home. But I miss being with my family. I miss my little sister a lot.

16-year-old boy

I was raped by my neighbour. After this happened I was sent to this institutions. I feel as if I did something wrong because I was taken out of my family after this happened. The person who did this to me is still with his family.

15-year-old girl

A RIGHT-BASED PERSPECTIVE

Sri Lanka, as one of the signatories of the UN child rights convention, is bound to give children their due rights. According to the UN CRC Article 9, *'The child has the right to live with his or her parents unless it is not deemed to be in his or her best interests; the child has the right to maintain contact with both parents if separated from one or both'*, and thus, it emphasises the right of a child to family and parents. In the current context of social and economic challenges, it has not been possible for all children to exercise the right to a family. Therefore, Article 20 of the convention should be given due importance as it emphasises that *'The State has an obligation to provide special protection for children without families and to ensure that appropriate alternative family care or institutional placement is made available to them, considering the child's cultural background'*.

Although it is the right of a child to live with family, at times, they are taken away from the family for various reasons. Thus, to provide suitable care for children who cannot live with their families, alternative options must be considered before institutionalisation. It is an unfortunate situation even if children are aware of their rights they are not able to exercise them due to the various social and economic factors.

CURRENT INTERVENTIONS IN SRI LANKA

In the midst of such challenges, the state is in the process of amending current laws and policies related to children. It is also notable that there are campaigns emphasising on current policy issues related to institutionalised children. Civil society organisations and other like-minded organisations are working at the grassroot level to promote alternative care mechanisms and strengthen FIT parent and foster care system in Sri Lanka.

The department of probation and child-care services strives to improve the standards of the existing institutions by providing training for staff in child-care institutions in partnership with civil society organisations.

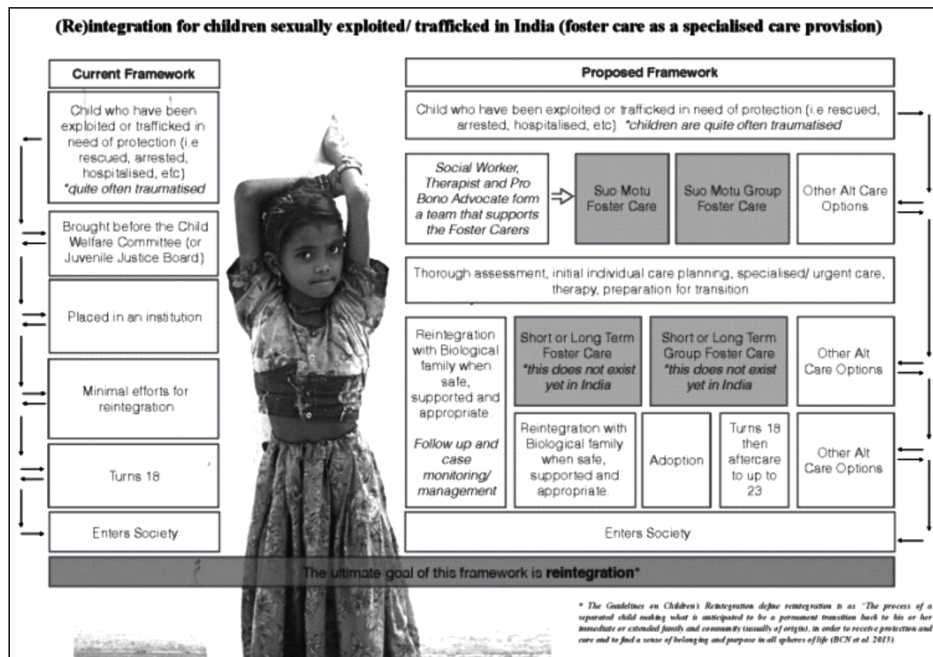
CONCLUSION

As the state is placing a foundation for alternative care options in Sri Lanka, the need for an interim plan is evident. Although de-institutionalising (DI) maybe the

desired end, socio-economic and other cultural factors will make it never an option that will be totally removed. Thus, the path to DI must be mapped and clear steps and criteria for improving existing care, resourcing the system, to transition and incorporate other alternate care models has to be introduced in a phased manner. As at the end of the day, it is the children who are currently in institutional care that face many challenges and are left with not much of a choice but to survive in the system. As we see the various factors affecting a child's emotional well-being, it is essential to understand that when a child is referred to an institution, the child already comes in with their own burden and emotional baggage from family and at times due to abuse. Often prior to addressing and dealing with such internal struggles, they are sent into an institution which is often unable to offer them the emotional care and support they need at such times. They are thus given an additional burden to carry with them, resulting from external factors and policy issues. It is also evident that the economy and social structures ultimately affect the children.

In the experience of LEADS, we have unfortunately borne witness to the emotional and traumatic effects and experiences of children in institutions. The child welfare system equally battles to balance the social issue against the limitation of resources. Though priority must be given to the problem, it may take time to move towards a child-focused system to ensure that alternative care methods are in place.

Even if the best care facilities are provided for children, a child would still yearn for love and belongingness as it is one of the basic human emotional needs. Of the



cases handled by LEADS, there have been instances where it has not been possible to trace one person at least, from the child's own family or extended family. When considering attachments as the foundation for one's emotions, the sense of self-worth is also shaken and, thus, children project their loss in forms of aggressive behaviour, self-harm and may seem depressed or withdrawn. Even if psychological interventions are administered, it is not easy to be able to restore the child's emotional state fully until the need for belongingness is met. On the basis of Abraham Maslow's hierarchy of needs, one reaches self-esteem when basic needs including the need for attachment are met.

To restore such a situation, it is essential that the right to family must be given as the first preference. In a case that it will not be in the best interest of the child, alternative methods should be considered rather than institutionalisation considered as the first option. Until such alternative options are in place, the care standards need to be given importance so that children are not re-traumatised. The process of DI should not harm children further; instead, it should be towards restoring the lost sense of belongingness. To prevent a generation of increased mental health problems, is it imperative that such issues are addressed both in a macro level and in grass root level?

ANNEXURE 1

Below is a recommendation on how the institutionalisation process can be done to ensure maximum benefit for the children. It is a framework of (re-)integration for sexually exploited/trafficked children in India.

REFERENCES

- Alanna Wissel, 2013. Qorking in residential child care. https://etd.ohiolink.edu/!etd.send_file?accession=miami1386174131&disposition=inline (accessed May 15, 2017).
- Diane E. Papalia, Sally Wendkos Olds, Ruth Duskin Feldman. Human development: 9th edition: Richard M Rickman, Abraham Maslow: Theories of personality, Status on child-care institutions and institutionalised children in Sri Lanka – a situational analysis 2013.
- What is attachment theory? Why is it important? <http://childprotectionresource.online/what-is-attachment-theory-why-is-it-important/> (accessed May 16, 2017).

Research Article

EXTERNALISING AND INTERNALISING BEHAVIOUR AMONG INSTITUTIONALISED STREET CHILDREN

Shefali Mishra^{1*}, Mazhar Khan², Amit Sen³ and Parvati C. Patani⁴

ABSTRACT

Background: Street children are at multiple risk factors such as poverty, broken homes, neglect, physical & sexual abuse, discontinued relationship and genetic factors which have an impact on the mental health. Several studies have found out that children living on street are at higher risk of developing externalising and internalising behaviour. **Objective:** The current study was conducted to explore the externalising and internalising behaviour among street institutionalised children. **Methodology:** Developmental Psychopathology Checklist (Kapur *et al.*, 1995. *Nimhans Journal*, Vol. 12, No. 1, pp. 9) and standardised clinical examination (according to the diagnostic criteria of Diagnostic & Statistical Manual IV-Text Revised) were used for the 419 participants for the assessment of externalising and internalising behaviour. **Results:** The results indicate that overall prevalence of externalising and internalising behaviour was 35.3%, in which externalising behaviour was 47.3%, internalising behaviour was 52.7%, respectively. **Conclusion:** It can be concluded that externalising and internalising behaviour are highly prevalent among street children in institutionalised care. However, there is a need to provide mental health services for such children.

Keywords: Externalising, Institutionalised care, Internalising behaviour, Protection, Street children

INTRODUCTION

India is home to the largest number of children in the world significantly larger than the number in China. According to the most recent statistics from United Nations International Children's Emergency Fund UNICEF, an estimated 31 million children in India, aged 0–17 years, are orphaned and abandoned. Such children bring with them the experiences of being orphaned and abandoned, with a past full of utter deprivation, and trauma arising from maltreatment. Among them, street children constitute one of the most vulnerable groups. Street children lives are marked by frequent, and in some cases, continuous exposure to violence. They have typically already suffered abuse at home in dysfunctional families and have grown up in poverty-evicted, chaotic neighbourhoods, experiencing both violence in the streets and mistreatment by police forces (de Benitez, 2007). These violent experiences, combined with the constant insecurity of having to struggle to find food and shelter,

¹Research Scholar, Department of Psychology, Guru Nanak Dev University, Amritsar, Punjab, India

²Counseling Psychologist, ³Senior Psychiatrist, ⁴Executive Director, Salaam Baalak Trust, New Delhi

*Corresponding author email id: shefali1791mishra@gmail.com

put these children at substantial risk of developing mental disorder (Cleverley and Kidd, 2011). The majority of street children leave home to reside or work on the street to escape dysfunctional families, physical battery, neglect or sexual abuse or out of a desire for freedom, and not because of socio-economic problems.

Children's mental health difficulties are generally classified as being one of two types: 'internalising' and 'externalising'. Children with internalising difficulties show behaviours that are inhibited and over-controlled. They may have a nervous or anxious temperament and be worried, fearful and/or withdrawn. Children with externalising difficulties show behaviours that are under-controlled. They may have a more challenging temperament, shown in impulsive or reactive behaviour. Sometimes, this pattern can lead to difficulties with attention, aggression or oppositional behaviour. Externalising behaviours cause difficulties for others as well as for the children themselves. Several studies suggest that children living in the streets frequently suffer from externalising and internalising difficulties, such as low-self-esteem, suicidal ideation or even suicidality, alcohol and substance abuse, depression and post-traumatic stress disorder (Kidd and Carroll, 2007). It can be assumed that the risk of developing behavioural problems is even higher for those children and adolescents who have faced maltreatment. Studies have shown Post Traumatic Stress Disorder (PTSD) prevalence rates between 20 and 50% for war-affected children in conflict regions such as Bosnia, Sri Lanka and Rwanda, even years after the exposure to war (Elbert *et al.*, 2009).

Institutionalised care is often the first line of defence in helping children living in the streets to support them with nutrition, places to sleep, medical care, access to education and psychosocial support (Williamson and Greenberg, 2010). The principal objective is the reintegration of these children into society, either by enabling them to return to their families or by helping them to start an independent life. Among various study performed, Malhotra and Patna (2014) found that ca. 23.3% of children and adolescents (5–18 years) in Indian community experience behavioural problems. In addition, children and adolescents (5–18 years) staying in institutionalised homes reported 45% to 49% more *externalising and internalising* problems than staying with their families (Ford *et al.*, 2007).

Thus, to extend the current literature, the present study is aimed at exploring externalising and internalising behaviour among institutionalised street children.

METHODOLOGY

Participants

A total of 419 participants (7–18 years) who were currently admitted in institutionalised homes. Purposive random sampling was followed in the present study. The inclusion and exclusion criteria are as follows:

● **Inclusion Criteria**

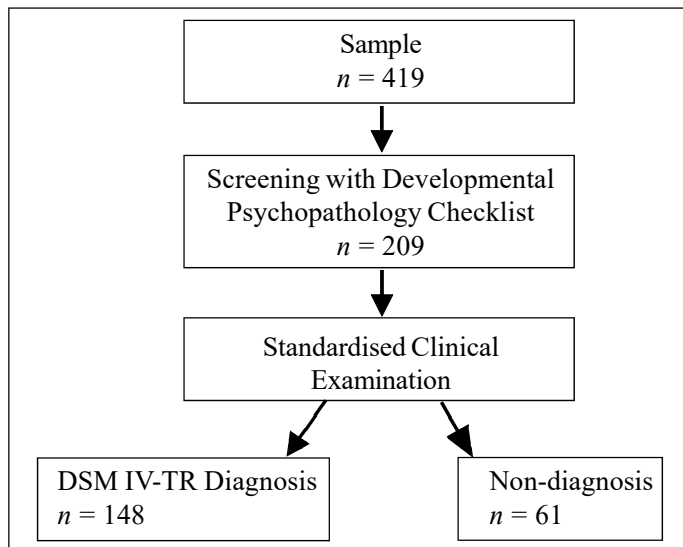
Normal healthy students with ages ranging between 7 and 18 years, belonging to both genders.

● **Exclusion Criteria**

Those who are staying in institutionalised home less than 2 months will not be covered in study, in addition to those who are going school and receiving vocational training in institutions.

Design

The present research follows cross-sectional design to study the externalising and internalising behaviour among institutionalised street children.



Tools

The following tools were used in the present research:

- **Developmental Psychopathology Checklist:** DPCL is a very useful tool to study child psychopathology from a developmental perspective. The reliability of the entire checklist tested employing interclass correlation coefficient via analysis of variance was found to be 0.965 ($p = 0.001$).
- **Standardised clinical examination:** Standardised clinical examination was done on the basis of Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (Text Revision).

Procedure

The data collection was conducted between January 2016 and December 2016 in the institution. The children were further assured that their information will be kept confidential and that there would be no negative consequences for whatever information was given. The study was based on the two-step design. First, the sample was screened using DPCL. On second level, those who were screened out, their standardised clinical examination was performed according to DSM-IV Text Revised) criteria. Thus, this aimed at allowing a standardised diagnosis of psychopathology by experienced psychiatrist & psychologist with clinical experience.

STATISTICAL ANALYSIS

The data was analysed using descriptive statistics.

RESULT

In the present study, the total prevalence of externalising and internalising behaviour among institutionalised children were 35.3%, in which externalising behaviour was 47.3% and internalising behaviour was 52.7%, respectively (Table 1). Among externalising behaviour, conduct disorder (27.7%) and Attention Deficit Hyperactive Disorder) (19.5%) were found to be more prevalent among group. Anxiety (31.7%) and mood disorder (20.9%) were present in internalising behaviour. Higher percentage of externalising and internalising behaviour had been found more among 11–15 years (Table 2). In total, 75.6% boys and 24.3% girls were having externalising and internalising behaviour among institutionalised street children (Table 3).

Table 1: Prevalence of externalising & internalising behaviour ($n = 148$)

Externalising & Internalising Behaviour	Frequency	Prevalence
Conduct disorder	41	27.7
ADHD	29	19.5
Anxiety disorder	47	31.7
Mood disorder	31	20.9
Total	148	35.3

Table 2: Age distribution among institutionalised street children

Age (years)	Frequency	Percentage
7–10	16	10.8
11–15	69	46.62
16–18	63	42.56

Table 3: Gender distribution among institutionalised street children

Gender	Frequency	Percentage
Female	36	24.3
Male	112	75.67

DISCUSSION

Children staying on the streets have risen worldwide; however, the debate on effect of this phenomenon on mental health of high risky population has not yet reached the multitude of this problem. A study by NIMHANS, Bangalore (2016) found that prevalence of mental disorders in age group 13–17 years was 7.3% and nearly equal in both genders. The present study found that prevalence of externalising & internalising behaviour was 35.3%. This finding indicated higher prevalence of psychiatric morbidity among institutionalised children than general children and adolescents. Hulseley (1989) study has shown that internalising and externalising disorders were found higher among foster children.

The high prevalence of anxiety disorder and mood disorder (52.7%) indicates that institutionalised street children are high on internalising behaviour (47.3%) than externalising behaviour (47.3%). A possible explanation could be the persistent exposure to direct violence in the form of physical, sexual, emotional that street children have faced. Inadequate or absence of early parental rearing may contribute as a risk factor for higher prevalence of psychiatric disorder among children. Providing shelter to street children offered at least some protection from violence experienced on a regular basis in the streets. On the contrary, children staying in institutional cares are extremely vulnerable to psychological problems and institutionalisation in long term (Flank *et al.*, 1996). This increases the likelihood that they will grow into psychologically impaired and economically unproductive adults.

The present study is not without limitation. The sensitivity of the clinical assessment for a comprehensive scope of externalising & internalising behaviour in childhood and adolescence was limited. Because of limited financial resources, it was necessary to compromise and use checklists. On the other hand, some strengths of our methodology support the value of the present findings. The two-step design allowed a control of our diagnostic procedures and cross-validated the results regarding psychopathology. The relatively large sample size of 419 children minimises the chance of a relevant selection bias.

CONCLUSION

The findings of the study revealed significant number of cases with externalising & internalising behaviour among institutionalised street children. This findings need to be addressed carefully. The results strongly suggest that it is equally important to adhere to the psychological needs of vulnerable children as it is to satisfy other basic lacking needs to help them successfully reintegrate into society. Professionals within the institutions should be trained in caring for such children and adolescents. Co-operation between child and adolescent psychiatrists, psychotherapists, social workers and caregivers within the institutions should strengthen the chance of

continuous care and avoid repeated breaking-offs. Therapeutic options in co-operation between institutions and child and adolescent psychiatry should be taken including appropriate diagnostic procedures, continued psychotherapy, staff counselling and medication.

