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Mental Health

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The problem of promoting mental health, in the educational context, in a developing country like India, occupies high priority on the agenda for human development. In particular, attaining the goal of mental health for all by AD 2000 is critically related to planning and implementing educational programmes. Also, pursuing education and attaining its goals requires achieving an optimally minimum level of health for the learners and instructors. Any disturbance or disruption in this process is likely to create risks and health hazards. At the same time, the educational process itself may have implications for the health status of teachers, students and the community. In other words, there is a reciprocal relationship between the health status of the broader community and that in the educational context. Since the institutions and processes of education are embedded within the broader social, economic and cultural systems, a comprehensive treatment of the issues of mental health in the educational setting cannot be undertaken in isolation from the broader societal context (Philips, N., 1992; Ramlingaswami, P. 1990). This makes the task more difficult as the country is undergoing a rapid and large scale socio-economic transformation. With this in mind, the present chapter presents a selective review of work done in the area of mental health, with special reference to the education context.

Within the context of the educational system, the issues related to health may be conceptualised in terms of three components, namely: students, teachers, and the immediate school context within which instruction is imparted. These three elements may be briefly described as follows:

Students

The students come to the educational institution with certain explicit and implicit expectations from the school and schooling and are endowed with certain characteristics at the point of entry. Thus, the family environment, the personality make-up and other dispositions (e.g., aptitudes, interests, abilities), assets and liabilities of a learner prepare him or her uniquely to interact with the school or college in healthy and productive or unhealthy and destructive ways. Considerable individual differences do exist in these characteristics. Health problems may arise due to incompatibility between the demands of the educational system and the characteristics of learners, or between learners' expectations and the educational processes, or both. Such incompatibilities are becoming more and more salient in the context of increasing competition in the job market, increased pressure for achievement from parents, uncertain future, and parental aspirations and

their desire for compensation through their progeny. Failure in examination, underachievement, and the resulting frustration are becoming prominent features of educational life at school as well as at the higher educational levels, leading to a wide range of health problems having far-reaching consequences for individual as well as societal well-being. This is reflected in a recent analysis of suicide among children and adolescents. Shah, G., Parkar, S. and Maheshwari, R. (1993) noted that failure in love affairs, failure in examination, and unemployment constitute the major causes of suicidal behaviour.

Teachers

Traditionally, the teaching job enjoyed a considerably high level of prestige and only dedicated and selected individuals joined this profession. The teachers were usually held in very high esteem by the different sections of people, and society was sensitive enough to take care of the needs of teachers. With the changing socio-economic scenario and increasing unemployment, the values of teachers and their professional concerns associated with the job have forcibly undergone a change. Many of them are now treating 'teaching' like any other profession, and making money has become very important. Extrinsic motivation has become important for them. Notwithstanding this fact the stresses and hassles of teachers have also increased. The economic condition of teachers also varies, depending on the nature and type of institutions they belong to. Their stresses often spillover from work to the family setting and vice versa. The changing relations between the teachers and the students also create problems (Crank, K. 1987). Under these conditions, the participation of teachers in the educational process is often rated to be at below the optimum level of functioning.

The Educational Process

The functioning of the educational process itself may become a source of stress and strain and ill health for its participants. This partly may be due to lack of the necessary aptitude and attitude in the learner and the instructor or in the features of the educational process (e.g., course content, teaching method, interaction pattern, climate, rewards and punishment, evaluation system). The problems related to these features oftentimes vary with the developmental stage of the learner. For instance, the load of the school bag has recently become an issue of deep concern for the educationists (MHRD 1993). It has been felt that small children are unnecessarily subjected to physical exertion by asking them to carry greater weight, both mental and physical, than what they can manage. Teaching strategies and behavioural styles of teachers are also potential sources of stress and strain if they do not respond adequately and effectively to the needs of the children. This point has been effectively demonstrated in a recent study by Roy, G.C.; Sinha, R.K. and Hassan, M. (1994) who found that under the nurturant task style of headship, the socioemotional climate was better than under the democratic and authoritarian styles. The students showed more mischievous activities under the authoritarian style and were more studious under the nurturant task style. In addition, the mode of classroom interaction, the social milieu and the physical environment of the institution play an important role in healthy regulation of the teaching process.

The health problems in the educational setting are multiplicative in nature. The three components described above do not operate in isolation. Oftentimes the different features reinforce each other and make the adaptive demands more complex. As a recent study by Verma, S. and Gupta, J. (1990) has shown, the academic stress among adolescents was caused chiefly by the examination system, the burden of homework, and the attitudes of parents and teachers. Their stress symptoms encompassed all the three areas, i.e., physiological, psychological and behavioural.