REFERENCES

- Cleverley K and Kidd S, 2011. Resilience and suicidality among homeless youth. *Journal of Adolescence*, Vol. 34, No. 5, pp. 1049-1054.
- de Benitez S, 2011. *State of the World's Street Children : Research*. [ebook] UK: Hobbs, Southampton, pp. 1-101. Available at: http://www.streetchildrenresources.org/wpcontent/uploads/2013/02/State_of_the_Worlds_Street_Children_Research_final_PDF_online.pdf
- de Benitez ST, 2007. *State of the world's street children: Violence street children series*. London: Consortium of Street Children.
- Elbert T, Schauer M, Schauer E, Huschka B, Hirth M, Neuner F, 2009. Trauma –related impairment in children-A survey in Srilankan provinces affected by armed conflict. *Child abuse & Neglect*, Vol. 33, pp. 238-246.
- Flank D, Klass P, Earls F and Eisenburg L, 1996. Infant and young children in orphanages. One view from pediatrics and child psychiatry. *Pediatrics*, Vol. 97, No. 4, pp. 569–578.
- Ford T, Vostanis P, Meltzer H and Goodman R, 2007. Psychiatric disorder among British children looked after by local authorities: comparison with children living in private household. *The British Journal of Psychiatry*, Vol. 190, pp. 319–325.
- Hulsey TC and White R, 1989, Family characteristics and measures of behavior in foster and non-foster children. *American Journal of Orthopsychiatry*, Vol. 59, No. 9, pp. 502–509.
- Kapur M, Barnabas I, Reddy MV, Rozario J and Uma H, 1995. Developmental psychopathology check list for children: a preliminary report. *Nimhans Journal*, Vol. 12, No. 1, pp. 1–9
- Kidd SA and Carroll MR, 2007. Coping and suicidality among homeless youth. *Journal of Adolescence*, Vol. 30, pp. 283–296.
- Malhotra S and Patra B, 2014. Prevalence of child and adolescent psychiatric disorders in India: a systematic review and meta-analysis. *Child and Adolescent Psychiatry and Mental Health*, Vol. 8, No. 1, pp. 22.
- NIMHANS. National Mental Health Survey of India (2015-2016): Prevalence, Pattern & Outcomes. Available from : <http://indianmhs.nimhans.ac.in/Documents/reports/Summary.pdf>].
- UNICEF. UNICEF India Statistics (Internet). Available from: [http://www.unicef.org/infobycountry/india_statistics.html].
- Williamson J and Greenberg A, 2010. *Families, Not Orphanages*. [ebook] USA, pp.1-26. Available at: <http://bettercarenetwork.org/library/the-continuum-of-care/foster-care/families-not-orphanages>.

Research Article

DEPRESSION IN CHILDREN LIVING IN ALTERNATIVE CARE

Roma Debabrata^{1} and Smritikana Ghosh²*

ABSTRACT

India with 1.21 billion people constitutes as the second most populous country in the world, while children represents 39% of total population of the country (abhimanuias.com/blogs/blogdetails_new.aspx?SelectionOfBlog=7608). 170 million are children in need of care and protection and out of them 20 million are estimated to be orphans (udayancare.org/Workshop-Report_17-02-2017.pdf). The reasons attributed to this significant high number are poverty, disability, parental neglect, natural calamity, trafficking and abuse; lose of parents; children with diseases and parents not able to give care and protection to their children and others. Different study also shows that in South Asia, the majority of children living outside parental care have parents who are alive. The need to provide quality alternative care has only been rising over the years. 'Alternative care' is care giving services available to the destitute children; it comes in various forms like children living with their extended families in kinship care arrangements, institutional care provided by the state or NGOs, adoption and foster care, and they are also practiced to a limited extent and others (Greenfield *et al.*, 2016). However, irrespective of magnitude of support, it has to be acknowledged that these services cannot replace the family set up and the psychological comfort provided by most of the parents and sanctioned by society. The protection and support provided by alternative care sometimes may be more than the parents can afford but, the set-up is different from regular families and community. Mostly, the children in need of care and support come with traumatic experience. The experience may appear to fade with time and assistance provided by the care giving institution, possibly with the acceptance of the children with their situation. But the deep-rooted unwanted feeling and singled out of being not from normal biological family set-up create a vacuum in the psyche of the child and sometimes resonates into depression along with a sense of rootlessness. Sometimes, this is not strikingly visible. For the all-round development of the child, it's crucial to address the issue of depression amongst the children in the alternative set-up primarily by case work and eliminating the stimuli from the environment; therefore, addressing depression is significant to contribute to the overall psycho-social development of a child. STOP Trafficking and Oppression of Women and Children (STOP) under the aegis of Ramola Bhar Charitable Trust rescues children from difficult milieu and rehabilitates them by social integration. It has a rehabilitative establishment modelled as children's home and also an after-care unit for institutional care giving. This paper will be based on the case studies based on the interventions of STOP, attempting an effort to build a replicable strategy to address the issue of depression in children living in alternative care.

Keywords: Abandoned child, Alternative care, Care and protection, Orphaned child, Psychological discomfort, Stake holders, Surrendered child

¹President, STOP Trafficking and Oppression of Women and Children, New Delhi, India

²Researcher, Programme Manager, STOP Trafficking & Oppression of Women and Children, New Delhi

*Corresponding author email id: stopglobalmovement@gmail.com

CONCEPT OF DEPRESSION

Depression is a low state of mood and activity that can affect a person's thoughts and behaviour, feelings and sense of well being (Salmans, 1997). People in depressive mood feel irritable, sad, hopeless, helplessness, loss of interest towards performance and in life. In extreme cases, it may express through relationship problems, fatigue, suicidal tendencies, insomnia, digestive problems and others (Halverson and Bienenfeld, 2016).

Sadness is also an important emotion of individual to deal with the environment. Prolonged sadness is also an indicator of depression, which many individuals experience at different stages of life. These individuals have their own coping mechanisms. This might be getting social support or engaging in some pleasure activity and others. But when it manifests as an illness and there are no alternatives to cope with the problem, the gaps need to be identified and addressed with utmost efficiency.

CHILDREN IN ALTERNATIVE CARE

In India, children's relationship with their parents is more of an intimate, affectionate and obedient relationship. Children in institutional care are devoid of any such relationship with the supervisory adults. In addition, they have their past traumatic experiences caused by negative life events. As observed, in institutional settings, they possibly have issues during their growing up years, around peer relationships (mostly forged by institutions), education, hopes, aspirations and future planning, as well as many others. Children in alternative care often have little exposure to the external world, which sometimes hinder development of their social and psychological skills essential for adult life. Sometimes, they have physical and learning disabilities and are also affected by malnutrition. Even the overprotective environment of the institution may prove as stimulus for depression among its residents. In this paper, we are using case study analysis to understand the type of depression, catharsis and the intervention (Ferrara *et al.*, 2013).

Case Study 1

Pinky¹, aged 7, was born to a destitute family – her mother had been a survivor of trafficking, and her father was a street hawker. Pinky lost her father when she was only 3 years old which created a deep vacuum in her life. Coping with her own traumatic experience from the past coupled with the loss of her husband, Pinky's mother was unable to provide the emotional support and affection which Pinky required. Pinky was placed in our family home. Affections from the older beneficiaries and the staff poured in on her primarily because she was the youngest and also that

¹Name changed to protect identity.

she had lost her father. She received attention and affection in excess that accustomed her to a way of life of leniency. When she was inducted into the formal schooling system, her entire world came crashing down. She wasn't ready to face the pressure that came with formal schooling system. Not receiving any special treatment in school coupled with the realisation that she wasn't the youngest in a set-up anymore, she became resistive and showed tremendous behavioural changes. She evolved from being a gentle easy-going child to an adamant child, choosing to keep herself aloof from others.

Gradually, she also turned into an introvert and stays silent even when she needs to speak out. It affected her daily life, education and largely her social behaviour. She would come across as a docile child, but the silence she exuded was an impact of her deep-rooted depression which stemmed from her father's death that fuelled her cravings for continuous attention and affection. The alarming sign of being introvert and adamant, in most cases, indicates depression.

Social therapy which includes interpersonal intervention, orientation of other members as well as behavioural therapy has been administered. More importantly, buddy system was also incorporated for her. The buddy system consisted of one of the elder girls she is close to. She was asked to talk to her buddy about her day, feelings and anything significant for the day on regular basis to be able to work on her social skills. Being introduced to such therapies, she has shown little changes in her behaviour towards others. Pinky's therapist believes that she has been introduced to social therapy at the right time. Giving therapeutic counselling in the formative stages of depression helps the sufferer deal with it better.

Case Study 2

Tulu², aged 19, is from Nepal. Four years ago, Tulu had been rescued from an exploitative situation and since then, she has been living in our family home as her family back in Nepal could not be traced. Tulu is a jovial person, who enjoys learning new things. At present, she is completing her education from an open school and simultaneously learning about tailoring and fashion designing. Adept at her work, she has been widely appreciated by STOP Trafficking and Oppression of Women and Children (STOP)'s friends and visitors from outside of India for her dedication and contributions. Things had been positive with her till a few months back. However lately, a lot of complaints on her attitude and improper behaviour were reported to the organisation. Her quality of work deteriorated heavily, which was something unusual. Sensing something amiss, STOP had to put her under surveillance without her knowledge. Gradually, it is exposed revealed that the constant sarcasm from her peers related to her looks (she has acid burns on her face) affected her confidence

²Name changed to protect identity.

and quality of work. She was gradually seeping into depression since she felt herself to be unattractive. Tulu resorted to defensive steps of improper behaviour as her defence mechanism to tackle her depression.

Although on the surface, apparently, the environment of the alternative care in STOP seems very cosy, non-coercive and peaceful, the undercurrents and the interpersonal relationships need to be understood. The members come from different and challenging backgrounds which develop a cut-throat competition among them, in other words, a struggle for the survival of the fittest. In this very case, Tulu's work has been recognised by the institution and the buyers, which is a threat to the other members and puts them in an insecure state. To demean her, some of the members humiliate her and raise issues with her products. Continuous humiliation and cornering over a period of time resulted in deep frustration which in this case turned into depression.

Tulu had gone through counselling and interpersonal therapy followed by interventions to help the peers reflect on their behaviour and work on it by making them focus on the consequences of their words and actions with Tulu's perspective in mind. Behavioural therapy has also been administered on Tulu. In this case her impatience coupled with strong desire of achieving too many goals within too short time keeping a challenging bar in front of her which is humanly impossible to cross, e.g. she is pursuing class VIII exam but clearing her XII exam within 2 years is really impractical.

Case Study 3

Reena³ is 17-year-old girl. She has been staying at our shelter home since the last 6 months, grappling to recover from the traumatic experience she has been through. Reena craved for social exposure – she desired to go out, make friends and learn about new things. She was not allowed much of these as she was under the guidance of the Child Welfare Committee. The organisation tried to admit her into regular schools right after she started staying at the family home, but she was denied admission as it was already mid-session in schools. Reena was highly disturbed to see her peers attending formal schools. She is now enrolling in Non-formal education system which did not satisfy her. For her social exposure, the organisation had decided to accommodate her in its city centre office, engage her in different activities that the other beneficiaries were involved in. Due to some exigency, the arrangement could not be made for a long time. The frustration accumulated with non-exposure to the external world induced the feeling of alienation which triggered an unruly outburst, after which she recoiled into a zone that was difficult to penetrate.

The alternative care giving institutions try to give all the support to the receivers but sometime it goes overboard. The overprotection sometime backfires the situation

³Name changed to protect identity.

where the beneficiaries revolt because of the lack of independence induced by the post-trauma and secluded life. The institutions are not wrong due to safety concerns of the beneficiaries if exposed to the external world. Having said so, there is a need to balance between protection and exposure. The reason should be explained properly to the beneficiaries with proper justification. If possible, there is a need to give exposure to the individual with proper security arrangement which is not like policing but of gentle concern. The main therapy administered on her is Trauma Informed Care (TIC), which consist of understanding the responsiveness of trauma with emphasises on the physical, emotional and psychological well-being. TIC included a lot of talk therapy to where she was encouraged to share every thought coming across and help deal with the trauma in a better way.

Case Study 4

Aarti⁴ came at our shelter home from a very exploitative situation. Last 6 years, she has been a resident of the children home. She attended a hotel management training programme and is now appearing her class 10th exam through open school. As part of social reintegration, she started working with STOP and is staying independently in a rented flat provided by STOP with four other beneficiaries who are also undergoing similar rehabilitation processes.

Aarti has always been an optimist and a happy person; however lately, she started showing signs of depression which affected her personal and professional life. She was infatuated with a boy who returned her affection for a short while before starting to ignore and neglect her openly. Upon investigation, it was revealed that the boy was engaged in nefarious activities and simultaneously he had been liaising with other women. Along with this, she had emotional outburst with her friends and peers which affected her quality of work, leaving her with feelings of guilt and worthlessness. Observing these changes, she was put under intensive casework.

Protective environment of alternative care sometimes hinders mixing up with the mainstream society. Being 'different' from other young adults block them from socialising. The limited interaction with the outer world often limits the understanding of the psyche of the mainstream society. Although in most of the cases, the alternative caregiving institution takes care of the child properly, there is a still deep-rooted desire to have their own personal, non-intrusive space. The complex psyche of individuals has the potential to get influenced by any person, who shows even a little affection and without proper understanding, often it results in entangling with the wrong person or group.

STOP has put her under interpersonal therapy and casework to set goals and keep adherence to achieve it. We are progressing gradually to help her overcome this phase.

⁴Name changed to protect identity.

CONCLUSION

Depression has different facets and can be induced by different stimuli. The factors that play a role in causing depression include the stress of facing traumatic life situations, sometimes triggered by needs with growing in age and peer pressure, humiliation, overprotection and inability to cope with the mainstream society. All these are very common in alternative care. Eliminating the stimuli from the system is an important provision of post-incident care to children affected by depression. This requires conscious effort by the institution, continuous monitoring of the home boarders, the creation of a supportive environment in the home and above all bringing efficient mental health professionals into the system. Government and NGOs can work with different volunteering agencies to identify the best practices related to mental health in children, most of which need huge financial investments. The government should focus on supporting private-run alternative care giving institutions with both financial and non-financial support to tackle this ever-growing challenge of depression in children in alternative care.

REFERENCES

- Ferrara P, Romani L, Bottaro G, Ianniello F, Fabrizio GC, Chiaretti A and Alvaro F, 2013. The physical and mental health of children in foster care. *Iran Journal of Public Health* [<http://ijph.tums.ac.ir/>] Published online 1 April 2013.
- Salmans S, 1997. *Depression: Questions You Have – Answers You Need*. People’s Medical Society, Allentown, United States. abhimaniuas.com/blogs/blogdetails_new.aspx?SelectionOfBlog=7608.
- Halverson JL, Bienenfeld D, 2016 Depression Differential Diagnoses. Online publication- Medscape [emedicine.medscape.com/article/286759-overview] http://emedicine.medscape.com/article/286759-overview.udayancare.org/Workshop-Report_17-02-2017.pdf.
- Greenfield M, Salmani K and Ian Anand Forber Pratt I, September 2016. *Assessing the Knowledge of Alternative Care among India’s Child Protection Stakeholders- National Survey*. Centre of Excellence, an Alternative Care, New Delhi, India.

International Perspective

**‘FUTURE GLOBAL GOALS AND CHALLENGES IN
ALTERNATIVE CARE’* – A DISCUSSION ON
INTERVENTIONS AND SOLUTIONS FOR CHILDREN
WITHOUT PARENTAL CARE**

Niels Peter Rygaard

ABSTRACT

On the basis of the experiences from the implementation of global online training programmes in cooperation with international governments and NGOs, the author discusses the global forces driving research, child policies and intervention programmes targeting children and youth without parental care. Special attention is given to the cultural clash between Western and developing country goals, mindsets and challenges of alternative care policies and outcomes.

Keywords: Challenges, Children, Future, Global goals

WHY ARE THE OUTCOMES OF GLOBAL CARE SYSTEMS SO POOR?

A decade ago, the author published a book on therapy for children with severe attachment problems due to neglect (Rygaard, 2007), later published in many languages. Following invitations for lectures on all continents and studying local care monitoring systems, the author’s conclusion was that the poor outcomes of institutional and foster care placement were mainly caused by a general lack of government support to build monitoring, supervision and education systems. This leaves frontline caregivers and their daily leaders underpaid and overworked, with a responsibility for large numbers of traumatised children, and no access to professional care education, organisational development and the rich research recommendations for quality care.

**HOW CAN CHILD CARE RESEARCH BE DISSEMINATED GLOBALLY
TO CARE ORGANISATIONS?**

Global Training Programmes by E-learning for Caregiver Groups

After two EU projects in 10 countries (Rygaard, 2010), the Danish Fairstart Foundation (hence: FF) was formed to create a meeting place for international child

*A discussion inspired by the Alternative Care Conference (Geneva 2016)

DPA authorized psychologist, Adoption expert for Socialstyrelsen VISO. www.fairstartfoundation.com
Email id: info@fairstartfoundation.com

researchers, child policy makers and frontline caregivers. The mission of FF is to provide other NGOs, local professional associations and government agencies with free training programmes online in local language versions at its site, translated and implemented by 2-year local partnerships.

The means to this end was the development of an international network of high risk child researchers to advice on the contents of free online group training programmes, for foster and residential cares, respectively. Recently, an international online education in programme use has also been developed, connecting participants from Indonesia, India, Russia, Estonia, Spain, Canada and Africa. Instructors only need internet access, or a USB and a projector to train large numbers of caregivers, using the training programmes in 17 local language versions.

The following discussion is based on the global overview from a decade of dialogues since 2005 with local partner organisations and professionals, and research in the causes of why parents are forced to give up parenting.

Global Forces in Parent–Child Separation: Migration and Urbanisation

From this perspective, we see the course of de-institutionalisation as being determined by two powerful global forces: migration and urbanisation, opening possibilities and also creating risks for the very core of our societies: the family system and its ability to create lasting bonds between parents and their children.

WHY DO PARENTS GIVE UP PARENTING AT SUCH AN ENORMOUS SCALE?

One important force is that the rural small village-based society with its extended family system is ending: in 2050, 66% of the world population will be living in still larger metropolis, as opposed by only 5% in 1840 [Department of Economic and Social Affairs (DESA), 2014]. Urban families often have two stressed parents (increasingly, only a single parent), who have to leave their children in the daytime to earn enough money to raise them. Major parts of these megacities are surrounded by a ring of impoverished former peasants and craftsmen and are beyond the control of social, health and other government services, whose budgets are also burdened by the increasing amount of elderly citizens [United Nations Centre for Human Settlements (UNCHS), 2001]. Rural areas are left behind, with a consequent lack of schools, social workers and other social units important for parenting. Even in wealthy countries such as the USA, families are thrown into poverty, and half a million children are placed in care.

The second force is inter-country migration and homelessness – created by wars, climate change, ethnic and religious conflicts, and the increasingly uneven distribution of wealth. Never before in history have so many fugitives been created, including a steeply increasing number of 50 million migrated and fugitive children and youth (United Nations, 2014).

The Two Concepts of Intervention Clashing

However, urbanisation, industrialisation and in-country migration started in the Western World and with some delay are now taking place in developing countries. This time lapse has created two conceptualisations of care interventions in the Western and the Developing World, respectively – produced by very different economic and social circumstances. What are the differences and how do they clash? This will be illustrated by comparing Western developments, giving Danish alternative care as an example, and impressions from developing country care systems and challenges.

The Western (Urban) Model of Care Intervention: The Individual Perspective

Urbanisation tends to reduce the extended rural family into two overworked parents or even a single parent and create a remarkable drop in birth rates in favour of a growing population of the elderly (the mean age in Denmark is now 42 years). This process of individualisation and upside-down turn of the population pyramid has profound effects on family structure and political priorities. In Denmark, the number of single female and male parents increased in 10 years by 25 and 50%, respectively, with a parental divorce rate growing from 5% in 1955 to the present 52% (Olsen *et al.*, 2005).

The traditional complementary gender roles and division of labour (mother at home, father at work) are replaced by symmetrical parental roles and responsibilities, constantly negotiated in court and family. Now, both parents are away in the daytime, in pursue of income and career. The effects of the weakening family system are obvious: more and more urban children are diagnosed, and the number of homeless Danish youth grown up in the process has increased by a third from 2009 to 2015. Today, the majority of Danes live alone rather than in marriage or other group settings.

Consequences for Child and Placement Policies

In this socio-economic context, parents and children are now a minority as governments struggle to lift the growing ‘burden of elderly citizens’. In Denmark, budgets for midwives, staff in kindergartens, schools, special needs facilities, universities and affiliated professions are constantly reduced. This of course also affects out-of-home placement: just to keep the total placement budgets of one billion Euro still, the number of placed children and youth has been reduced from 15,000 to 10,000 in 5 years, and placement in foster care increased from 27 to 62% in the period. County foster care consultants and supervisors are reduced in favour of a regional unit focusing on physical environment, payment, craving regular documentation of progress in child development. In other words, New Public Management prevails. The increased control has reduced the number of substandard placements, but many criteria in the regional procedure are not related to scientific proof for improved child development.

The economic process also alters the scope of research from care outcomes towards economic outcomes. The formerly independent National Institute of Social Research is now being taken over by a privately funded institute manned by economy and administration experts, and the agenda for interventions is the documentation of revenue from any initiative. This also prevents NISR from documenting negative outcomes of government social policies.

Danish foster families are lavishly paid compared with other countries, but worry about being excluded from work market legislation, unpaid retirement (most foster carers are aging out), and a lack of supervision and education in the still more complex cases in foster care. For this reason, FF recently invited the family departments of five Danish counties in a 2-year project to develop an online county consultant education in training groups of foster families with our programmes. This will be accompanied with an effect study by NISR, and be financed by private foundations.

These trends are similar to the process in other Western countries. However, more than government policies, international research has also accelerated the preference for foster care versus small group home and institutional care.

ABANDONING GROUP CARE GLOBALLY – BUT HOW FAST?

Looking at group care settings, the Western urge and world policies for a general institution closure also stems from the 1990s research by Zeanah, Rutter and others, who mapped the consequences of extreme concentration camp-like orphanages in the former communist countries of Russia, Romania and Bulgaria. The subsequent stance to close all orphanages was absolutely relevant in many Eastern Europe countries but has become a generalised Western mantra. Today, both the UN, USAID, the NGO Lumos and other economically powerful influencers advocate universal closure, as well as focusing on using rather costly solutions for each individual child, and the promotion of children's rights. This increases the risk of a local administrative collapse after the first waves of external investment and enthusiasm, as reported by the author's colleagues in Romania, Estonia, Cambodia, Indonesia and other countries.

Another consequence as world governments obey to this call is the excessive speed of reorganising care management. The hasty process of closing Eastern Europe orphanages in many cases resulted in foster families receiving 6–12 traumatised and formerly institutionalised foster children, without government funded supervision or training, causing many of the already scarce number of foster families to resign. In Rwanda, the quick closure allegedly caused many children failing family reunion and becoming street children (AlJazeera, 2015).

The Urban Clash between Family Structures, Ideals and Beliefs

A third impact – inter-country migration making every city and village an intercultural meeting place – also affects Western placement and migration policies. For example, in spite of dropping birth rates, Danish Government reduced subsidies for families giving birth to the third, fourth and fifth child, clearly targeting immigrant and fugitive families. African and Near Orient mothers must learn Danish, enter the work market, and legislation to make kindergarten and preschool training mandatory for their children is discussed. Some political parties now advocate the rejection of unaccompanied fugitive children at the border. This forced adaptation to intercultural cities of course disrupts many migrated families and creates rootless second generation youth. Young fugitives tend to refuse being alone and alienated in a foster family and prefer staying with their peer group.

From Inter-country to In-country Adoption Policies

Nowhere is the cultural clash more obvious than in inter-country adoption, created by the Western high mean age of parents, and consequent infertility. Where adoptee identity formerly started in the recipient airport from an unknown background, global communication has created groups of adoptees claiming to be traded, returning to their country of origin and in some cases even becoming residents there.

Like other immigrants, adoptees form groups to cope with the challenges of having two identities and belong in neither. Due to these impacts, the number of foreign adoptions has decreased drastically in Denmark from 1,100 in 2006 to 420 in 2014. Legislation to avoid adoption trafficking has been made, but at the same time, foreign aid has been cancelled. As a state advisor for Danish counties, it is very clear to this author (in line with research) that adoption after age three is a high risk affair for both adoptees and adoptive parents.

Another cultural clash arises when many recipient countries accept gay and single adoptive parents, and ceding countries prohibit these categories of parental eligibility.

The Decreasing Influence of Western Intervention Models

Until now, the global intervention agenda has been dominated by the Western perspective of care, but the Western share of the world population is dwindling, democratic institutions are paralysed by antagonistic parliament conflicts over migration, and inter-country trade and economic treaties (such as the British exit from the European Union and the United States annulment of trade agreements) are replaced by nationalist agendas.

Although Western culture faces this crisis, the developing countries in Africa, Latin America and Asia are growing out of poverty, following the same path as the West. This, for example, increases the number of in-country adoptions on these continents.

Many Western aid organisations respond to this by increasingly adjusting interventions to empower local care culture. The major obstacle preventing developing countries from building independent care systems is that their child researchers and professional care workers still depend on and must adjust to Western financing. The lack of efficient state investment and monitoring systems is probably due to the traditional extremely low status in many developing countries of children with no extended family.

The Developing-Country Model of Intervention: The Group Perspective

Many cultures – especially Asian and Muslim – put very little emphasis on the individual child, continuing a long tradition of strong group and extended family identities as the social instrument of growing up securely. Researcher Tuhin Khalil demonstrates in a longitudinal study of madrasahs in Bangladesh (Khalil, 2012) that children growing up in madrasahs are more successful in adulthood than their peers outside, because they are provided with a long-term secure group. Japanese attempts to introduce foster care were temporarily terminated because of a steep increase in youth suicides, foster care being alien to the strong family tradition of the Japanese culture [Department of Economic and Social Affairs (DESA), 2014]. To start this process, child psychiatry professor Kamikado Kazuhiro kindly translated all FF programmes into Japanese at the Nagano University and the FF website.

The demographic age distribution in developing countries is also quite different from the West – for example, the mean age in Uganda is a mere 15 years, due to many childbirths and high infant mortality, quite similar to European societies a hundred years ago. This means that some developing countries have an overwhelming number of children and youth without their parents, making the Western meticulous individual case management almost impossible to practice.

Insufficient Monitoring Systems of Social Care

Apart from traditional family values, the frequent lack of social infrastructure in developing countries is also obvious. When training orphanage leaders in Indonesia a few years ago, a report (BPSW, 2009) stated that Indonesia had 250 social workers for a population counting as many million inhabitants, responsible also for overseeing the 8,000 orphanages with approximately half a million children and youth. While training, a government representative dryly announced that all children should either enter foster families or return to parents. It goes without saying that Indonesia had no foster care system at the time. Indonesian villages have a very strong sense of community, many even have their own informal citizen police corps – the village is the social unit responsible for its members. So, group care and the importance of peer groups are the traditional units for socialisation in these cultures – a strength to be included in intervention designs.

The Future Challenge of the Developing Countries: The Rush into Cities

The vulnerability of traditional families also calls for reconsideration of reunion and family support projects. Urbanisation in the developing countries takes place at a speed creating chaos, accelerated by foreign economic exploitation of small farmers.

One example to illustrate the need for discussing this development stems from our research report in Cambodia for SOS Children's Villages Denmark (Rygaard, 2016), where we also interviewed a number of other NGO leaders. Rural families all over the country have been bought out by major foreign companies, creating a vast and sudden migration to of poor farmers to Pnom Penh. When organisations try to reunite children, the parents are much overburdened by work and often live apart – the 'family' in the traditional sense simply does not exist. When children become teenagers, they tend to drop out of school to work illegally in neighbouring countries, where wages are 10 times higher – only SOSCV schools are able to keep most of their students. A large part of the generation that will lead the country in the future is thus uneducated and rootless, and urban social services are overwhelmed. The author has observed similar scenarios in Istanbul, Cairo, Lima and so forth.

Thus, there are two global trends in intervention philosophies and designs: the Western and the emerging developing world concepts of care intervention. These trends are embedded in geopolitical and cultural agendas. International intervention research is relatively more independent, to some degree able to rise above the ideological bias of clashing cultural, religious and economic circumstance.

WHAT DOES RESEARCH HAVE TO SAY ABOUT INTERVENTIONS AND CHILD DEVELOPMENT?

Placement Type is not as Important as the Quality of Care

If the reader will allow an inexcusable simplification of 60 years of research in child placement – for the sake of clarity – the complex research can be summed up in a number of brief statements. The overall conclusion being that *placement type is not as important as the quality of care* (McCall, 2014). 'Care quality' is defined by a number of aspects (references are representative of a number of studies):

- *Adoption is superior to foster care, and foster care is superior to institutional placement (the latter: only if staff shifts are frequent due to work legislation – this is not often the case in the developing countries where few staff work round the clock) (van den Dries et al., 2010).*
- *The principle of continuity in caregiver relations also extends to the professionals monitoring the placement. Frequent shifts in case managers and other professionals also reduce child development outcomes (Crockenburg et al., 2008).*

- *Especially in early childhood, continuity in care – i.e. long-term secure attachments to very few caregivers – is decisive for lifespan vitality. Final placement with long term caregivers before age three is important – the more shifts in caregivers (during the day, the week, by shifts in care replacement), the poorer the outcome (Ghera et al., 2009).*
- *The earlier in life interventions are targeted (from the start of pregnancy and during early childhood years), the better the outcome (Campbell et al., 2014).*
- *Small child/youth groups with educated and supported caregivers yield the best results (Christoffersen et al., 2014).*
- *Belonging to – and being accepted in – a long term group of peers is increasingly important after age three, for later social inclusion and school success. This includes adult life: living in supervised peer groups after care increases the likelihood of educational and work market success, as opposed to living alone (Λ).*
- *Special support and mentor teaching during school and education can outweigh the negative impacts of early traumas and placement outside the family (Vinnerljung, 2014).*

These statements may be valuable as basic guidelines for any type of interventions, spurring another question for debate: What are the key practical target points for future interventions?

HOW CAN OUR WORK AND COOPERATION BE COORDINATED TO MEET THESE CHALLENGES?

At the Geneva Conference on Alternative Care (2016), the many participant NGOs, organisations and government agencies from more than 70 countries presented much divided agendas, covering a broad range of interventions and target groups.

The main task was pointed out by UNICEF representative Jean-Paul Legrand: de-institutionalisation and other initiatives are perhaps not as basic agendas as discussing how to support and create micro-social systems – in poverty-stricken rural, as well as in stressed urban environments – able to reduce the vulnerability of parents, prevent separations and create secure units for child rearing and bonding? So to speak: can we create a mega city full of small villages and rural units able to provide the social services of a city?

As the overall agenda was clearly de-institutionalised, verbalised from the podium in a way which clearly excluded the discussion of group care solutions, many developing participants and organisations remained silent, preventing an open debate on important

topics, such as the scale of the challenge in developing countries, and the great work done by organisations to improve care and educate staffs in group care solutions.

IS FOSTER CARE AND FAMILY REUNION THE ONLY SOLUTION?

The above-mentioned agenda also prevented a debate about pro's and con's for various solutions.

One may question the efficiency of the Western models. For example, Swedish and Danish children and youth in foster care have extremely low school and education ratios (only 36% of Danish children in care pass the ninth grade and start youth education), whereas for example international SOS Children's Village group homes have very high success rates, even in poor countries. A survey provided to the author by SOS Children's Villages ex-CEO Richard Pichler documents *'The database is stripped of all what is questionable, or where for national data protection reasons we are not allowed or able to reconcile into a global report. But the 51.000 children represent 2/3 of all our children in SOS families globally and give a very strong sample of the 100%. Only 1.7% is not enrolled in school for behavioural/adaptation problems. 80% of the children are in age adequate grades = they caught up well with the delays they had upon admission. 13% have bachelor or higher education'*.

This outcome is a result of the much criticised group care and can probably be ascribed also to the daily organisation of SOSCV Villages, providing a professional mother around the clock, and children were encouraged to bond like brothers and sisters in a family, as well as high level educated teachers.

DISCUSSION: WHAT MAY BE COMMON GLOBAL GOALS FOR AID ORGANISATIONS, PROFESSIONALS AND GOVERNMENTS?

The overview of experiences and research in this paper is all to say that we suggest an open minded and qualified debate about how we can support the formation of long-term local government monitoring systems, and a range of equally respected placement solutions. One simple and major question being: how do we make governments make long-term investments in high-risk children, beyond a first internationally funded effort, often reduced to nil when funding runs out? In a special issue, the author and researchers McCall and Groark asked child researchers worldwide how their results influence government child policies, and this tendency was clear (McCall *et al.*, 2014).

Perhaps, the key to the successful de-institutionalisation is that we all see this as the long-term goal and simply slow down the speed of the complex de-institutionalisation process. We should apply a range of solutions to the very diverse challenges, rather than argue about agendas, and focus on developing quality of care, rather than argue about placement types.

Moreover, future aid projects must prioritize support to local governments building monitoring systems – especially in the megacities – and offer solutions to the question of how to protect and empower urban families by creating small stable environments, manageable for parents, enabling their children to grow up with secure long-term relations, regardless of being related by blood or not.

The author hopes that these reflections will be useful in the ongoing debate and thanks readers and partners for sharing their knowledge and experiences.

REFERENCES

- Al Jazeera, 2015. Retrieved from: [<http://www.aljazeera.com/indepth/features/2015/12/closure-rwanda-genocide-orphanages-exacts-heavy-toll-151215114710827.html>].
- BPSW (Building Professional Work in Developing Countries), 2009. *The State of Professional Social Work and Social Services in Indonesia*. Retrieved from: [www.bpsw.org].
- Campbell F, Conti G, Heckman JJ, Moon SH, Pinto R, Pungello E and Pan Y, 2014. Early childhood investments substantially boost adult health. *Science*, Vol. 28, pp. 1478–1485.
- Christoffersen MN, Hoejen-Soerensen AK and Laugesen L, 2014. *Daginstitutionens Betydning for Boerns Udvikling (the Significance of Nursery and Kindergarten Quality for Child Development)*. SFI (Danish National Center for Social Research).
- Department of Economic and Social Affairs (DESA), 2014. *Human Rights Watch (HRW)*.
- Geneva Conference on Alternative Care, 2016. [<http://www.alternativecaregeneva2016.com/index.php/en/>].
- Ghera MM, Marshall PJ, Fox NA, Zeanah CH, Nelson CA, Smyke AT and Guthrie D, 2009. The effects of foster care intervention on socially deprived institutionalized children's attention and positive affect: results from the BEIP study. *Journal of Child Psychology and Psychiatry*, Vol. 50, No. 3, pp. 246–53.
- Khalil TS, 2012. *The Experiences of Young People Leaving Residential Child Care Institutions in Bangladesh*. School of Social and Political Science, University of Edinburgh, Doctoral dissertation.
- McCall R, 2014. *Research on Institutionalized Children: Principles for International Child Welfare Practitioners and Policy Makers*. Unpublished Manuscript: Pittsburgh, PA: University of Pittsburgh, Office of Child Development.
- McCall R, Groark C and Rygaard NP, 2014. Global research, practice, and policy issues in the care of infants and young children at risk. *Infant Mental Health Journal*, Vol. 35, No. 2, pp. 87–191.
- Olsen AL, Larsen D and Lange A, 2005. *Vielser og skilsmisser – børn i skilsmisser. (Marriage and divorce – children in divorce)*. Copenhagen, Denmark: SFI.
- Rygaard NP, 2007. *Severe attachment disorder in childhood – a practical guide to therapy*. New York: Springer Wien.
- Rygaard NP, 2010. Designing the fair start project – a free E-learning and organizational development for orphanages and foster families in quality care giving. *Clinical Neuropsychiatry*, Vol. 7, No. 6, pp. 181–187.
- Rygaard, 2016. *SOS Children's Villages and Fairstart Foundation – Research, Analysis and Recommendations for Staff Training Programs in Cambodia*. Unpublished.

Niels Peter Rygaard

United Nations Centre for Human Settlements (UNCHS), Istanbul+5, 2001. *Urbanization: Facts and Figures. General Assembly for an Overall Review & Appraisal of the Implementation of the Habitat Agenda*. Istanbul, Turkey: UNCHS.