PREVIOUS REVIEWS: AN OVERVIEW

Although mental health constitutes an important facet of the educational process, it has not received sufficient attention by the researchers. (For early treatment of this topic in the international context, see Bernard, H.W. 1970; Wall, W.D. 1955). As a result, the previous reviews in education and allied disciplines could only partly and peripherally cover this domain. In the Indian context several reviews have been undertaken. Buch, M.B.'s (1972) review on educational psychology in the first ICSSR survey of psychology refers to studies on adjustment, correlates of academic achievement and personal problems. In the First Educational Survey, Rao, T.V.; Mehta, P. and Rao, M.L. (1974) have contributed a chapter on personality, learning and motivation based on a review of doctoral works. It included six Ph.D. studies on adjustment, four on neuroticism, four on aggression and anxiety and five on topics like fear, security-insecurity, frustration and shyness and personality of juvenile delinquents. The reviewers noted a predominance of instrument-dependent research, more focus on student's sample and less concern with teachers. The studies were largely exploratory in nature and showed no impact of earlier studies. In the same survey, Dave, P.N. (1974) has reviewed the correlates of achievement and similar trends were noted. In the Second Survey, Rao, T.V.; Mehta, P. and Rao, M.L. (1979) reviewed doctoral and other studies in the area of personality, learning and motivation. The personality of juvenile delinquents and adjustment problems continued to be the important topics. The reviewers noted that the studies do not go beyond survey and comparison. Dave, P.N. and Anand, C.L. (1979) had reviewed the correlates of achievement, and more or less common trends were deciphered. In the Third Survey, brought out by the NCERT, Anand, C.L. and Padma, M.S. (1987) have reported trends on correlates of achievement. It is documented that anxiety, self-concept and adjustment influence academic performance and academic adjustment.

In the Fourth Educational Survey brought out by NCERT, Panda, K.C. (1991) has contributed a chapter on psychology of education. He has noted that the studies focus on personality characteristics of different groups of children (e.g., mentally retarded, drop-outs, emotionally disturbed, sportsmen, political affiliation, and unemployed youth), parental deprivation, and relationship of personality with various factors, including adjustment. Stress management among school-teachers has received some attention. Stress was found to be negatively related to the level of job satisfaction. Addressing the issues of mental health and adjustment, attention has been directed to teacher-stress and burn out, student stress, and stress among the unemployed. Adjustment problems of different groups, including tribals, have been related to personality and other background variables. Clinical and psycho-analytic studies of deviance have revealed the role of child-rearing practices. Correlates of mental health and effects of anxiety and tension on the achievement of students have also been examined, and intervention for anxiety reduction has received some attention. Padma, M.S. (1991) has reviewed the correlates of achievement. Studies indicate a negative relationship between anxiety and achievement. Security-insecurity has also been related to adjustment problems.

Satyavati, K. (1988) has reviewed Indian researches on mental health in the third ICSSR survey in psychology. This review also discusses the problems of educational counselling/ guidance and juvenile delinquency. In the same review, Verma, S.K. (1988) has contributed a chapter on mental health and treatment. He has reported the findings of epidemiological studies on the student population. Also, behaviour modification and other treatment methods are described. Thus these reviews do furnish the evidence that mental health in relation to educational processes had received some

attention from researchers but no attempt was made to examine mental health and related issues in their own right.

CONCEPT OF HEALTH AND ILLNESS

Conceptualising 'health' unequivocally and in a way acceptable to everybody has proved to be a great challenge for the students of health. The complexity of this issue is revealed in an interesting recent analysis of health and illness as represented in different segments of the population (Capewell, S. 1994). It was noted that differences in language, attitudes and expectations result due to differences in the perspectives of the social and community groups (popular arena), non-professional helpers (folk arena) and scientific medicine (professional arena). Often doctor-patient relationships happen to be transactions between disease (medical) and illness (social) models of sickness. The layman's definitions are important as they moderate the want of health and the subjective view of the people. Srinivasmurthy, R. and Wig, N.N. (1993) have noted that there is considerable variety in the views on mental health and illness across lay people, medical practioners and social scientists. However, following WHO's proposition, health is increasingly being treated as not merely absence of illness but a positive state of well-being. Following Sushrut, the great Indian scholar of *Ayurveda*, Sinha, D. (1990) has brought into focus man's symbiotic relationship with the environment and included physical, mental and spiritual well-being within the orbit of health. From this angle, health is a state of delight, of a feeling of spiritual, physical and mental well-being. The concepts of stress, suffering and coping have also been analysed from different perspectives, including indigenous ones (Murthy, R.S. 1993; Pestonjee, D.M. 1992; Raina, B.L. 1990; Sharma, S. 1988; Singh, T.; Misra, G.; and Varma, S. (in press); Wig, N.N. 1990). In most of these efforts the transactional and contextual perspective has received greater weightage, in which the notion of person-in-environment as a unit has become crucial. In recent years attention has been paid to theoretical and empirical analysis of various concepts. Thus Daguar, B.S. (1988) has analysed the concept of anxiety—and concluded that it is a distressing psycho-physiological reaction ensuing out of apprehended uncertainty of one's moral integrity, competence and embeddedness. Misra, G. and Jain, U. (1991) and Jain, U. and Misra, G. (1991) have used an innovative approach to analyse the subjective construction of anxiety in Indian students.