United Nations, 2014. *The 2014 Revision of the World Urbanization Prospects*.

United Nations, 2016. *Uprooted Growing Crisis or Refugee and Migrant Children*. New York: UNICEF, United Nations Children's Fund.

van den Dries L, Juffer F, van IJzendoorn MH and Bakermans-Kranenburg MJ, 2010. Infants' physical and cognitive development after international adoption from foster care or institutions in China. *Journal of Developmental & Behavioral Pediatrics*, Vol. 31. No. 2, pp. 144–150.

Without dreams – Children in alternative care in Japan. 978–1–6231–31227. USA.

Good Practices and Models of Alternative Car

**WHAT ARE THE FACTORS ASSOCIATED WITH
DEPRESSIVE SYMPTOMS AMONG ORPHANS AND
VULNERABLE CHILDREN IN CAMBODIA?**

***Ken Ing Cherng Ong¹, Siyan Yi², Sovannary Tuot², Pheak Chhoun²,
Akira Shibamura¹, Junko Yasuoka¹ and Masamine Jimba^{1*}***

©2015 Ong *et al.* This is an Open Access article distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/4.0>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly credited. The Creative Commons Public Domain Dedication waiver (<http://creativecommons.org/publicdomain/zero/1.0/>) applies to the data made available in this article, unless otherwise stated.

ABSTRACT

Background: Compared to general children, orphans and vulnerable children (OVC) are more exposed to negative outcomes in life such as abuse and neglect. Consequently, OVC are more susceptible to depression. This paper investigated factors associated with depressive symptoms among OVC in Cambodia. **Methods:** In this cross-sectional study, data of 606 OVC from the Sustainable Action against HIV and AIDS in Communities (SAHACOM) project were analyzed. The data were collected from five provinces and analyzed separately for boys and girls. Multiple linear regression analysis was used to identify factors independently associated with levels of depressive symptoms. **Results:** Both boys and girls who reported having been too sick making them unable to attend school or go to work in the past six months (boys: B = 3.5, 95%; CI = 0.7, 6.2; girls: B = 5.7, 95%; CI = 2.9, 8.5) and who had witnessed violence in the family (boys: B = 5.6, 95%; CI = 1.6, 9.6; girls: B = 5.8, 95%; CI = 1.7, 9.9) had a higher level of depressive symptoms. Girls who were older (B = 8.5, 95%; CI = 3.0, 14.0), who did not have enough food in the past six months (B = -8.7, 95%; CI = -13.7, -3.7) and whose parents were separated, divorced or dead (B = 3.9, 95%; CI = 0.5, 7.2) had a higher level of depressive symptoms. Higher level of school attachment was negatively associated with depressive symptoms in both genders (boys: B = -1.4, 95%; CI = -2.0, -0.9; girls: B = -1.4, 95%; CI = -2.0, -0.9). **Conclusions:** Factors such as physical health and exposure to violence may affect mental health of OVC in Cambodia. As health is of utmost importance, better healthcare services should be made easily accessible for OVC. Schools have the potential to act as a buffer against depressive symptoms. Therefore, efforts should be made to keep OVC in school and to improve the roles of school in Cambodia.

Keywords: Cambodia, Depressive symptoms, Mental health, Orphans and vulnerable children (OVC)

¹Department of Community and Global Health, Graduate School of Medicine, The University of Tokyo, 7-3-1 Hongo, Bunkyo-ku, Tokyo 113-0033, Japan

²Center for Population Health, KHANA, Phnom Penh, Cambodia, India

*Corresponding author email id: mjimba@m.u-tokyo.ac.jp

BACKGROUND

Childhood is a pivotal period for a child's overall development [1]. The survival and development of a child's optimal potential are disrupted if the family environment is jeopardized due to illness or death of the parents or guardians [2]. The loss of parents or guardians might also cause withdrawal, anxiety, and depression in adolescence [2].

Adverse childhood experiences (ACEs) are stressful events such as physical abuse, emotional abuse, sexual abuse, parental separation or divorce, neglect, and violence in the family [3]. ACEs could leave a long-lasting adverse impact on a child's mental development [4, 5]. In addition, stress response as a result of ACEs could also affect the neurobiological development of a child's brain. When a child encounters a stressful experience such as abuse, the development of certain parts of the brain such as the hippocampus and the corpus callosum is hindered [6, 7]. Consequently, this may lead to the manifestation of psychiatric disorders such as schizophrenia, attention deficit hyperactivity disorder (ADHD), and unipolar and bipolar depression [6, 7]. Moreover, ACEs have been found to be associated with lower self-esteem in early adulthood, and lower well-being or clinical disorder later in life [8, 9]. In addition, ACEs have also been linked to early alcohol initiation and ever using alcohol during adolescence [10].

Orphans and vulnerable children (OVC) comprise orphans and children who are more exposed to detrimental events such as abuse, neglect and exploitation compared to their peers. OVC include street children, children made vulnerable by AIDS, children in the worst forms of child labor, children affected by armed conflict, children living with disability, and children in multiple OVC categories [11]. OVC are at a higher risk of ACEs such as physical abuse, emotional abuse, or sexual abuse than general children [12].

Furthermore, OVC might also be forced to shoulder the responsibility of an adult, while still coping with the trauma of losing a caregiver such as parents [13]. OVC have to take care of their younger siblings or become the sole breadwinner of their household [14]. Consequently, these OVC might be forced to suspend school or drop out of school to take care of their family [15]. OVC with extra workload were more likely to exhibit depressive symptoms [16]. Moreover, OVC are also more likely to face stigma and discrimination in the community [14].

Psychological distress might lead OVC to engage in risky sexual behaviors [17]. As a result, these OVC might be more susceptible to HIV infection, and their offspring might also become vulnerable; thus perpetuating the negative cycle. In addition, OVC also have a higher tendency to possess juvenile delinquent traits such as theft and poor socialization [18, 19].

What are the factors associated with depressive symptoms among orphans and vulnerable children

Cambodia is a low income country in South East Asia with a population of 15.1 million and a GDP of \$15.2 billion as of 2014 [20]. Several decades of war and conflict have shattered this South East Asian kingdom that was once the center of one of the greatest civilizations in the region. Similar to OVC in other parts of the world, OVC in Cambodia are more likely to be malnourished and to drop out of school and prone to depression [21].

Notwithstanding the situation in Cambodia, most studies on the psychological well-being among OVC were conducted in sub-Saharan Africa [14, 15, 17–19]. Moreover, different studies in different countries and cultures yielded different results. To illustrate this point, a study in South Africa showed that female OVC tended to have a higher level of depressive symptoms compared to male OVC [22]. In contrast, a study in Uganda found that male OVC were at a greater risk of depression compared to female OVC because girls tended to receive more nurturing and attention in the Ugandan context [23]. Therefore, OVC's psychological response to their own situation is very contextual with the influence from each child's unique background, surrounding, and gender.

In a previous study, several factors such as exposure to family and community violence were associated with depressive symptoms among adolescent students in Cambodia [24]. However, no studies have yet explored factors associated with the psychological well-being among OVC in the Cambodian context. We, therefore, conducted this study to fill in this knowledge gap to identify factors associated with depressive symptoms among OVC in Cambodia. Findings from this study would extend the understanding of the effects of social factors on psychological well-being in different adolescent populations in the country.

METHODS

This is a cross-sectional study, and data were collected in April and May 2014 as part of the impact evaluation of the Sustainable Action against HIV and AIDS in Communities (SAHACOM) project. The details of participants and sampling have been described elsewhere. Briefly, data were collected from five provinces in Cambodia: Battambang, Pailin, Pursat, Siem Reap, and Takeo. These five provinces were chosen because more than 70 % of the total number of OVC covered by the SAHACOM project was from these provinces. The OVC were randomly selected from a name list of OVC who received care and support services from each selected health center in the five provinces [25].

For this study, only participants aged 11 and above were included in the final analysis as depressive symptoms were only assessed among participants in this age group. After excluding OVC with missing responses to key variables, the final sample size for the analysis was 606.

Socio-demographic characteristics

Demographic variables in this study included age, self-reported HIV status, orphan status, sibling care practices, food security, and general health status. For age, participants were categorized into four groups: 11–12, 13–14, 15–16, and 17–18. For the self-reported HIV status, participants were grouped into three categories: HIV positive, HIV negative, and don't know. Regarding the orphan status, we grouped the participants into non-orphans, single orphans, and double orphans. To assess sibling care practices, we asked the participants whether they had to take care of siblings or relatives younger than five years in the past 12 months. Concerning food security, we inquired the participants whether they had enough food to eat in the past six months prior to the interview. As for general health status, we asked the participants whether they had been very sick making them unable to work or go to school the past six months.

Depressive symptoms

The main variable is depressive symptoms, and it was measured using the Asian Adolescent Depression Scale (AADS). This scale contains 20 items measuring four dimensions: negative self-evaluation (seven items), negative affect (five items), cognitive inefficiency (four items), and lack of motivation (four items) [26]. This scale provides a five-point Likert's response options ranging from 'Strongly disagree' to (5) 'Strongly agree.' The total score is the sum of the 20 items ranging from 20 to 100. Higher level of depressive symptoms is indicated by a higher score. This scale has been used to measure depressive symptoms among Cambodian adolescents in other studies [24, 27, 28]. The Cronbach's α for this study was 0.87.

Adverse childhood experiences

For ACEs, five questions were adapted from the brief screening version of the Childhood Trauma Questionnaire [29, 30]. The five questions asked about the experience of physical abuse, emotional abuse, sexual abuse, physical neglect, and emotional neglect. The response options for each question range from (1) 'never' to (5) 'very often.' Participants who responded 'never' and 'rarely' were grouped together as those without ACEs. Participants who answered 'sometimes,' 'often', and 'very often' were grouped together as those with ACEs.

Family dysfunction

Five items adapted from the brief screening version of the Childhood Trauma Questionnaire were used to enquire about family dysfunction [29, 30]. These five items asked about 'witnessing violence against a family member,' 'having an alcoholic or drug user family member,' 'having a family member who was depressed, mentally ill or who has attempted suicide,' 'having parents who had been separated or divorced,'

What are the factors associated with depressive symptoms among orphans and vulnerable children

and 'having a family member who has been to prison.' The response options for all the items were 'yes' or 'no,' except for 'having parents who had been separated or divorced.' For this item, an-other response option was added to the 'yes' or 'no' responses to indicate if one or both parents had died. For the analysis in this study, participants whose parents had divorced or separated were grouped together with participants whose parent/s had died.

School attachment

School attachment was measured using a seven-item scale adapted from a previous study [31]. These seven items were: 'I like school,' 'My teachers like me,' 'I like my teachers,' 'School is fun,' 'I am accepted in school,' 'I feel like an outsider in school,' and 'I feel like I fit in at school.' These seven items were measured on a 4-point scale that includes (0) 'not at all,' (1) 'not much,' (2) 'some' and (3) 'a lot.' The response to 'I feel like an outsider in school' was reverse coded before obtaining the total score for all seven items. Better school attachment is indicated by a higher score. This scale had been used in previous studies among Cambodian adolescents [24, 27]. The Cronbach's α for this study was 0.56.

Data analyses

The total scores for the AADS and School Attachment Scale were calculated. To address gender differences, analyses were conducted separately for boys and girls [24, 32, 33]. For bivariate analyses, one-way analysis of variance (ANOVA) or t-test was used.

In the multiple linear regression models, variables were included when they were found to be associated with depressive symptoms in previous studies. These variables were age, HIV status, orphan status, sibling care practices, food security, general health status, ACEs, family dysfunction, and school attachment [23, 28, 34–36].

Multicollinearity was not a concern in the models. This conclusion was reached by obtaining the variance inflation factor (VIF) values for all the variables after running the regression. All the variables had the VIF values less than 2.0, which were far below 10.0, the recommended VIF value to further examine the data for multicollinearity [37]. All tests were two-tailed and statistical significance was set at $p < 0.05$. Stata Version 12.1 (College Station, Texas, USA) was used for all analyses.

Ethical considerations

KHANA obtained the ethical approval from the National Ethics Committee for Health Research, Ministry of Health, Cambodia, for the data collection (No. 082NECHR). This study protocol was reviewed and approved by the Research Ethics Committee of the University of Tokyo (No. 10723). Privacy of the participants was strictly protected as no personally identifying information was used in this study. In addition,

the participants were ensured the confidentiality of their responses to allay their fear when answering sensitive questions such as physical abuse, sexual abuse, and family dysfunction. A written informed consent was also obtained from the OVC's parent or guardian.

RESULTS

There were 606 participants in this study, of whom 303 (50.0 %) were boys. All participants were 11–18 years old at the time of data collection, and the mean age was 13.4 years (SD 1.7). Regarding the HIV status, 471 (77.7 %) participants reported that they were HIV negative, 116 (19.1 %) were HIV positive and 19 (3.1 %) were not sure about their HIV status. Concerning the orphan status, 360 (59.4 %) OVC were non-orphans, while 182 (30.0 %) and 64 (10.6 %) were single orphans, and double orphans, respectively. The majority of boys (97.3 %) and girls (97.3 %) were currently in school.

Table 1: Comparisons of mean AADS score in socio-demographic characteristics stratified by gender

	Boys			Girls		
	n (%)	Mean	p-value	n (%)	Mean	p-value
Age						
11-12	102(33.7)	46.2	0.534	90(29.7)	43.8	0.002
13-14	138(45.5)	47.9		116(38.3)	46.9	
15-16	49(16.2)	47.4		76(25.1)	45.6	
17-18	14(4.6)	50.3		21(6.9)	55.5	
Self-reported HIV Status						
Positive	64(21.1)	48.3	0.763	52(17.2)	46.2	0.479
Negative	231(76.2)	47.1		240(79.2)	46.5	
Don't know	8(2.6)	47.8		11(3.6)	41.6	
Orphan Status						
Non-orphan	184(60.7)	47.9	0.392	176(58.1)	46.2	0.076
Single orphan	93(30.7)	47.1		89(29.4)	44.6	
Double orphan	26(8.6)	44.6		38(12.5)	50.3	
Regularly taken care of siblings and younger relatives younger than five years						
Yes	103(34.0)	48.1	0.471	106(35.0)	48.6	0.018
No	200(66.0)	47.0		197(65.0)	45.0	
Have enough food to eat in the past 6 months						
Yes	286(94.4)	47.2	0.239	279(92.1)	45.3	<0.001
No	17(5.6)	50.6		24(7.9)	57.3	
Have been very sick in the past 6 months						
Yes	113(37.3)	49.7	0.008	106(35.0)	50.2	<0.001
No	190(62.7)	46.0		197(65.0)	44.1	

AADS Asian Adolescent Depression Scale

What are the factors associated with depressive symptoms among orphans and vulnerable children

Table 1 shows the comparisons of mean AADS score in socio-demographic characteristics stratified by gender. Both boys and girls who reported having been too sick making them unable to attend school or go to work in the past six months had a significantly higher mean AADS score ($p = 0.008$ for boys & $p < 0.001$ for girls). However, only girls who were in the older age group ($p = 0.002$), who had to regularly take care of younger siblings ($p = 0.018$), and who did not have enough food to eat in the past six months had a significantly higher mean AADS score ($p < 0.001$).

Table 2 shows the comparisons of mean AADS score in ACEs and family dysfunction stratified by gender. Experiences of all forms of ACEs were not significantly associated with the mean AADS score in boys. However, mean AADS score was significantly higher among girls who had been physically abused (53.8 vs. 45.5; $p = 0.001$), emotionally abused (51.4 vs. 45.2; $p = 0.002$), and emotionally neglected (56.6 vs. 46.0; $p = 0.021$). Both boys and girls who had witnessed violence in the family had a significantly higher mean AADS score (51.9 vs. 46.6; $p = 0.007$ for boys & 53.1

Table 2: Comparisons of mean AADS score in adverse childhood experiences and family dysfunction stratified by gender

		Boys			Girls		
		n (%)	Mean	p-value	n (%)	Mean	p-value
Physical abuse	Yes	46(15.2)	47.4	0.990	28(9.2)	53.8	0.001
	No	257(84.8)	47.4		275(90.8)	45.5	
Emotional abuse	Yes	55(18.2)	48.8	0.327	52(17.2)	51.4	0.002
	No	248(81.8)	47.1		251(82.8)	45.2	
Sexual abuse	Yes	6(2.0)	52.2	0.316	3(1.0)	43.7	0.728
	No	297(98.0)	47.3		300(99.0)	46.3	
Physical neglect	Yes	9(3.0)	47.3	0.993	7(2.3)	48.9	0.589
	No	294(97.0)	47.4		296(97.7)	46.2	
Emotional neglect	Yes	8(2.6)	46.4	0.810	8(2.6)	56.6	0.021
	No	295(97.4)	47.4		295(97.4)	46.0	
Witnessed violence in family	Yes	42(13.9)	51.9	0.007	37(12.2)	53.1	<0.001
	No	261(86.1)	46.6		266(87.8)	45.3	
Had an alcoholic/drug using family member	Yes	65(21.5)	48.1	0.577	61(20.1)	49.2	0.045
	No	238(78.5)	47.2		242(79.9)	45.5	
Had depressed or mentally ill family member	Yes	32(10.6)	44.5	0.152	43(14.2)	52.7	<0.001
	No	271(89.4)	47.7		260(85.8)	45.2	
Had a family member who had been to prison	Yes	15(5.0)	45.9	0.631	14(4.6)	52.8	0.052
	No	288(95.0)	47.4		289(95.4)	45.9	
Parents separated/divorced or died	Yes	161(53.1)	47.4	0.946	176(58.1)	47.5	0.047
	No	142(46.9)	47.3		127(41.9)	44.5	

AADS Asian Adolescent Depression Scale

vs. 45.3; $p < 0.001$ for girls). However, only among girls, OVC who had a family member who used alcohol or illicit drugs (49.2 vs. 45.5; $p = 0.045$), who had a depressed or mentally ill family member (52.7 vs. 45.2; $p < 0.001$), and whose parents had separated, divorced or died (47.5 vs. 44.5; $p = 0.047$) had a significantly higher mean AADS score.