The contextual nature of health-related issues is borne out by a number of studies in which gender differences have been noted. For instance, Bhogle, S. and Murthy, V.N. (1990) observed that fear of success was greater in girls and closely associated with feminine sex-role orientation. Kumar, P. and Jadeja, C.B. (1993) noted that female students entertain larger number of sex-related myths than male students. Reddy, S.V. and Nagarathnamma, B. (1993) have observed better health state in girls than boys. Gupta, A. and Bonnell, P. (1993) found that female college students distinguish between mental illness and other afflictions more than boys. Males believed more in the efficacy of treatment, while females perceived mental illness as less likely to be attributable to inadequate, deprived or poor interpersonal experiences.

DEVELOPMENT OF NEW MEASURES

Development of adequate tools to assess various aspects of health/illness is a prerequisite for scientific analysis of various related issues. Also, it is important for diagnosis, follow-up and evaluation of the impact of any health programme. During the present review period some studies have appeared which deal with this problem.

Anand, S.P. (1988) has developed a mental health scale (neuroticism) for adults (teachers). Pradhan, S.L. (1988) has tried to develop psychological tests for differential diagnosis of

mental disorders. On the basis of comparison of performance of psychiatric referrals and normals, he noted that the Mosaic Test is a very powerful tool to tap the behavioural patterns involved in different mental disorders. In contrast, the Insecurity and Inferiority Questionnaire and the Tennessee Self-Concept Rating Scale were less powerful (but useful) in differentiating the response patterns across different mental disorders. On the whole, a quantitative relationship between the pattern of test performance and differential diagnosis of mental disorders was evident.

Jai Prakash, I. and Bhogle, S. (1992) have reported norms for different age-groups (15-19 to 60-64 years) for Benton's Visual Retention Test which assesses visual perception, visual memory and visuo-constructive abilities. In a subsequent study, Jai Prakash, I. and Bhogle, S. (1994) factor-analysed a coping check-list and found 13 factors. The female students used more emotion-oriented coping which was related to distress. Odera, P. and Hassan, Q. (1993) have developed a measure to assess the difficulties of foreign students in India. It has eight factors, including relations with the host steward, stress due to habits and lifestyles of the hosts, treatment meted out, pleasantness of interaction, suspiciousness of host-guest relations, reaction to unfamiliar people and situations, accommodation and crowding and problems of interaction and choice. Dalal, A.K. (1993) has developed Disability Attitude-Belief-Behaviour (DABB) Instrument useful for various types of disabilities.

A LIFE-SPAN PERSPECTIVE ON HEALTH

Health concerns and problems tend to vary across different stages of human life. This is largely due to changes in the external environment, changes in the extent of vulnerability, stress tolerance, functioning of immune system, physical strength and capability. All this necessitates a life-span perspective more pertinent to the analysis of health problems. The salient features of health problems during different stages emerging from the studies reviewed are summarised as follows:

Problems of Mental Health at Various Stages of Childhood

The mental health problems during childhood are often analysed under the speciality of developmental psychopathology. In a recent analysis, Kapur, M. (1993) has considered it as an emergent discipline in which much work is yet to be undertaken. However, data on the incidence of various types of disorders are gradually being obtained (Kapoor, M.; Kellam, S.; Tartes, R. and Wilson, R. 1992; Malhotra, S.; Malhotra, A. and Varma, V.K., 1992; Mehta, S.R., 1982; Prabhu, G.G., 1987 and Prasad, B. 1993).

Childhood is the most vulnerable period in the entire life-span of man. On the one hand, the child is generally dependent on adults and happens to be the centre figure in the family. On the other, it is the period with the maximum potential for prevention of emotional and behavioural problems. In recent years, emotional and behavioural difficulties (EMB) in children are receiving greater attention (Chazen, M.; Laing, A.F. and Davies, D., 1994; Cooper, P.; Smith, C.J. and Upton, G., 1994; Gray, J. and Richer, J. 1988; Upton, G. and Cooper, P., 1990; Varma, V.P. 1990). EMB is replacing the use of the terms 'maladjustment' and 'behaviour disorder'. Rather than being treated as a 'latency' period, childhood is considered as a 'critical' period. As Erikson, E.H. (1950) noted, lack of appropriate skills during this period of life results in the sense of inadequacy and inferiority. It is a period of significant growth, characterised by achievement of independence, consolidation of physical skills, success in school subjects, development of understanding and interaction with peers. EMB includes three types of behaviours, i.e., anti-social (over-reacting), withdrawn (under-reacting) and mixed pattern. The danger signals for EMB include

deterioration in school work, restlessness, and lack of interest in school. These behaviours are caused by medical/physical, home background, and school environmental factors. Coping with these problems includes behavioural management, social skills training, group work and group support and cognitive structuring/ restructuring (Booth, T.; Potts, P. and Swann, W., 1987; Copper, P., 1993; Copley, B. and Forryan, B. 1987; Molner, A. and Lindquist, B. 1989; Stone, L. 1990). Within the ecosystemic framework Tyler, K. (1992) has proposed that problem behaviour is a product of social interaction. Therefore intervention has to focus on those interactional systems which maintain and promote various behaviours. Indian researchers have paid considerable attention to the different types of problems encountered during childhood. Manjuvani, E. (1990) found that in Class VIII to Class X children, home environment explained variation in the three mental health components, i.e., assets, liabilities and index. The school environment also contributed to liabilities and index. Vijaylalita, K.Y. (1989) noted that lateral dominance had significant influence on behaviour pathology. Left-handers reported greater pathology. However, pathogenic parental interaction was similar in both the groups. It correlated significantly with behaviour pathology. Low birth-weight and being the first-born were related to left-handedness. However, the IQ of the two groups was not different. Close relatives of left-handers were more frequently left-handed. School interaction, lateralisation, SES and age contributed 57% of variance in behaviour pathology.

Chashoo, F.A. (1992) examined the role of parental variables in behavioural disorders. It was found that marital status was different in disordered and in normal children. The fathers of the disordered children showed theoretical and religious values and mothers aesthetic values. The incidence of suppression of aggression, seclusion of mother, ascendance of mother, avoidance of communication and ignoring the child was more frequent in the group of disordered children. Brar, S. and Brar, S.S. (1990) have reported that child-rearing attitudes fostering dependency, and marital conflict contributed significantly to behavioural problems in children. Jose, K. (1990) had investigated the family dynamics of maladjustment. Working on families of psychotics and normals, it was observed that sons of Manic Depressive Psychotics (MDP) suffer from paranoid personality disorders and more mothers and daughters of MDP suffer from Schizophrenic Personality Disorders (SDP). Schizophrenia in wives was correlated with Histrionic Personality Disorder (HPD) in husbands. Agarwal, A. (1989) found that orphans are more neurotic, depressive, submissive and anxiety prone. They express greater use of defense mechanisms and show low academic achievement.

Sorubarani, S. (1991) found that the use of punishment decreased the self-concept of school-going children. Highly educated parents used more punishment. The positive approach increased with self-concept. No sex difference was noted in the incidence of abuses. They were similar in working and school-going children. The use of punishment did not influence the self-concept of working children. Singh, S. (1990) has examined the educational programmes for reformation of delinquents. Raychaudhari, J. (1989) noted developmental changes in aggressive reactions. Such reactions did not indicate sex differences. However, SES and intelligence were significantly related to disorders. Achievement was positively related to intraggression and negatively to extraggression.

Physical disability is caused by multiple factors. Low SES, rural background, vitamin deficiency and malnutrition constitute some of its important correlates. Some researchers have identified the personality correlates of children having disorders and handicaps. Thus Kureshi, A. and Jain, N. (1992) noted that the handicapped were characterised by greater need for aggression, abasement, endurance and less

succorance, dominance, deference and exhibition than the normals. Sood, P. (1994) has reported that children with learning disabilities showed greater anxiety, low self-concept and low reasoning ability. Depression has been found to be greater in learning-disabled children (Sethia, P.; Sinha, S.P. and Saxena, S. 1994). It has been observed that the process of integrating the handicapped needs policy changes and social transformation (Sen, A. 1988).

Sex differences have been noted in some studies. Rozario, J. et al. (1991) have examined the pattern of adjustment in disturbed and non-disturbed students as visualised by teachers. It was noted that while school and peer relationships were crucial for boys, home, school and teachers were important in the case of girls. Girls are also found to experience greater degree of worry than boys (Sud, A. 1991). Singh, A and Broota, A. (1992) found that girls were more test anxious, worrisome and emotional than boys. Parental pressure and the parents' professional background also influenced the degree of test anxiety experienced. Ranganathan, N. (1988) has examined stress symptoms in children. Padmasri, J.V. (1992) has investigated stressful life events in the school system and noted that boys experienced greater stress which was negatively related to health. Muralidharan, R. et al. (1991) have undertaken a mental health programme for Class VII children.

Thus it is evident that researchers have generally paid greater attention to the contribution of family environment and parental characteristics towards the health status of children.