Table 3 shows factors associated with depressive symptoms after controlling for other factors in the models. Having been too sick making them unable to attend school or go to work in the past six months (boys: $B = 3.5\%$; $CI = 0.7, 6.2$; girls: $B = 5.7$; $95\% CI = 2.9, 8.5$) and having witnessed violence in the family (boys: $B = 5.6$; $95\% CI = 1.6, 9.6$; girls: $B = 5.8$; $95\% CI = 1.7, 9.9$) were positively associated with a higher level of depressive symptoms among both boys and girls. Having a mentally ill family member was negatively associated with a higher level of depressive symptoms only among boys ($B = -5.5\%$; $CI = -9.9, -1.1$). Among girls, being in the older age group ($B = 8.5$; $95\% CI = 3.0, 14.0$), and having parents who were separated, divorced, or dead ($B = 3.9$; $95\% CI = 0.5, 7.2$) were positively associated with a higher level of depressive symptoms. Having enough food to eat in the past six months ($B = -8.7$; $95\% CI = -13.7, -3.7$) was negatively associated with a higher level of depressive symptoms only among girls. Having a higher level of school attachment was negatively associated with a higher level of depressive symptoms for both boys ($B = -1.4$; $95\% CI = -2.0, -0.9$) and girls ($B = -1.4$; $95\% CI = -2.0, -0.9$).

DISCUSSION

This study adds to the literature on factors associated with depressive symptoms among OVC in Cambodia. Both boys and girls who reported having been too sick making them unable to work or go to school in the past six months had a higher level of depressive symptoms. In Cambodia, infectious diseases such as acute respiratory infections and malaria still affect the general population including the younger generation [38]. These diseases cause a loss in productivity and prolonged illness among those affected [39]. Moreover, injuries from traffic accidents have also become a major health issue among young people in Cambodia [38, 40]. Injuries from traffic accidents are a major concern as they could cause permanent loss in productivity. Prolonged illness might cause a sense of despair among the affected OVC as they had to cope with both the demands of the illness and their daily chores. On top of that, being very sick would affect the OVC's school attendance, and this in turn would affect the OVC's psychological well-being. A study in Zimbabwe reported that a higher prevalence of psychological distress was more common among OVC who were out of school [41].

In the family where a guardian was physically hurt by another family member, both boys and girls had a significantly higher level of depressive symptoms. However, a

What are the factors associated with depressive symptoms among orphans and vulnerable children

Table 3: Factors associated with depressive symptoms among orphans and vulnerable children in Cambodia

	Boys			Girls		
	B	p-value	95% CI	B	p-value	95% CI
Age (vs. 11–12)						
13-14	2.7	0.074	(-0.3, 5.7)	2.2	0.161	(-0.9, 5.3)
15-16	3.1	0.125	(-0.9, 7.1)	2.1	0.247	(-1.5, 5.6)
17-18	1.6	0.629	(-5.0, 8.2)	8.5	0.003	(3.0, 14.0)
HIV Status (vs. HIV positive)						
Negative	-1.0	0.525	(-4.2, 2.2)	1.4	0.430	(-2.1, 4.9)
Don't know	2.2	0.608	(-6.3, 10.8)	-1.8	0.638	(-9.2, 5.6)
Orphan status (vs. non-orphans)						
Single orphans	-1.6	0.370	(-5.2, 1.9)	-3.4	0.059	(-7.0, 0.1)
Double orphans	-2.3	0.409	(-7.8, 3.2)	-0.5	0.834	(-5.0, 4.1)
Having to take care of younger siblings/ relatives	-1.2	0.399	(-4.1, 1.6)	2.1	0.120	(-0.5, 4.8)
Having been too sick in the past 6 month	3.5	0.014	(0.7, 6.2)	5.7	<0.001	(2.9, 8.5)
Having enough food to eat	-2.0	0.504	(-8.0, 3.9)	-8.7	0.001	(-13.7, -3.7)
Physical abuse	-0.8	0.688	(-4.6, 3.1)	4.0	0.091	(-0.6, 8.6)
Emotional abuse	1.5	0.388	(-1.9, 4.9)	2.1	0.254	(-1.5, 5.7)
Sexual abuse	2.3	0.629	(-7.2, 11.8)	-0.7	0.909	(-13.7, 12.2)
Physical neglect	1.1	0.775	(-6.7, 8.9)	3.9	0.395	(-5.1, 12.9)
Emotional neglect	3.8	0.358	(-4.3, 12.0)	0.2	0.969	(-8.3, 8.6)
Witnessed violence in family	5.6	0.006	(1.6, 9.6)	5.8	0.006	(1.7, 9.9)
Had an alcoholic/a drug using family member	-2.2	0.213	(-5.8, 1.3)	1.0	0.541	(-2.3, 4.4)
Had a mentally ill family member	-5.5	0.014	(-9.9, -1.1)	1.4	0.493	(-2.6, 5.3)
Separated or divorced or dead parents	1.1	0.540	(-2.3, 4.4)	3.9	0.026	(0.5, 7.2)
Had a family member who had been to prison	1.5	0.631	(-4.7, 7.7)	5.6	0.075	(-0.6, 11.7)
School attachment	-1.4	<0.001	(-2.0, -0.9)	-1.4	<0.001	(-2.0, -0.9)

CI confidence interval

different study in Cambodia reported that no significant association was detected between family violence witnessing and depressive symptoms among boys and girls [24]. The contrasting results in this study might be because witnessing violence on another family member aggravates the psychological burden already present among OVC. This would leave the OVC in constant fear of being harmed themselves.

Exposure to violence during childhood has been found to be an independent risk factor for depressive symptoms in early adulthood [42]. By the same token, children's exposure to violence could result in internalizing and externalizing behavior problems during adolescence [43].

Boys who had a mentally ill family member reported a significantly lower level of depressive symptoms. OVC usually have to shoulder extra responsibilities such as caring for other ill family member [16]. However, it is very demanding to care for other family members, especially those with mental illness. This could result in resentment and distress among the caregivers [44]. Although very demanding, caring for other mentally ill family members has positive effects on the caregiver as the caregiver might feel a sense of fulfillment and perceived uplift [45]. Further-more, compared to female caregivers, male caregivers were found to have a better style of managing mentally ill persons under their care and thus, were able to detach themselves from stressful situations resulting from their responsibility [44]. The sense of fulfillment and perceived uplift, and a better style of managing mentally ill persons among male caregivers might explain why boys with a mentally ill family member had a significantly lower level of depressive symptoms.

In this study, older age, lack of food, and parents' separation or death resulted in a significantly higher level of depressive symptoms among girls. However, boys in the same categories did not exhibit a significantly higher level of depressive symptoms. More women are affected by depression compared to men [33]. Higher level of depressive symptoms among girls could be accounted for by considering the status of women in the Cambodian context. Girls might be facing constant pressure to conform to societal norms. According to a traditional Khmer proverb, 'Men are gold; women are cloth,' women are considered vulnerable and fragile and once defamed, the damage to their reputation could not be undone [46]. In households with OVC, boys are still given preference over girls when it comes to providing education in resource-limited settings [47].

When parents of girls were separated, divorced or dead, the girls exhibited a significantly higher level of depressive symptoms. This may be because girls are more likely to exhibit internalizing symptoms such as withdrawal, anxiety, and depression in stressful situations [48]. The same reasoning could also be used to account for the higher level of depressive symptoms among girls who did not have enough food to eat. In this study, 35.0 % of the girls had to take care of a younger sibling or relatives. As these girls were entrusted with the task of caring for younger siblings or relatives, the lack of food to feed their younger charges might also be a cause of stress and depression.

In this study, HIV status and orphan status were not significantly associated with depressive symptoms. The reason might be because the majority of OVC in this

What are the factors associated with depressive symptoms among orphans and vulnerable children

study benefited from the support provided by the SAHACOM project. This is evident in the improvement of the key indicators at the end of SAHACOM project such as an increase in school attendance and also child care support [25, 49].

Higher school attachment was found to have a positive effect on mental health of OVC in this study. Boys and girls with a higher level of school attachment had a significantly lower level of depressive symptoms. The role of school transcends that of a place that provides only academic guidance for the OVC [50]. School is a place where OVC can find comfort and connect with their peers. OVC who attended school regularly were also found to have a higher level of perceived social support and in turn, exhibited lower degree of depression and higher self-esteem [15].

Findings in this study should, however, be interpreted in light of several limitations. First, the cross-sectional design of this study did not allow us to infer the causal relationship between depressive symptoms and the related factors. Second, the use of self-reported data in this study might be subject to recall bias. However, to ensure the quality of the data collected, all the interviewers and field supervisors were thoroughly trained on the data collection method before going to the field [25]. Third, some of the measures such as ACEs and family dysfunction were adapted from previous studies, and have not been validated in the Cambodian context. Finally, the types of sickness among the OVC were not determined. Hence, future studies should also attempt to identify the types of sickness among the OVC to help create a more efficient healthcare service for the OVC in Cambodia. Notwithstanding the limitations above, findings from this study have strengths and implications for policy development and future research. To the best of our know-ledge, this is the first study to explore the factors associated with mental health wellbeing among OVC in the Cambodian context.

CONCLUSION

This study highlighted important factors associated with depressive symptoms among OVC in Cambodia. As evident from the results of this study, there are both similar and different factors affecting depressive symptoms among boys and girls. As physical health is of utmost importance for both boys and girls for survival, more comprehensive healthcare services should be made easily accessible for OVC all over the country. In addition to that, healthcare workers should also be trained to identify depressive symptoms, especially for girls as they are more susceptible to depression. Furthermore, schools have the potential to act as a protective factor against depression among OVC. Therefore, more efforts should be channeled into improving the role of schools in Cambodia. Teachers should be trained to distinguish children with depressive symptoms and pay more attention to children who are identified as OVC. Future research might also attempt to focus on factors associated with depression among sub-groups of OVC such as maternal orphans, children

living with HIV or children affected by HIV. Additionally, future interventions might also focus on empowering OVC by developing their perceived control of the future. A study conducted in China indicated that positive future orientation and hopefulness could alleviate the adverse effects of traumatic events among OVC [51]. This might give OVC hope and motivation for the future and help them chart out their own life; one where they could live with dignity.

COMPETING INTERESTS

The authors declare that they have no competing interests.

AUTHORS' CONTRIBUTIONS

KO developed the research question, analyzed the data, interpreted the results, and drafted the article. SY designed the study, developed the research protocol and tools and assisted in the conceptualization of the research question and interpretation of the results. ST and PC supported the study design and protocol and tools development and were responsible for trainings and data collection. AS helped with the data analysis and interpretation of the results. JY helped with the development of the research question and data analysis. MJ helped to conceptualize ideas and interpret results. All authors contributed to the writing and approved the final manuscript.

ACKNOWLEDGEMENTS

The SAHACOM project was funded by the United States Agency for International Development (USAID). The authors thank KHANA's Senior Management Team, Programs Division, research assistants, implementing partners and their staff members, local authorities, community support volunteers, outreach workers as well as all participants for their excellent contribution in this study. Without such extensive supports this study would have been impossible.

REFERENCES

1. UNICEF. Inequities in Early Childhood Development: What the data say. 2012. http://www.unicef.org/lac/Inequities_in_Early_Childhood_Development_LoRes_PDF_EN_02082012%281%29.pdf. Accessed 28 Dec 2014.
2. UNAIDS, UNICEF, USAID. Children on The Brink 2004. 2004. http://www.unicef.org/publications/cob_layout6-013.pdf. Accessed 8 Jul 2014.
3. WHO: Violence and Injury Prevention-Adverse Childhood Experiences International Questionnaire (ACE-IQ). 2014. http://www.who.int/violence_injury_prevention/violence/activities/adverse_childhood_experiences/en/. Accessed 17 Dec 2014.
4. Walker SP, Wachs TD, Grantham-McGregor S, Black MM, Nelson CA, Huffman SL, et al. Inequality in early childhood: risk and protective factors for early child development. *Lancet*. 2011;378(9799):1325–38.
5. Rääkkönen K, Pesonen AK, Roseboom TJ, Eriksson JG. Early determinants of mental health. *Best Pract Res Clin Endocrinol Metab*. 2012;26(5):599–611.

What are the factors associated with depressive symptoms among orphans and vulnerable children

6. Teicher MH, Andersen SL, Polcari A, Anderson CM, Navalta CP, Kim DM. The neurobiological consequences of early stress and childhood maltreatment. *Neurosci Biobehav Rev.* 2003;27(1–2):33–44.
7. Teicher MH, Tomoda A, Andersen SL. Neurobiological consequences of early stress and childhood maltreatment: are results from human and animal studies comparable? *Ann N Y Acad Sci.* 2006;1071:313–23.
8. Maxwell K, Huprich S. Retrospective reports of attachment disruptions, parental abuse and neglect mediate the relationship between pathological narcissism and self-esteem. *Personal Ment Health.* 2014;8(4):290–305.
9. Mc Elroy S, Hevey D. Relationship between adverse early experiences, stressors, psychosocial resources and wellbeing. *Child Abuse Negl.* 2014;38(1):65–75.
10. Dube SR, Miller JW, Brown DW, Giles WH, Felitti VJ, Dong M, et al. Adverse childhood experiences and the association with ever using alcohol and initiating alcohol use during adolescence. *J Adolesc Health.* 2006;38(4):444.e441–410.
11. World Bank: A Toolkit on how to support Orphans and Other Vulnerable Children (OVC) in Sub-Saharan Africa (SSA). 2005. <http://documents.worldbank.org/curated/en/2005/08/9467192/ovc-toolkit-ssa-toolkit-support-orphans-other-vulnerable-children-ovc-sub-saharan-africa-ssa>. Accessed 16 Nov 2014.
12. Morantz G, Cole D, Vreeman R, Ayaya S, Ayuku D, Braitstein P. Child abuse and neglect among orphaned children and youth living in extended families in sub-Saharan Africa: what have we learned from qualitative inquiry? *Vulnerable Child Youth Stud.* 2013;8(4):338–52.
13. Chitiyo M, Changara DM, Chitiyo G. Providing psychosocial support to special needs children: a case of orphans and vulnerable children in Zimbabwe. *Int J Educ Dev.* 2008;28(4):384–92.
14. Dalen N, Nakitende AJ, Musisi S. “They don’t care what happens to us.” The situation of double orphans heading households in Rakai District, Uganda. *BMC Public Health.* 2009;9:321.
15. Okawa S, Yasuoka J, Ishikawa N, Poudel KC, Ragi A, Jimba M. Perceived social support and the psychological well-being of AIDS orphans in urban Kenya. *AIDS Care.* 2011;23(9):1177–85.
16. Yu Y, Li X, Zhang L, Zhao J, Zhao G, Zheng Y, et al. Domestic chores workload and depressive symptoms among children affected by HIV/AIDS in China. *AIDS Care.* 2013;25(5):632–9.
17. Nyamukapa CA, Gregson S, Wambe M, Mushore P, Lopman B, Mupambireyi Z, et al. Causes and consequences of psychological distress among orphans in eastern Zimbabwe. *AIDS Care.* 2010;22(8):988–96.
18. Delva W, Vercoetere A, Loua C, Lamah J, Vansteelandt S, De Koker P, et al. Psychological well-being and socio-economic hardship among AIDS orphans and other vulnerable children in Guinea. *AIDS Care.* 2009;21(12):1490–8.
19. Musisi S, Kinyanda E, Nakasujja N, Nakigudde J. A comparison of the behavioral and emotional disorders of primary school-going orphans and non-orphans in Uganda. *Afr Health Sci.* 2007;7(4):202–13.
20. World Bank: Cambodia. 2014. http://data.worldbank.org/country/cambodia#cp_wdi. Accessed 3 Jan 2015.
21. UNICEF. Orphans, Children Affected by HIV and Other Vulnerable Children in Cambodia: A Situation and Response Assessment, 2007. 2008. http://www.unicef.org/eapro/OVC_Situation_Assess_June_2008.pdf. Accessed 11 Jul 2014.

22. Cluver L, Gardner F, Operario D. Psychological distress amongst AIDS-orphaned children in urban South Africa. *J Child Psychol Psychiatry*. 2007;48(8):755–63.
23. Kaggwa EB, Hindin MJ. The psychological effect of orphanhood in a matured HIV epidemic: an analysis of young people in Mukono. *Uganda Soc Sci Med*. 2010;70(7):1002–10.
24. Yi S, Poudel KC, Yasuoka J, Palmer PH, Jimba M. Exposure to violence in relation to depressive symptoms among male and female adolescent students in Cambodia. *Soc Psychiatry Psychiatr Epidemiol*. 2013;48(3):397–405.
25. Yi S, Chhoun P, Brant S, Kita K, Tuot S. Improving education opportunity, health, and quality of life of orphans and vulnerable children: The Sustainable Action against HIV and AIDS in Communities (SAHACOM). *Int J Trop Dis Health*. 2015;5(1):37–47.
26. Woo BS, Chang WC, Fung DS, Koh JB, Leong JS, Kee CH, et al. Development and validation of a depression scale for Asian adolescents. *J Adolesc*. 2004;27(6):677–89.
27. Yi S, Poudel KC, Yasuoka J, Palmer PH, Jimba M. Role of risk and protective factors in risky sexual behavior among high school students in Cambodia. *BMC Public Health*. 2010;10:477.
28. Yi S, Poudel KC, Yasuoka J, Palmer PH, Yanagisawa S, Jimba M. Sibling care, school performance, and depression among adolescent caretakers in Cambodia. *Asian J Psychiatr*. 2012;5(2):132–6.
29. Bernstein DP, Stein JA, Newcomb MD, Walker E, Pogge D, Ahluvalia T, *et al.* Development and validation of a brief screening version of the Childhood Trauma Questionnaire. *Child Abuse Negl*. 2003;27(2):169–90.
30. Bernstein DP, Ahluvalia T, Pogge D, Handelsman L. Validity of the childhood trauma questionnaire in an adolescent psychiatric population. *J Am Acad Child Adolesc Psychiatry*. 1997;36(3):340–8.
31. Henry KL, Slater MD. The contextual effect of school attachment on young adolescents' alcohol use. *J Sch Health*. 2007;77(2):67–74.
32. Jegannathan B, Kullgren G. Gender differences in suicidal expressions and their determinants among young people in Cambodia, a post-conflict country. *BMC Psychiatry*. 2011;11:47.
33. WHO. Depression. 2012. <http://www.who.int/mediacentre/factsheets/fs369/en/>. Accessed 3 Jan 2015.
34. Escueta M, Whetten K, Ostermann J, O'Donnell K. Team POFOR. Adverse childhood experiences, psychosocial well-being and cognitive development among orphans and abandoned children in five low income countries. *BMC Int Health Hum Rights*. 2014;14:6.
35. Govender K, Reardon C, Quinlan T, George G. Children's psychosocial wellbeing in the context of HIV/AIDS and poverty: a comparative investigation of orphaned and non-orphaned children living in South Africa. *BMC Public Health*. 2014;14:615.
36. Kumar SP, Dandona R, Kumar GA, Ramgopal S, Dandona L. Depression among AIDS-orphaned children higher than among other orphaned children in southern India. *Int J Ment Health Syst*. 2014;8:13.
37. UCLA: Statistical Consulting Group: Stata Web Books Regression with Stata Chapter 2 Regression Diagnostics. 2014. <http://www.ats.ucla.edu/stat/stata/webbooks/reg/chapter2/statareg2.htm>. Accessed 4 Jan 2015.
38. WHO. Cambodia: Western Pacific Region Health Databank. In: WHO, Western Pacific Region Health Databank. 2011. http://www.wpro.who.int/countries/khm/4cam_tab2011_finaldraft.pdf?ua=1. Accessed 5 Jan 2015.

What are the factors associated with depressive symptoms among orphans and vulnerable children

39. Bhutta ZA, Sommerfeld J, Lassi ZS, Salam RA, Das JK. Global burden, distribution, and interventions for infectious diseases of poverty. *Infect Dis Poverty*. 2014;3:21.
40. UNICEF. Situation Analysis of Youth in Cambodia. 2009. http://www.unicef.org/cambodia/FINAL_UN_Youth_SitAn_2009.pdf. Accessed 5 Jan 2015.
41. Nyamukapa CA, Gregson S, Lopman B, Saito S, Watts HJ, Monasch R, et al. HIV-associated orphanhood and children's psychosocial distress: theoretical framework tested with data from Zimbabwe. *Am J Public Health*. 2008;98(1):133–41.
42. Russell D, Springer KW, Greenfield EA. Witnessing domestic abuse in childhood as an independent risk factor for depressive symptoms in young adulthood. *Child Abuse Negl*. 2010;34(6):448–53.
43. Sousa C, Herrenkohl TI, Moylan CA, Tajima EA, Klika JB, Herrenkohl RC, et al. Longitudinal study on the effects of child abuse and children's exposure to domestic violence, parent-child attachments, and antisocial behavior in adolescence. *J Interpers Violence*. 2011;26(1):111–36.
44. Shah AJ, Wadoo O, Lato J. Psychological distress in carers of people with mental disorders. *Br J Med Pract*. 2010;3(3):18–25.
45. Pinquart M, Sörensen S. Associations of stressors and uplifts of caregiving with caregiver burden and depressive mood: a meta-analysis. *J Gerontol B Psychol Sci Soc Sci*. 2003;58(2):112–28.
46. Hill PS, Ly HT. Women are silver, women are diamonds: conflicting images of women in the Cambodian print media. *Reprod Health Matters*. 2004;12(24):104–15.
47. Serey S, Many D, Sopheak M, Sokkalyan T, Sela SA, Chanravuth L, et al. Addressing the special needs of orphans and vulnerable children (OVC): a case study in Kien Svay district, Kandal province, Cambodia. *J AIDS HIV Res*. 2011;3(2):43–50.
48. Leadbeater BJ, Kuperminc GP, Blatt SJ, Hertzog C. A multivariate model of gender differences in adolescents' internalizing and externalizing problems. *Dev Psychol*. 1999;35(5):1268–82.
49. Yi S, Chhoun P, Brant S, Kita K, Tuot S. End-of-Project Evaluation: The Sustainable Action Against HIV&AIDS in Communities (SAHACOM). 2014. http://www.khana.org.kh/publicationimages/publican_pdf/RE018.pdf. Accessed 5 Jan 2015.
50. Pufall EL, Gregson S, Eaton JW, Masoka T, Mpandaguta E, Andersen L, et al. The contribution of schools to supporting the well being of children affected by HIV in eastern Zimbabwe. *AIDS*. 2014;28 Suppl 3:S379–87.
51. Zhang J, Zhao G, Li X, Hong Y, Fang X, Barnett D, et al. Positive future orientation as a mediator between traumatic events and mental health among children affected by HIV/AIDS in rural China. *AIDS Care*. 2009;21(12):1508–16.

Movie Review

PHILOMENA

Sonia Parikh, MD

Philomena is a 2013 British film directed by Stephen Frears based on the book *The Lost Child of Philomena Lee* by journalist Martin Sixsmith. The movie portrays the true story of an elderly Irish woman searching for the son, she forcibly gave up for adoption as a teenager living in a convent. Painful flashbacks into the ill treatment of Philomena by the nuns of the convent are folded into the contemporary journey of Sixsmith and Philomena as they attempt to uncover the mystery of Philomena's past.

Philomena was one of thousands of Irish women 'put away' during the 1950s for getting pregnant out of wedlock. The movie shows, via flashes to the past, how a teenage Philomena was disowned by her family for becoming pregnant at the age of 18 and taken in by Roman Catholic nuns at Sean Ross Abbey in Roscrea in Ireland. There, she worked as a servant in return for shelter and was allowed to see her child, Anthony, for only an hour a day. When Anthony was a toddler, he was put up for adoption in the United States without Philomena's consent. One moving scene shows him being placed in the back of a car and driven out of Philomena's life forever – and she never even had the chance to say goodbye.

The church coerced Philomena to take a vow of silence about the situation going forward. It was not until 50 years after the traumatic loss that Philomena began her search for her son with the help of Sixsmith. Together, Philomena and Sixsmith eventually discover that Anthony was renamed Michael Hess and was a prominent lawyer and senior official in the Reagan and George H. W. Bush administrations in the United States. They also learn that he was gay and died many years earlier from AIDS. Even more poignant, they discover that shortly before his death, Michael had visited the Abbey in Ireland to learn more about his birth mother and to hopefully find her. Unfortunately, the nuns led Michael to believe that his mother had abandoned him and they denied that they knew of her whereabouts. But Michael instinctively knew otherwise and decided to be buried in the Abbey – likely in an attempt to reunite with his mother eventually should she ever try to find him.

The movie brings light to the very deep rooted and special bond between a mother and a child. Even after 50 years of forcible separation due to the cruel circumstances of the times, Philomena and Michael are able to find their way back to one another eventually. Although Michael, adopted by wealthy Americans, presumably led a good life in the United States, it seems that he felt a part of him to be missing – and that

Philomena

part of him was Philomena. The movie, while set in Ireland and the United States, brings up the question of belonging and identity in the many fostered, adopted and orphaned children who exist all over the world, who either do not know their biological roots or have been rejected or abandoned by them. The movie speaks to the fact that knowledge of and/or connection with one's biologic or familial origins can, in many circumstances, become important for the full development of the sense of self. Unfortunately, in many cases, orphaned and adopted children never get that chance.

Book Review

MY HEART AND OTHER BLACK HOLES - JASMINE WARGA

Kakul Hai

‘Anyone who has actually been that sad can tell you that there’s nothing beautiful or literary or mysterious about depression’. It is, in fact, a ‘black slug’ that stays in the pit of your stomach, gnawing away at your insides, eating them up, emptying you of all feelings and emotions and leaving you with nothing except for a deep and dark black hole. And no one knows it better than 16-year-old Aysel (pronounced Uh-zell, as she is quite particular about it). For her, ‘depression is like a heaviness that you can’t ever escape. It crushes down on you, making even the smallest things like tying your shoes or chewing your toast seems like a twenty-mile hike uphill. Depression is a part of you; it’s in your bones and your blood. If I know anything about it, this is what I know: it’s impossible to escape’.

At an age when most of her contemporary teenage girls in Kentucky, like her half-sister Georgia, are mainly interested in participating in the next beauty pageant, Aysel lives in a dark black hole that consumes her entire state of being. While her English teacher heaps praises on the poetry of English romantics, all she can see in these poets is sadness and depression that they couldn’t escape and which is blaringly present in their poetry, transcending the beauty of their literary works. ‘Can’t you see that they are just depressed and sad people’, she wants to yell at her teacher and the entire class. Physics, on the other hand, makes sense to her. But it also bothers her. She constantly ponders over the fact that potential energy never fades away, it only gets transferred and transformed. She is concerned about what will happen to her potential energy when she dies? If her potential energy doesn’t die with her, then will she still be alive in some alternate universe? This thought greatly discomforts her because she doesn’t want even an iota of her essence of being to linger on. She hates herself that much.

She hates herself for the murder that her father committed of a young, bright and Olympics-bound athlete, Timothy Jackson, and the fact that now his younger brother, Brian Jackson, is taking his place and the news of his achievement is all over town, and also reminder of the crime that her father committed is also all over town. People don’t openly talk about it, but it is on everyone’s mind, as Aysel can feel it in their glances and their whispered talk whenever she passes by. ‘I wonder what my classmates are going to do with all their hate and anger and fear once they don’t have me here anymore’, Aysel wonders. And she won’t be around for much longer because she is planning her suicide.

Aysel doesn't blame herself for what her father did, though she does feel that if she was around, she could have prevented him from committing the act. After all, her father was also depressed, the black slug was also gnawing away at his insides. She was just too young to realize it. The cause of her depression roots from the fear that she is just like him. 'I'm terrified that whatever madness was inside of him lives inside me, too. That I'm capable of doing something just as awful'. And there is no one to tell her that that's not true, that she is not like her father. But then again, she might not believe it if she was told that. Her relationship with her mother is a distant one. The only person she really cares about is her 10-year-old half-brother, Mickey. But he's too young to realize her state of mind and to help her. But his affection towards Aysel is one of the first things that make her realize what she will miss when she kills herself.

But going through with suicide is not easy for Aysel. 'The problem with suicide, which most people don't realize, is that it's really hard to follow through. I know, I know. People are always yammering on and on about how "suicide is the coward's way out". And I guess it is – I mean, I am giving up, surrendering. Running away from my black hole of a future, preventing myself from growing into the person I'm terrified of becoming. But just because it's cowardly doesn't guarantee it's going to be easy', she thinks. But the suicide website, Smooth Passages, provides her with an opportunity to leap this hurdle in the offering of a suicide partner. And this is where she meets Roman.

Roman is a 17-year-old ex-basketball champ who wants to end his life on 7 April, because that is the day his baby sister drowned in the bathtub due to his negligence. Unable to surpass the guilt, he wants to die in a likewise manner. He wants Aysel and himself to jump off a cliff and drown in the river below. And based on this pact, their friendship begins, blossoming into an understanding and care akin to love, which eventually saves both of them.

The first book of young writer, Jasmine Warga, *My Heart and Other Black Holes*, shows us the depth of emotion, and the perceived lack of it by Aysel and Roman (whose screen name is FrozenRobot), felt by depressed teenagers, their level of disengagement with the outside world, their perceived lack of support, as in Aysel's case who later discovers her mother's support when she finally opens up to her, and also, on the other hand, the apathy towards a parent's concern, as in Roman's case, whose mother is overprotective of him because of fear for his well-being. Warga shows us how to connect with someone, as Aysel and Roman did with each other, and finding a person who doesn't judge you for who you are or for what you did can pull two people out of the depths of depression propelling them to suicide and give them hope and reasons to continue living. The black slug, as Aysel discovers, can indeed be thwarted, and her potential energy, which had gotten lost in a black hole, can indeed be transformed into positive light that gives her a new lease on life.

‘Everything used to seem so final, inevitable, predestined. But now I’m starting to believe that life may have more surprises in store than I ever realized. Maybe it’s all relative, not just light and time like Einstein theorized, but everything. Like life can seem awful and unfixable until the universe shifts a little and the observation point is altered, and the suddenly, everything seems more bearable’.

By finding Roman, Aysel finds a reason to not just live on herself, but also to pull him out of his black hole and take him to the ocean so that he can fulfil his life’s desire of becoming a marine biologist. Roman’s understanding and unconditional acceptance save Aysel, who in turn then saves him right back. And they both decide to embark on a life of possibilities that until some time ago were on the list of wishes they’d like to experience before they thought of dying on 7 April.

Brief Communications

1. One-day Consultation on ‘Trauma-informed Care: Concepts & Practices for Children in Alternative Care’, New Delhi, India

December 2016

Udayan Care organised a 1-day consultation on ‘trauma-informed care: concepts & practises for children in alternative care’ on 17th of March 2017 at New Delhi. At the 1-day discussion, Dr. Kiran Modi, managing trustee of Udayan Care, stressed on the facts that in India there are 170 million children in need of care and protection and an estimated 20 million children who have lost one or more parents and are out of the safety net of family protection. But India has just about 75,000 orphanages, and most of them are lacking quality care in a family-like setting, counselling or emotional bonding. Adding to this, the adoption rates in India is as low as 0.18%. All children living in alternative care have been exposed to some form of trauma. Some may have experienced more than one form of trauma or repeated trauma. Caregivers and service providers should understand the long-term permanent effects of such trauma and be sensitive in their dealing with children, so that no child has to relive the trauma. The key note address was delivered by renowned and experienced psychotherapist and psychoanalyst Dr. Monisha Nayar-Akhtar. The panel of expert professionals consisting of Dr. Jitendra Nagpal, Dr. Naveen Grover, Dr. Rajesh Sagar and Dr. Deepak Gupta was moderated by Dr. Akhtar. Dr. Sagar stressed upon the fact that a shift is required from seeing a ‘bad child’ as someone who has had bad things happened to them with a trauma-informed care approach. Dr. Nagpal stressed upon the fact that there needs to be more work done in the context of family to orient them on child rights to balance the work being done in schools. Dr. Grover said that this consultation will help initiate discussion on the criticality of trauma-informed care while caring for children. Dr. Gupta explained how the brain development gets impacted by trauma and how we could work to minimise its negative impact. Participants also got into group work to discuss practical ways of becoming informed on trauma care. Deliberations and recommendations from the day will be submitted to the Govt. of India and the agenda will be taken forward by the organisers.

Dr. Manju Mehta the chief guest and former president of the Indian Association of Clinical Psychology stressed upon the importance of continuing this discussion and took it forward as it is much required for childcare. Mr. Oma Anand, Director of mental hospitals at the Ministry of Health and Family Welfare, Govt. of India, was the guest of honour. The 7th issue of ‘Institutionalised Children: Explorations and

Beyond', (ICEB) was released in their August presence. Experts, psychologists, psychiatrists, social workers, volunteers, members of various child welfare committee (CWC), District Child Protection Units (DCPU) officers, counsellors, senior organisation heads and civil society members came together to discuss aspects of trauma-informed care for children living under alternative care. Most children who come to alternative care have undergone traumatic experience of abuse, neglect or abandonment, and as practitioners in childcare settings involved in the day-to-day care of out of home care children, the consultation discussed for the first time in India the importance of dealing with such trauma and the need to protect children so that they do not have to relive and recount the trauma again and again. The participants at the consultation was just the right range of expertise which raised compelling questions related to the practices and policies of mental health and care of children in alternative care. Participants actively took part in a group work post-lunch to get a nuanced understanding of Trauma-Informed-Care (TIC) and be able to apply it in the case situations that were relevant to their day-to-day working life. The consultation ended with a vote of thanks to all participants and resource persons and a resolve to continue the discussion and deliberations on this important aspect of child and youth care in India. This certainly has been the beginning of a long-term agenda on child protection for children living in alternative care.

2. 'Depression: Let's Talk' Says WHO, as Depression Tops List of Causes of Ill Health, Geneva

March 2017

In a press release issued by World Health Organisation (WHO), it has been noted that depression is the leading cause of ill health and disability worldwide. According to the latest estimates from WHO, more than 300 million people are now living with depression, an increase of more than 18% between 2005 and 2015. Lack of support for people with mental disorders, coupled with a fear of stigma, prevents many from accessing the treatment they need to live healthy and productive lives. The new estimates have been released in the lead-up to World Health Day on 7th April, the high point in WHO's year-long campaign 'Depression: let's talk'. The overall goal of the campaign is that more people with depression, everywhere in the world, both seek and get help. The WHO Director-General, Dr. Margaret Chan said that 'These new figures are a wake-up call for all countries to re-think their approaches to mental health and to treat it with the urgency that it deserves'. One of the first steps is to address issues around prejudice and discrimination. 'The continuing stigma associated with mental illness was the reason why we decided to name our campaign Depression: let's talk', said Dr. Shekhar Saxena, Director of the Department of Mental Health and Substance Abuse at WHO. 'For someone living with depression, talking to a person they trust is often the first step towards treatment and recovery'.

3. Supporting Institutional Caregivers in a Children's Home in Rural South India

Elizabeth J.^{1*} and Levey²

¹MD, Child, Adolescent & Adult Psychiatrist at Global Psychiatry Research Fellow, Massachusetts General Hospital, Boston, USA

²MD, Harvard Medical School, Boston, MA, USA

*Corresponding author email id: ELEVY@mgh.harvard.edu

ABSTRACT

Orphans and other institutionalised children frequently have histories of maltreatment prior to entering institutional care. Better understanding of the impact of these maltreatment experiences is essential to meet the needs of these children. Institutional caregivers are challenged to address the unique and complex needs of these children. A team of child psychiatrists and mental health specialists visited a children's home in South India to provide consultation to the caregivers. The cases of two adolescent girls illustrate two distinct presentations, following histories of significant maltreatment and early loss. One of the girls was significantly dysregulated. The other was struggling academically after leaving the home but was better able to regulate her affective states. The team recommended supporting the children's existing defensive structures and allowing them to speak about any past traumas on their own terms without being pushed to do so. The team also considered the self-regulating function of the cultural practices in which the children engaged and encouraged them to continue these activities.