Adolescents

The period of adolescence has traditionally been considered as a locus of largescale psycho-physiological and social changes of great significance. Rapid growth spurt, dramatic endocrinal changes and upsurge of sexual maturation make it a very distinct stage. The developmental problems having implications for mental health include variation in attaining pubertal landmarks, menstruation and breast development in girls, and nocturnal emissions, masturbation and acne in boys. Also, related problems with more psychological undercurrents are premarital sex, sexually transmitted diseases (STD), disinterest in studies, smoking, use of drugs and alcohol. In contemporary India, mass media, socio-economic transformation, and modernization (Chakraborty, A. 1990) are posing important challenges in adjustment and coping for adolescents. Mukhi, S. (1991) notes that the physical environment has changed a lot but the pace of change in the human environment is limited. Shah, B. (1991) has noted that boys from a positive home-climate were better adjusted in school than those from a poor home-climate. In the case of girls, in urban areas family climate has been found to be positively related to school adjustment. In rural areas the opposite results are found. The effect of family climate on adjustment varied with SES, intelligence, sex and locality of the adolescents. The prevalence rate of health hazards has been estimated at 6.42% (Rozario, J.; Kapur, M. and Kaliaperumal, D. 1990) with greater disturbance at the age of 13 years in boys, resulting in poor academic performance and adjustment.

Sapru, A.K. (1988) examined personality pattern and reactions to frustration in high and higher secondary schoolboys of Srinagar. The introverts and normals differed significantly on group-conformity rating. Delinquency-prone and normals differed in ego-defence and need-persistence. Neurotics and normals differed on ego-defence, while introverts and normals differed on intragression. Multiple regression analysis revealed that group conformity was predicted by extragression, need persistence, proneness to disease, intragression, extraversion, obstacle dominance, ego-defence and imagression. Broota, A.; Mirakhur, D. and Singh, A. (1992) found that Class X students have greater examination anxiety than Class XII students and high-anxious students showed type-A behaviour pattern and low achievement.

Rayalu, R.T. (1990) compared the fears of Indian and British adolescents and found that neuroticism and fear were positively related among the British boys. Extraversion was negatively related to the fear score. Boys were found to be more intelligent than girls. Girls were more phobic and had high fear score. The boys showed greater extraversion and psychoticism while girls showed more neuroticism. British adolescents scored higher on the intelligence test. Indian adolescents showed more phobic tendency and fear than the British, who showed greater degree of neuroticism. A content analysis showed that Indians' fears dealt with failure, hosts and living away from the family. In contrast, fear among the British included sexual assault, mental illness, drugs, offensive odour and being ugly. It was recommended that counselling service for the 'at-risk-adolescents' is needed.

Kaur, F. (1990) found that females experienced greater loneliness than males. They were relatively more anxious and depressed. Males expressed greater hopelessness. In males, loneliness was positively related to hopelessness and external locus of control. Loneliness was not related to sex-role orientation. Emptiness and isolation emerged as the major cause of loneliness. While males attributed loneliness to a selfish world and uncertain and bleak future, females emphasised the feelings of low esteem. Watching TV and engagement in some work were the main strategies to cope with loneliness. More recently, Upmanyu, V.V.; Sehgal, R. and Upmanyu, S. (1994) have reported that in their sample of university students social deviance increased the probability of loneliness for introverts. Loneliness was structurally unrelated to anxiety, neuroticism and social desirability.

Anand, S.P. (1989) found that the mental health of children was dependent upon the educational and occupational status of parents. Sound mental health was positively related to academic achievement, and both of them were positively related to parental status. The degree of mental health was also related to the type of school, being the highest in convent schools, followed by Sainik, DAV and DM schools, respectively.

Mamta, R. (1988) compared personality and frustration reactions among accepted and non-accepted 12-13-year old girls of Class VIII in Agra. It was noted that parentally accepted students differed in affiliation, change and order needs. Differences in all aspects of reactions to frustration were significant except the extrapunitive direction of aggression. No difference was found on the measure of achievement need. Need persistence was significantly related to achievement, affiliation and change needs among the acceptors. Obstacle dominance was related to change and order needs. In non-acceptors, the relationships were not significant except between need for order and persistence, and achievement need and ego defence and persistence reactions.

Youth as a stage is characterised by responsibility, goal-setting and preparation for a family life. However, it is only recently that the category of youth has begun to emerge as a group whose health-needs require better understanding and special attention.

Allem, S. (1992) found that male university students share a cluster of personality disorders, consisting of anti-social, borderline, histrionic narcissistic and avoidant, dependent, passive-aggressive and obsessive-compulsive in nature more than females. However, paranoid, schizoid and schizophrenic tendencies were common to male as well as female students.