Keywords: Child maltreatment, Emotion regulation, Culture, Institutional care, Case report, mental health, Trauma

BACKGROUND

Child abuse is a global problem with life-long consequences. The global prevalence estimate for child emotional abuse is 36% (Stoltenborgh *et al.*, 2012), child physical abuse is 23% (Stoltenborgh *et al.*, 2013) and child sexual abuse is 12% (18% among girls) (Stoltenborgh *et al.*, 2011). Children who experience abuse are at increased risk for numerous physical and mental health problems in adulthood, including chronic inflammation (Danese *et al.*, 2009; Bertone-Johnson *et al.*, 2012), asthma (Coogan *et al.*, 2013), substance abuse (Banducci *et al.*, 2014), depression (Chapman *et al.*, 2004), suicidal behaviour (Dube *et al.*, 2001) and post-traumatic stress disorder (Frans *et al.*, 2005). Although child abuse and its negative mental health consequences can be found around the world, the same risk factors do not necessarily lead to the same illness presentation.

Among institutionalised children, rates of abuse and neglect would be expected to be significantly higher, due to both the circumstances they experience before arriving at the institution and the treatment they receive in the institution. Although the data is limited, a few studies suggest that this is the case. One study found that 53% of institutionalised children in Jordan had mental health problems. Male gender, history

of prior maltreatment, time in care and number of transfers were all predictors of problems (Gearing *et al.*, 2013). A study in Tanzania found that children who were institutionalised prior to age five reported higher rates of maltreatment in institutions and were also more likely to develop mental health problems than those institutionalised later (Hermenau *et al.*, 2014).

This paper examines the experiences of institutionalised children in India with histories of early maltreatment, with the goal of enhancing understanding of their emotional and developmental needs and identifying strategies to support their caregivers in meeting these needs.

CASE EXAMPLES

As a child psychiatry trainee, I was part of a team of child psychiatrists and infant mental health specialists that visited a children's home in rural South India. Seventy-six children live in the home. They attend a school on the grounds that also serve children who live with their families in the local community. By law, children cannot be placed into institutional care before the age of five; they must remain with their families or with other caregivers in the community.

Our team offered consultation to the caregivers at the home using Alexandra Harrison's consultation model for institutional caregivers (Harrison, 2015). In this model, the consultation team develops a long-term relationship with an institution in an international setting, sustained through episodic visits to perform evaluations and provide workshops for caregivers on topics of interest and regular video conferencing to address problems and questions as they arise. During this visit, eight children were interviewed individually at the request of the staff due to the concerns that children appeared sad or withdrawn or were demonstrating behavioural dysregulation. The cases of two adolescent girls illustrate two distinct presentations, following histories of significant maltreatment and early loss. One of the girls, N, was significantly dysregulated. The other, T, was struggling academically after leaving the home but was better able to regulate her affective states.

N was 17 years old at the time of the interview. The team was asked to evaluate her because of frequent episodes of tearfulness and feelings of abandonment. She had previously run away from the home but had not done so in more than a year. Her father was verbally and physically abusive. He drank and blamed for things she had not done. He did not send her to school but sent her to the street to beg. She often felt humiliated. She continued to relive these experiences. She cried and felt overwhelmed. She could identify nothing that comforted her or helped her to feel better. When she was 11, a tourist found N and brought her to the home. She continued to sponsor her but had not visited in 4 years because she wanted N to learn to be more 'self-reliant'. N spoke of this woman frequently. She was eager for her to return. When asked how she felt about her absence, N looked away and

did not respond. Her father had started visiting and bringing gifts in an attempt to repair their relationship. The staff was not sure how to handle this. N accepted his gifts but was more interested in contacting with the tourist and with her brother, who had married and moved away.

T was 16 years old. She first came to the home around the age of nine after her father beat her mother to death and made it look like a suicide. She ran away many times from the children's home. On one such occasion, when she was 12, she was raped by a friend of her father. She reported that she was quiet and 'did not scream. When she returned to the home, she was engaging in sexual behaviour with other girls, which alerted staffs that something had happened to her. She did well enough in secondary school to be accepted into a specialised technical programme. T frequently came to the home to visit her housemother, despite the distance. She was anxious about her academic performance because she wanted to finish the programme so that she could get a good job and support herself. She felt comforted by the visits with her housemother and the other girls at the home. She had no contact with her father.

Although they both had histories of severe maltreatment, T had no contact with her family of origin and had formed a close relationship with her caregiver at the home. Their distinct presentations were likely due to the combined effects of differences in their innate temperaments, differences in their relationships with their families of origin and differences in their individual experiences with specific caregivers at the home.

DISCUSSION

The team was asked to make recommendations about how best to support these girls and their peers at the home. In many cases, children arrived at the home following the death of a parent or another serious traumatic event that was known to the staff, and they were anxious about how to address this. The team advised the staff to support the children's existing defensive structures and celebrate their strengths as much as possible. Staffs were counselled about the importance of allowing children to speak about any past traumas on their own terms and not to be pushed to share such details. This allows them to build a sense of control in their new environments, rather than repeating the experience of being forced to do something uncomfortable and frightening.

The team considered similarities between certain cultural practices, like chanting, prayer, dance and therapeutic techniques used in the treatment of individuals who struggle with self-regulation. By encouraging these cultural practices in the children's home, the staff is supporting the development of regulatory capacities that may not have developed earlier, in the context of maltreatment.

ACKNOWLEDGEMENTS

I gratefully acknowledge the important contributions of team members Dr. Alexandra Harrison and Alayne Stieglitz. I would also like to thank Professor G.S. Jayadev, the Director of the Deena Bandhu Trust, the staff at the children's home, the teachers at the school and all of the children. Special thanks to the MGH Center for Global Health for providing funding for my travel to India.

REFERENCES

- Banducci AN, Hoffman EM, Lejuez CW and Koenen KC, 2014. The impact of childhood abuse on inpatient substance users: specific links with risky sex, aggression, and emotion dysregulation. *Child Abuse Neglect*, Vol. 38, No. 5, pp. 928–938.
- Bertone-Johnson ER, Whitcomb BW, Missmer SA, Karlson EW and Rich-Edwards JW, 2012. Inflammation and early-life abuse in women. *American Journal of Preventive Medicine*, Vol. 43, No. 6, pp. 611–620.
- Chapman DP, Whitfield CL, Felitti VJ, Dube SR, Edwards VJ and Anda RF, 2004. Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of Affective Disorders*, Vol. 82, No. 2, pp. 217–225.
- Coogan PF, Wise LA, O'Connor GT, Brown TA, Palmer JR and Rosenberg L, 2013. Abuse during childhood and adolescence and risk of adult-onset asthma in African American women. *Journal of Allergy and Clinical Immunology*, Vol. 131, No. 4, pp. 1058–1063.
- Danese A, Moffitt TE, Harrington H, Milne BJ, Polanczyk G, Pariante CM, Poulton R and Caspi A, 2009. Adverse childhood experiences and adult risk factors for age-related disease: depression, inflammation and clustering of metabolic risk markers. *Archives of Pediatrics and Adolescent Medicine*, Vol. 163, No. 12, pp. 1135–1143.
- Dube SR, Anda RF, Felitti VJ, Chapman DP, Williamson DF and Giles WH, 2001. Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: findings from the Adverse Childhood Experiences Study. *Journal of the American Medical Association*, Vol. 286, No. 24, pp. 3089–3096.
- Frans O, Rimmo PA, Aberg L and Fredrikson M, 2005. Trauma exposure and post-traumatic stress disorder in the general population. *Acta Psychiatrica Scandinavica*, Vol. 111, No. 4, pp. 291–299.
- Gearing RE, MacKenzie MJ, Schwalbe CS, Brewer KB and Ibrahim RW, 2013. Prevalence of mental health and behavioral problems among adolescents in institutional care in Jordan. *Psychiatric Services*, Vol. 64, No. 2, pp. 196–200.
- Harrison AM, 2015. 'Los momentos magicos': a practical model for child mental health professionals to volunteer by supporting caregivers in institutions in developing countries. *Institutionalised Children Explorations and Beyond*, Vol. 2, No. 1, pp. 77–91.
- Hermenau K, Hecker T, Elbert T and Ruf-Leuschner M, 2014. Maltreatment and mental health in institutional care-comparing early and late institutionalized children in Tanzania. *Infant Mental Health Journal*, Vol. 35, No. 2, pp. 102–110.
- Stoltenborgh M, Bakermans-Kranenburg MJ, Alink LR and van Ijzendoorn MH, 2012. The universality of childhood emotional abuse: a meta-analysis of worldwide prevalence. *Journal of Aggression, Maltreatment & Trauma*, Vol. 21, No. 8, pp. 870-890.

- Stoltenborgh M, Bakermans-Kranenburg MJ, van Ijzendoorn MH and Alink LR, 2013. Cultural-geographical differences in the occurrence of child physical abuse? A meta-analysis of global prevalence. *International Journal of Psychology (Journal International de Psychologie)*, Vol. 48, No.2, pp. 81–94.
- Stoltenborgh M, van Ijzendoorn MH, Euser EM and Bakermans-Kranenburg MJ, 2011. A global perspective on child sexual abuse: meta-analysis of prevalence around the world. *Child Maltreatment*, Vol. 16, No. 2, pp. 79–101.

4. Two-day Workshop on Alternative Care for Children, New Delhi

December 2016

Udayan Care, a child rights organisation based out of Delhi organised a 2-day workshop on ‘alternative care for children’ in India on the 8th and 9th of December 2016 at New Delhi. The deliberations over the 2 days covered critical issues of child and youth care in India such as gatekeeping, family-strengthening measures, mental health care programming and concept of mentoring. The workshop was supported by UNICEF and attended by representatives of UNICEF, Ministry of Women and Child Development, NGO members, child welfare committee members, officers from the district child protection units, professionals and practitioners in the field. The workshop was helpful in building a momentum on the discussions and debates on deinstitutionalisation and the pros and cons of it. Everyone unanimously agreed that the best interest of the child is of paramount importance, and childcare should be a dynamic process with in-built mechanisms for review and monitoring. A number of recommendations were made at the workshop forging the way forward for all key stakeholders to come together and continue the dialogue on this issue at a national level in India.

The workshop also served as the venue for the release of Udayan Care’s recent advocacy material titled ‘a series on alternative care’. This is a compendium containing informative booklet on adoption, foster care, aftercare and standards of care in child rights institutions. For copies of the booklets, one may write to advocacy@udayancare.org.

5. Orphanages can be a Child's Best Hope

Kiran Modi

New Delhi, India

The Baltimore Sun, 12 May 2017

<http://www.baltimoresun.com/bs-ed-orphans-letter-20170511-story.html>

I write in response to the commentary featuring the work of Lumos and the call to 'end orphanages' everywhere and the reference of the 'horrific' situation in India ('an end to orphanages', May 7). I was both heartened and saddened to read the piece. Heartened because there is no greater need for our children than that of keeping them in their families and with your global influence, and there can be no better ambassador for a worldwide embracing of alternative care options for vulnerable children. Saddened because the reasons the authors have so rightly listed – those of extreme poverty, discrimination and disability – are not so easily wished away by the single-minded focus on closure of institutional care.

In a country like India where the number of vulnerable children is expected to be more than 24 million by 2030 and rate of adoption is abysmally low (for reasons ranging from social stigma to extreme vetting to counter the danger of trafficking) and community-based programmes are in their infancy, institutional care with a rights-based approach and individual childcare plan is often the child's only hope. India has some small group care models that are well established and are able to provide children with access to safety, health, education and social development tailored to their individual needs, a solution where other forms of alternative care are yet to evolve or even be conceptualised.

Our experience of 22 years has shown that Indian children in institutional care are mostly orphans or, equally heartbreakingly, have been abandoned by their own families. Those who have some distant family are very reluctant to take responsibility for them. The prime objective of Lumos is to transform an outdated and harmful system into one which supports and protects children and enables them to have a brighter tomorrow. We see an obvious connection between Lumos and Udayan Care here, perhaps through a wider lens. We think it important to differentiate between large childcare institutions and other models, like Udayan Care which has small group homes, lifetime-committed mentors to the children, personalised care and social integration that includes community schooling and a participatory approach.

Interestingly, Harry Potter himself finds the love of a true family only once he is at Hogwarts in Hagrid and Dumbledore and friends that are like siblings, far away from the 'kinship care' of the Dursleys. Hogwarts too is an institution, one that values Harry for who he is as a special individual, just like each child in our care.

The dilemma here is that in circumstances where the ground realities are complex and do not allow for the child to be safe and protected in other forms of alternative care, is it not simplistic to undermine the role that safe institutions can play? Should then the emphasis not be on improving standards of care and monitoring mechanisms at institutions rather than propagate for their full closure?

With the global trend towards de-institutionalisation, we at Udayan Care have been facing several such challenges and questions. The recently held International Conference on Alternative Care in Geneva, at which I had an opportunity to participate, clearly laid the way towards de-institutionalisation. But the core question that remains to be addressed is how. Do we have the right understanding and strategy required to achieve this in the best interests of our children? Is there only one answer? Could it not be harmful to our children being placed in foster or kinship care with little or no monitoring mechanisms, the possibility of exploitation looming large in their young lives?

At Udayan Care, we're committed to working with like-minded organisations, governments and international bodies to find implementable solutions to the vulnerabilities that South Asian children are subjected to every day in their lives.

One of our other key advocacy efforts has been the publication of an academic journal titled 'ICEB'. This journal was launched in 2014 and has become very popular among key stakeholders on child and youth care and social work universities in India and abroad. We invite you to subscribe to the journal. We would love to have your contributing articles for the forthcoming issues.

We recently had Jason Isaacs spent an afternoon with the girls of one of our homes. We would love anyone to have visit us too and see what a living in family environment at Udayan Home really is and meet the young adults that still call Udayan Care home.

Copyright © 2017, The Baltimore Sun, a Baltimore Sun Media Group publication.

6. India's Supreme Court Endorses Family-based Care and Institutions as a Last Resort – National and Global Implications

Ian Anand Forber Pratt, MSW

India National Programme Director, Children's Emergency Relief International, Kingwood, TX, USA

In early May 2017, the Supreme Court of India issued directions to the Indian states and union territories to shift focus to family-based care. Comments from the Supreme Court Bench included, 'it is imperative that the Union government and the governments of states and UTs must concentrate on rehabilitation and social re-integration of

children in need of care and protection’, and ‘it is time that the governments of the states and union territories consider de-institutionalisation as a viable alternative’ (<http://www.hindustantimes.com/india-news/supreme-court-asks-governments-to-prepare-database-of-kids-in-orphanages/story-qTVQafbS6sNMU359ZjbJ5O.html>)

The implications of these directives both in-country and globally are significant. The simple fact that India has the second largest population of children in the world begins to paint a picture. India’s increasing influence in child protection in South Asia (<https://www.planindia.org/sites/default/files/National%20Declaration%20FINAL.pdf>; https://www.unicef.org/eapro/activities_22250.html | https://www.unicef.org/eapro/activities_22250.html) expands the picture of influence to a regional and global scale.

With more than a third of its population below the age of 18, India has a child population of over 400 million children (<http://www.childlineindia.org.in/child-in-india.htm>). Estimates that of these 400 million at least 40% fall under some form of vulnerability with an increasing amount of sexual abuse and exploitation (<http://timesofindia.indiatimes.com/city/delhi/40-of-kids-vulnerable-ministry/articleshow/56606949.cms>).

India still lacks a ‘denominator’ to quantify the number of children in out-of-home care or in institutional care. Regional and state efforts have begun, and a national survey of institutions data is awaited from the Ministry of Women and Children. In fact, in the 2016 National Plan of Action for Children included the first national mapping of child vulnerability (<http://wcd.nic.in/sites/default/files/National%20Plan%20of%20Action%202016.pdf>). Still, there are many steps forward needed to properly assess the needs of children outside of parental care.

The fact is that family-based solutions do not yet exist in a safe way in India. But we’re headed that way. On the journey, however, children must remain safe, and all existing institutions must be reduced in size, highly regulated and supported to expand their services to family-based care. If a child goes before a local district official right now for care and protection, their only option is institutionalisation. Don’t worry, it’ll change through collaborative hard work, but social change is slow, must be strategic and very exciting.

This is not, however, just a problem of India. Globally, 250 NGOs, led by Lumos and SOS Children’s Villages, have launched a campaign titled, All Children Count that addresses this data gap and ‘wants the SDGs (Sustainable Development Goals) monitoring framework to ensure that all children who live outside of parental care are represented in disaggregated data, and the data collected in that way are expanded and improved to make this possible’ (<https://www.theguardian.com/global-development-professionals-network/2017/may/03/how-can-you-leave-no-one-behind-when-millions-of-children-are-unaccounted>).

The context here, however, is important, child protection is still young in India. This makes the shift from institutions as a first resort to that of a last resort a very sensitive situation. A young system often resists change, and evidence-based research shows that mindset change is difficult. On the road to childcare system reform India will mostly likely succeed, fail, learn and innovate in multiple ways and forms.

The first time a law mandated a child & protection for children both in conflict with law CIL (Children in conflict with law) and in need of care and protection Children in need of care and protection (CNPC) came in the form of the Juvenile Justice Act (JJ Act) in 1986. However, as India's national child protection organisation comments, 'The Juvenile Justice Act (JJA) (GOI, 1986) was inadequate as non-institutional methods such as family and school based preventive services to deal with juvenile delinquency were neither specified nor explored. Moreover, the Act did not directly deal with child sexual abuse. Despite the law, children were taken for interrogation overnight, detained, tortured and released in the morning. So, the Juvenile Justice Act (GOI, 1986) got replaced by the most comprehensive law to deal with children's right, Juvenile Justice (Care & Protection of Children) Act (GOI, 2000)' (<http://www.childlineindia.org.in/1098/b15jjact-intro.htm>).

The 2000 JJ Act, revised in 2006 included sponsorship, foster care, adoption and institutionalisation as the four forms of care and protection with provisions for after-care mentioned in the Act. Family preservation/strengthening was not mentioned in the Act overtly. Principles and main directives, however, were missing in both the 2000 JJ Act and the revision in 2006 (<http://khoyapaya.gov.in/mpp/resources/Juvenile%20Justice%20Act%202000.pdf>).

In 2015, Child Care and Protection began to expand rapidly at the policy level in India. Between 2015 and 2017, the Government of India passed a new JJ Act, corresponding JJ Rules, model guidelines for foster care, adoption regulations and many standard operation procedures on child trafficking, JJ, missing children and other more targeted forms of childcare and protection. Clear directives were included in a new section, 'general principles of care and protection of children', that included '(iv) Principle of best interest: All decisions regarding the child shall be based on the primary consideration that they are in the best interest of the child and to help the child to develop full potential' and '(v) Principle of family responsibility: The primary responsibility of care, nurture and protection of the child shall be that of the biological family or adoptive or foster parents, as the case may be' and '(xii) Principle of institutionalisation as a measure of last resort: A child shall be placed in institutional care as a step of last resort after making a reasonable inquiry' (<http://wcd.nic.in/acts/juvenile-justice-care-and-protection-children-act-2015>).

However, even today, foster care has not been systematised at national or state levels, and family strengthening/preservation and aftercare are still in their infancy.

States and union territories are beginning to ‘adapt or adopt’ central guidelines for foster care (<http://www.wcd.nic.in/sites/default/files/November2016-FC.pdf>) and the bridge between policy and practice is vast.

The opportunities for childcare and protection are immeasurable as India has the human resources on the ground at each district (nearly 700 districts in the country) of a child welfare committee, district child protection unit and JJ board. These bodies, with proper training and resource, can champion the shift from institutions as a first resort to that of a last.

The risks must also be considered. The shortcomings of capacity and resources at district levels mean that children may be placed with families without proper monitoring, evaluation or training. The country is scrambling to bridge these gaps and to its credit, is making strong efforts, in collaboration with non-governmental organisation, to mitigate the gaps between the new policies and the implementation on the ground. Much more needs to be done, and quickly. Luckily, an increasing canon of evidence-based research exists on changing mindsets and transitioning change in the field of de-institutionalisation of childcare services and systems.

The main implications of India’s shift from institutions as a first resort to that of a last comes back to the sheer number of people. Globally, if 1/6th of the world’s population stands up to say, children belong in families, social change research indicates that the tipping point is near.

REFERENCES

- [1] [<http://www.hindustantimes.com/india-news/supreme-court-asks-governments-to-prepare-database-of-kids-in-orphanages/story-qTVQafbS6sNMU359ZjbJ5O.html>].
- [2] [<https://www.planindia.org/sites/default/files/National%20Declaration%20FINAL.pdf>].
- [3] [https://www.unicef.org/eapro/activities_22250.html] [https://www.unicef.org/eapro/activities_22250.html].
- [4] [<http://www.childlineindia.org.in/child-in-india.htm>].
- [5] [<http://timesofindia.indiatimes.com/city/delhi/40-of-kids-vulnerable-ministry/articleshow/56606949.cms>].
- [6] [<http://wcd.nic.in/sites/default/files/National%20Plan%20of%20Action%202016.pdf>].
- [7] [<https://www.theguardian.com/global-development-professionals-network/2017/may/03/how-can-you-leave-no-one-behind-when-millions-of-children-are-uncounted>].
- [8] [<http://www.childlineindia.org.in/1098/b15jjact-intro.htm>].
- [9] [<http://khoyapaya.gov.in/mpp/resources/Juvenile%20Justice%20Act%202000.pdf>].
- [10] [<http://wcd.nic.in/acts/juvenile-justice-care-and-protection-children-act-2015>].
- [11] [<http://www.wcd.nic.in/sites/default/files/November2016-FC.pdf>].

Upcoming Events

1. The Third Biennial International Conference on Alternative Care for Children: with Special Focus on South Asia

16–17 March 2018, India

www.bicon.udyanicare.org

Udayan Care has, since 2014, instituted biennial international conferences (BICON) with a strong focus on South Asia. The first BICON was focused on ‘Standards of Care and Mental Health for Children in Institutional Care’, whereas the second BICON was titled ‘Improving Standards of Care for Alternative Child and Youth Care: Systems, Policies and Practices’. At both the BICONS, issues of mental health of OHC children, standards of care, models and best practices of care have been discussed, shared and deliberated upon. Reports can be downloaded from first BICON and second BICON.

The third BICON, now scheduled in March 2018, aims to keep the momentum alive in the South Asian region on ACC. It aims to explore and take stock of the evolving trends in the region and bring together those involved in providing care and protection to OHC children in the region as well as other parts of the globe. It looks at understanding existing models of care and evolving trends to bring out issues, dilemmas and challenges of transition, application of deinstitutionalisation (DI) in South Asia, concepts of trauma informed care and mental health aspects of OHC children. The theme of the third BICON is ‘Evolving Trends in Alternative Care for Children and Youth in South Asia’.

KEY OBJECTIVES OF THE THIRD BICON

The third BICON is being held primarily with the following objectives:

- Improve knowledge and understanding on alternative care settings in South Asia
- Examine existing standards, legislative and policy frameworks on alternative care in South Asia
- Share and exchange experiences, research and models of care
- Identify challenges related to shift away from institutional care in South Asia
- Create a network of like-minded organisations to advance the advocacy work of implementation of policy measures on alternative care in South Asia.

CONFERENCE DESIGN

Main Conference: will consist of three plenary sessions each day. Presenters will be invited to speak on the following themes:

- Trends on alternative care internationally and particularly in South Asia
- The DI debate and its application in South Asia
- Models of care appropriate in SA context
- Country analysis of the situation of alternative care in SA countries
- Models of alternative care in SA countries

Parallel sessions will have workshops format, which will consist of two sessions each day focusing on stakeholders themselves. Both workshops will present outcomes at the plenary sessions on the respective days.

- Workshop on Day 1: Being able to provide the right care to children
- Workshop on Day 2: Hearing direct voices of foster families, young adults and other direct role-players.

Poster Presentation: Posters, being a popular feature at the earlier BICONS, will once again be on display at the foyer of the conference venue, throughout on both the days of the third BICON. Like last time, all posters will be judged by a panel set up by the Steering Committee and the best two posters will be awarded a cash prize of Rs. 10,000 each at the closing session on Day 2 of the conference.

PARTICIPANTS

The third BICON is for everyone involved in the care of OHC children and youth in South Asia. It will bring together national and international experts, individuals and organisations working on child protection and alternative care and civil society representatives from SA countries. Delegates from government offices and agencies responsible for child protection and members of the media will also be invited.

To register and know more, please visit bicon.udayancare.org.

2. 10th International Conference of the International Society for Health and Human Rights (ISHHR)

<http://ishhr.com/>

Organiser: The International Society for Health and Human Rights (ISHHR)

Location: Novi Sad, Serbia

The International Society for Health and Human Rights (ISHHR) will be hosting its 10th International Conference in the city of Novi Sad in Serbia, on 26-29 Sept. 2017.

The title of the 2017 ISHHR Conference is 'Mental Health, Mass People Displacement and Ethnic Minorities', and it will focus on the displacement of communities as a result of conflict, the phenomenon of mass-traumatisation and the response of the European neighbourhood (particularly Central Europe) to the mass influx from the Middle East and North Africa (particularly as a result of the Syrian crisis). However, we will also welcome contributions from experts and speakers in Latin America, Africa and the Asia-Pacific region, as mass people displacement and migration is a global challenge.

3. Eurochild Partnering with IFCO 2017 World Conference

<https://childhub.org/en/child-protection-events-south-east-europe/eurochild-partnering-ifco-2017-world-conference>

Date of event: 01 Nov 2017, 9:00 am to 04 Nov 2017, 6:00 pm

Location: Valletta, Malta

Conference subthemes include but are not limited to

- Child protection systems and DI reform: overall care system reform and DI and family-based care in different regions across the world
- Meeting the needs of children due to migration
- Formal and informal educational outcomes for children during care and for care leavers
- Foster carers and social workers: education, training, assessment, approval, supervision and retention
- Understanding trauma and its effect
- Prevention, intervention, early childhood and permanency
- Partnership, engagement and children and youth participation
- Measuring success: preventative services, suitable placements, successful transitions and aftercare and the impact and measurement of care leavers' successes and attainments.

4. Nurturing Hope 2018: fourth Biennial California Community Services & third Child and Youth Care World Conference

Hosted by Casa Pacifica Centers for Children and Families and the International Child and Youth Care Network

15–18 January 2018

https://www.casapacifica.org/training/2018_nurturing_hope_conference

Children, youth and families – as well as those who provide care and support to them – are living in a time where hope for the future is needed. Hope is an integral part of the healing experience and is exactly what those facing difficult circumstances in life need.

This conference aims to explore, restore and promote hope for those involved in strengthening families around the world. Conference keynotes and workshops as well as optional pre-conference and networking opportunities will equip and refresh you in your personal and professional work with children, youth and families. For the first time, this conference brings together 8 years of a state-wide conference focused on supporting the most challenged children and youth in the community together with the third Child and Youth Care Conference, which has gathered in Newfoundland and Labrador (Canada), Vienna (Austria) and now in Southern California (USA).

The conference venue is located just steps from the Pacific Ocean in Ventura, California – an hour north of Los Angeles International airport or the Bob Hope Burbank airport or a half hour south of the Santa Barbara airport. Rail access is available one block from the hotel from Bob Hope Burbank airport. You are invited to join like-minded colleagues for 4 days of learning, networking and strengthening your work in supporting children, youth and families.

5. Youth and Justice Congress 2017, 25th to 27th October 2017 in Toronto, Ontario, Canada

Canadian Youth & Justice Congress 2017 will look at the evolving youth justice system and showcase preventative and innovative initiatives and research that address underlying factors that impact youth involvement in the criminal justice system.

Organised by: CJAO, CCJA and MCYS.

Website: <http://www.cjao.ca>

Contact person: Sherry Sim

6. AVLIC 2018, Little Hands, Big Message: Working with Deaf Children and Youth

9–14 July 2018

Sheraton on the Falls, 5875 Falls Ave, Niagara Falls, ON, Canada L2G 3K7

<https://www.avlic2018.com/>

This conference, Little Hands, Big Message – Working with Deaf Children and Youth, promises to be exciting and enlightening, with something for everyone. At some point in your interpreting career, you have or will interpret in a situation where deaf children and/or youth are involved. This conference will provide you with a framework to work in a variety of settings. Topics will include ASL acquisition, ASL depictions, cognitive development, best practices in medical, mental health and educational interpreting, as well as exploring the language use of children and teens. For interpreters who are either native or second language users of ASL, being familiar with developmental and linguistic milestones will better equip you to monitor input and output in your environment and to identify next steps for your own learning.

7. CDPECY 2018: 20th International Conference on Developmental Physical Education for Children and Youth

New York, USA

The ICDPECY 2018: 20th International Conference on Developmental Physical Education for Children and Youth aims to bring together leading academic scientists, researchers and research scholars to exchange and share their experiences and research results about all aspects of Developmental Physical Education for Children and Youth. It also provides the premier interdisciplinary forum for researchers, practitioners and educators to present and discuss the most recent innovations, trends, concerns, practical challenges encountered and the solutions adopted in the field of Developmental Physical Education for Children and Youth.

<https://waset.org/conference/2018/10/new-york/ICDPECY/home>

Form IV (See Rule 8)

Statement about ownership and other particulars about “**Institutionalised Children Explorations and Beyond**” to be published in the each issue every year.

- | | |
|--|---|
| 1. Place of Publication: | New Delhi |
| 2. Periodicity of its Publication: | Half Yearly |
| 3. Printer’s Name:
Address: | Vandana Gurwara at
Ajanta Offset & Packaging Ltd.
Plot No. 61, Sector-27-C
Faridabad |
| Nationality: | Indian |
| (a) Whether a citizen of India? | Yes |
| (b) If a foreigner, the country of origin | NA |
| Address | - |
| 4. Publisher’s Name: | Vandana Gurwara on behalf of
Diva Enterprises Pvt. Ltd. |
| Address: | C-62, Inderpuri,
New Delhi- 110012 |
| Nationality | India |
| (a) Whether a citizen of India? | Yes |
| (b) If a foreigner, the country of origin | NA |
| Address | - |
| 5. Editor-in-Chief’s Name: | Dr. Monisha C. Nayar-Akhtar |
| Address: | Udayan Care, 16/97-A, First Floor,
Vikram Vihar, Lajpat Nagar-IV
New Delhi-110024 |
| Nationality | India |
| (a) Whether a citizen of India | Yes |
| (b) If a foreigner, the country of origin | NA |
| Address | - |
| 6. Names and addresses of individuals
who own the newspaper and partners
or shareholders holding More than one
per cent of the total capital. | Mrs. Vandana Gurwara
Mrs. Divya Gurwara
B-9, Block-A, Naraina Vihar,
Ring Road, New Delhi-110028 |

I, Vandana Gurwara, hereby declare that the particulars given above are true to the best of my knowledge and belief.

Date: 14 September, 2017

S/d
Vandana Gurwara
Publisher

Institutionalised Children Explorations and Beyond# Subscription Order Form - 2017

Name of the Subscriber: _____

Designation: _____

Organization/Institute: _____

Address : _____

City: _____ Pin: _____ State: _____

In case of individual subscription, please provide your residence address to receive the copy

Telephone No. (With STD code): _____

Fax (With STD Code): _____ E-mail ID: _____

Subscription rates for the year: 2017

Option	Indian (Rs.)	Foreign (US\$)	Frequency
Print**	1,500	160	2
Online*	1,180	118	

Site Licensing Price: **INR 5900.00 & USD 590.00**

1. Cheque/DD/. _____ Date: _____ INR/USD: _____
drawn on _____ in favour of **Indianjournals.com** payable at New Delhi
2. Please send Bill/Proforma Invoice (in Duplicate / Triplicate)
3. Please send the rates/details for the site licensing Yes No

Terms & Conditions:

1. **Print** Subscription** includes **Complimentary Online Access** of current year + back files, if available.
2. Online only subscription* rates are inclusive of GST.
3. **Five Concurrent users are allowed with unlimited downloads**
4. Print subscription is volume based, whereas online subscription is calendar year based.
5. Online subscription rates are for single user/IP access only.
6. For online access, please give your Static IPs.
7. Payment by demand draft or local cheque (payable at par) in favour of **Indianjournals.com**, outstation cheques are not acceptable.
8. In case of foreign subscription, payment is preferred by Bank Transfer. For details contact **subscription@indianjournals.com**

Please send this form to Sales Department, Indianjournals.com, B-9 Local Shopping Complex, A Block Naraina Vihar, New Delhi 110028, Tel: 011-45055555 ext. 535/538

#Udayan Care has partnered with **Indianjournals.com** to promote the journal

GUIDELINES FOR SUBMISSIONS

MANUSCRIPTS AND EDITORIAL COMMUNICATIONS must be submitted in MSWord (2003/2007) through online submission gateway available on www.indianjournals.com. Please follow the hyperlink “**Article Submission**” on the home page of the website and upload your manuscript files following the instructions given on the screen. Queries regarding article submission can be sent at submission@indianjournals.com. Each author will be sent an acknowledgment, confirming receipt of submission. **Editorial e-mail:** Kiran Modi: iceb-journal@udayancare.org or Monisha Akhtar: monisha_akhtar@hotmail.com. Each submission should conform to APA format for manuscripts for main text and references, and be no more than 3500 words with a 500 word abstract. Please see the Publication Manual of the American Psychological Association, 6th Edition (2010) for APA format specifics. Submission guidelines can be located on the ICEB website at

http://udayancare.org/iceb-journal/home_iceb.html. All papers must be submitted in English. Direct initial inquiries prior to submitting a manuscript should be sent to the same e-mail addresses indicated above. Manuscripts can be submitted by any individual working with any of the following countries: Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Sri Lanka, and Pakistan. Manuscripts can address research issues, issues of standards of care and policy, pertaining to children, out of family network, and in alternative care; legal concerns related to alternate care and management issues, home care strategies and care-giver solutions, developing monitoring systems, for children in need of care and protection, for looked after children in alternative care, as well as with special needs such as disabilities, juvenile delinquency, or children diagnosed with HIV/ AIDS. Regional and local issues can be considered. Original Articles can be accepted for publication only on condition that they are contributed solely to the ICEB journal. Authors of articles already published in foreign-language journals should communicate with the journal Editor and obtain appropriate permissions before sending manuscripts. Only then will a manuscript be considered for publication in the ICEB Journal. JOURNAL THEMES will cover a wide range of topics. From time to time, an issue may be devoted to a particular theme as in addressing mental health concerns and treating trauma in this population. Authors are encouraged to submit their ideas for particular themes and can work with the editor-in-chief to develop their ideas into a special issue. We hope to encourage creativity in thinking and promote a desire to develop new initiatives in research and care in this field. Authors who are interested in editing a special issue should contact Dr. Monisha Akhtar at monisha_akhtar@hotmail.com

Registration No. - DELENG/2014/57400



Published, printed & edited by Dr. (Mrs.) Kiran Modi on behalf of UDAYAN CARE and printed at Ajanta Offset & Packaging Ltd., Plot No.61 Sector -27 -C, Faridabad-121003, and published at Udayan Care, 16-97 A, First Floor, Vikram Vihar, Lajpat Nagar-IV, New Delhi-110024.