Evans, G.W.; Palsane, M.N. and D'Souza (1983) have analysed the pattern of life stresses in the Indian setting. They note that the relationship between life stress and illness is weak. A study of life events and strains by Albuquerque, Z.M. et al. (1990) revealed that college students experienced about five life events in one year and had to undergo a mild degree of distress. The males reported relatively

greater degree of distress. The majority of such events were experienced in the educational domain, followed by health. Bereavement and financial loss were more distressing. The female students reported greater degree of subjective distress than male students. Gada, M. (1987) observed that the prevalence of depression is increasing at the rate of 3% per annum. In a study of university students, Agrawal, M. and Naidu, R.K. (1988) reported that undesirable events, and not the change predicted, the degree of strain as related to stress.

Problems of the Aged

Systematic studies of aged population are of recent origin. Sunanda, Y. (1991) found that middle-aged people show greater extragression and imaggression and obstacle dominance. Life-satisfaction was high in the middle-aged and urban people. Middle-aged and advanced middle-aged non-urban people accept life conditions more easily. People with more extragression and imagression and obstacle dominance and need persistence showed greater degree of life-satisfaction. High life-satisfaction and high self-acceptance were positively related. Intragressive and ego-defensive reactions were related to low self-acceptance due to changes of aging and low life-satisfaction. Social networks are found to moderate the health status of the aged (Willigen, J.V.; Chadha, N.K. and Kedia, S. 1994).

MENTAL HEALTH OF TEACHERS

With increasing emphasis on consumerism and economic values and changed priorities in life, the teaching profession is increasingly becoming more stressful (AMMA 1986). Kamau, C.W. (1992) has examined burn-out and mental health among the teachers. Male teachers were found to be emotionally overextended, exhausted, internally controlled, anxiety-ridden, callous toward students, more personally accomplished, and less capable of establishing constructive relationships. They were more capable of coping with ordinary demands and stresses of life as compared to females. Urban high-school teachers were less emotionally overextended, less satisfied, more internally controlled, anxious, and had poorer mental health than rural teachers. Government school-teachers, trained, married and those with internal control were more concerned with their well-being, less anxious, less emotionally overextended, more competent, more internally controlled than their counterparts.

Das, M.J. (1989) examined mental health of primary school children. The teachers (50%) reported that the workload was heavy and the relationship between teacher and the authority was not satisfactory. Teachers (60%) were well respected by the students. Different pay-scales were perceived as major factors creating friction. The teachers perceived that they are neglected by the society. It was opined that a more supportive social environment is needed for good mental health of teachers.

Mishra, K.N. and Panda, K.C. (1992) found that internally controlled teachers sorted out differences with headmasters even at the cost of neglecting their own concerns. They were obliging and avoided complications. Externally controlled teachers ignore the expectations or concern of their seniors and subordinates.

Das, M.J. (1989) noted that different aspects of burn-out, i.e., emotional exhaustion, depersonalisation and personal accomplishment were related to demographic background factors. The teachers viewed their work as joy, and rewarding. They experienced burn-out due to physical and emotional strain. Panda, R. (1990) has observed that the working life does not influence the perception of the family. Subcultural differences emerged in certain aspects of family environment. The Bengali family was found to be more advanced in the perception of their family environment. Work and subcultural groups interacted to influence the degree of independence and control. Working

housewives felt emotionally more exhausted than non-working housewives. The non-working housewives experienced greater degree of depersonalisation but had less stress than working housewives. Singh, H. (1989) has investigated burn-out among teachers.

HEALTH/STRESS AMONG OTHER PROFESSIONS

Many researchers have analysed the stress experienced in other professions. Mohapatra, C. (1992) noted significant differences in the degree of job stress experienced by police officers, lawyers and doctors. The lawyers and doctors differed in the degree of mental health. Lawyers differed in the area of coping from the other two groups. Lawyers and police officers differed in general unhappiness and vulnerability feelings. Mohanty, S. (1992) found that private sector executives in general experienced a greater degree of job stress and mental health problems and perceived greater organizational support than their public sector counterparts. They used problem focused coping to a greater extent. Also, the pattern of stress and coping differed between frontline and middle line executives. Agashe, C.D. (1991) observed that psychoticism and neuroticism were negatively related and extraversion positively related to mental health among players and non-players. Participation in physical exercise contributed to positive mental health. Reen, M. (1989) observed that non-employed married women had greater neuroticism than employed married women.

DRUG ADDICTION

The problems of drug addiction and alcoholism are assuming alarming proportions. Their incidence has increased as a result of new life-styles, particularly among the youth in big cities and metropolitan centres. In fact, some researchers have coined the phrase 'lifestyle diseases' to refer to health-related consequences of social, cultural, political and psychological demands on the people (Jha, S.S. 1994). The lifestyle of the young generally involves higher risk-taking pattern. They adopt a short-term time perspective and a relaxed attitude to seek pleasure and fun. Much of their behaviour is hazardous to health. Drug use, problem drinking, tobacco use, problems related to sexual behaviour, injuries and violence, and stress of certain types are common lifestyle diseases having long-term consequences.

In recent years, drug addiction has become a serious health hazard. Sreekumar, S.K. (1992) has analysed drug addiction and alcoholism among college students in Kerala (n=25,000). The results showed that 20.72% students were alcoholic. The male students were more addicted than the females and urban students were more involved in alcoholism than rural. Also, students from the professional stream were more involved in it than arts students. Also, high-SES students were found to be more involved than low-SES students. A similar pattern emerged about drug addiction. Inadequate parental control and peer-group pressure, freedom and unhappy family atmosphere emerged as major factors responsible for pathological behaviours. Conflicts with parents and poor self-concept are common in drug addicts (Gupta, P. and Nalwa, V. 1986).

Sharma, H.I. (1990) studied drug addiction among adolescents in Manipur. It was found that 1% population of adolescents used drugs and depressants. Unsatisfactory home, health, and emotional adjustment, nuclear type of family, addicted working partners, hostile parental attitude, strict parental control, non creative action and high income emerged as important contributors to the incidence of drug addition. Similarly, Arora, N. (1992) noted that extramarital relationship, unfulfilled ambition, excessive leisure and money, lack of a male child, pathological family model, frustration in love, alienation, anxiety, bereavement, weak personality, and neglect of basic needs were the main background factors associated with

alcoholism and drug addiction. Alcohol addicts hold low theoretical values, low positive attitude toward self, low environmental mastery and health status. The drug addicts score significantly lower on measures of integration, autonomy, environmental mastery, and total mental health status (Shylaja, H. and Sunanda Raj, H.S. 1994).

TREATMENT

Prevention and treatment of diseases, and rehabilitation linked with social, psychological and cultural variables in recent years has changed the health scenario. Fatal diseases are being prevented to a large extent. Life expectancy has increased from 32 to 59 years. However, longevity has led to increase in aging-related degenerative diseases. There is increase in chronic diseases (Srinivasmurthy, R. and Wig, N.N. 1993). The cultural aspects of health, including attitude, life-style, personal characteristics, etc., have become more important. Now there is recognition of plurality in perspective and a shift from biomedical to a socio-medical model, and health is being considered as a right (Voluntary Health Association of India, 1992; Gillespie, S. and McNeill, G. 1992).

Effective intervention is very crucial for restoring health and well-being. Some researchers have put in efforts in this direction. In recent years such interventions have been explored in various systems of healing, particularly the indigenous ones. Kakar, S. (1982) has given a vivid account of such practices used by Shamans and mystics. Balodhi, J.P. (1990) has discussed the traditional Indian therapies, including Vedic, Upanishadic, Ayurvedic and Yogic ones. Kumar, K. (1988) tried to examine the impact of Yoga teaching for 24 hours spread-over six months on Class VII, Class IX and Class XI students. It could not yield the expected changes in personality, creativity, attitude and classroom attentiveness. Srivastava, P. (1989) studied the symptoms, treatment and rehabilitation of drug addicts and alcoholics. Drug addiction appeared to be a disease of a socially permissive society where drugs are relatively more accessible. From this angle, the age-group of 15-30 years is most vulnerable. Adverse life conditions, stress, broken home, middle and lower economic strata irrespective of caste, low or average intelligence, social stress of criticism, involvement in risky occupation, upper strata-aristocratic status and personality differences are noted as important factors leading to drug addiction.

ANXIETY REDUCTION

Gupta, A. (1992) found that test anxiety influences performance negatively on moderately difficult tasks among the high test-anxious—high-intelligence group but not in the low-test anxious—high-intelligence group. Systematic rational restructuring improved performance of the former group (high school subject). Jain, P. (1990) used the progressive muscle relaxation (PMR) and cognitive methods, and a combination of these two to treat Dysmenorrhea (mustard pain). PMR was found to be most effective in reducing its symptoms.

Broota, A. and Dhir, R. (1990) and Broota, A. and Parekh, C. (1994) found that the Broota relaxation technique, consisting of yoga and auto-suggestion, was better than Jacobason's relaxation technique. Sood, P. (1993) has used cognitive therapy to reduce test anxiety. Looking at the cognitive factors, Sud, A. and Katoch, S. (1994) observed that the middle point of assessment is more anxiety-provoking on task-debilitating cognition. In contrast, task-facilitating positive evaluation was greater in the high scholastic students. In another study, Sood, P. (1994) has demonstrated the efficacy of attentional skills training in moderating worry-state, emotionality-state, anxiety-interference and task-generated interference. On the other hand, cognitive modelling was found to be limited to worry-state and task-generated interference.

The National Institute of Mental Health has run group parent training programmes. These dealt with the nature and medical aspects of mental handicap, speech and language aspects, skill training and use of behaviour modification. They included lectures, demonstrations and role-play. The results showed significant effects on parental behaviour (Peshawaria, R. et al. 1991). Another interesting attempt has been made by Rajendran, R. and Kaliappan, K.V. (1990). They used behavioural programmes (e.g., relaxation training, study skills training, systematic desensitisation, assertive training, and audio-visual programmes) to deal with personal inadequacy, fear of failure and interpersonal difficulty in Class VII and Class IX students. Recovery from illness is related to a number of psychological factors among which beliefs are very important. It was found to be moderated by cosmic beliefs (Agarwal, M. and Dalal, A.K. 1993), Karma (Naidu, R.K. 1986) and Anasakti (Detachment) (Panda, N. and Naidu, R.K. 1992).

In a recent analysis, Hans, G. (1994) has proposed that there is need for lifestyle education for the Indian youth. Its objectives include the following:

(i) to inculcate good health as a value;
(ii) to understand the relationship between health and one's lifestyle;
(iii) to acquire knowledge on major health problems amongst the youth;
(iv) to seek health-related information and process, its relevance to one's personal family and the social context;
(v) to acquire knowledge and develop skill for living a healthy lifestyle; and
(vi) to identify the health needs of the students.

This programme should be based on students' initiative so that in the process of its implementation students develop the values of good health and take most decisions in life on the basis of their appropriateness to sound physical, mental and social health. Provisions for student's guidance and consultancy have to be made.

HEALTH EDUCATION AND PLANNING FOR HEALTH PROMOTION

Health education stands for the strategies related to information, education, and communication directed toward transmitting knowledge, attitude and beliefs among people towards maintaining health and promoting pro-health behaviours. This is important because, as Mane, P. (1994) has rightly remarked, most health problems merit action prior to the onset of 'ill health' and therefore, creating an environment conducive to physical and emotional well-being becomes pertinent.

The problem of health education and promoting positive action is a challenge having several facets, i.e., cultural, economic, social, educational and maturational. During childhood health care extends to include nutritional interventions, immunization and health monitoring (Murlidharan, R. and Kaul, V. 1993; Phadke, S. 1993; Swaminathan, M. 1993). A variety of programmes have been initiated by different agencies to meet the demands of different groups of children, particularly from the deprived sections of the society, and those having special needs (Kaur, B. and Karanth, P. 1993). Involvement of the community in health care and extension of health care services to the different sections of society has been emphasized since long (Bhore Committee Report 1946) and subsequent developments in the arena of the National Mental Health Programme (NMHP) show some positive changes. The NMHP was accepted for India in 1982. Its objectives are:

(i) To ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the majority population;
(ii) to encourage application of mental health knowledge in general health care and in

social development; and

(iii) to provide community participation in the mental health service development and to stimulate efforts towards self-help in the community.

A National Policy for Children (NPC) was adopted in 1974 which, in addition to other welfare measures, stressed covering all children by a comprehensive health programme. Subsequently, a variety of programmes, such as the Integrated Child Development Services (ICDS), the Integrated Education for Disabled Children (IEDC), and the District Rehabilitation Centre (DRC) Scheme, were adopted. It clearly recognized the need for child mental health and emphasized nutrition, immunisation, and school health programmes. In the NMHP, the role of the education sector in mental health care was clearly articulated. It stated that "social, behavioural and learning problems are manifesting themselves in schools. The addition of mental health inputs in the school health programmes is likely to play a major role in their amelioration. Teachers should, therefore, be given adequate orientation in early diagnosis of most of the common mental health problems" (p.15). In addition, attention was to be given to the needs of specific groups of children suffering from different types of handicaps and disabilities.

However, a review of achievements while implementing the NMHP led Srinivasamurthy, R. (1992) to conclude that "the implementation of the 'child' component of the mental health programme has not been as satisfactory as that relating to adult problems" (p.84). He noted that the policy and programmes in India are oftentimes influenced by international trends and international funding goals. These are not in harmony with the overall needs of children and the developmental stage of the services. This also makes the goals less realistic. The changes introduced in this process are often confusing and make the programme less successful.

At present specialised health facilities and provision for teaching and training are available at PGI, Chandigarh, NIMHANS, Bangalore, and the National Institute for the Mentally Handicapped at Secunderabad. The Child Guidance Clinics were estimated to be 120 in 1989. As Malhotra, S. (1992) has noted, "although the prevailing conditions are far from satisfactory and much needs to be achieved, certain positive policies emerging at the national level are significant. It is understood, for instance, that economic and social progress must parallel the support for human development. The interests of children are being given priority in national planning and broad-based public policies in support of children are taking shape. If these national policies can be translated into reasonably successful programmes, an improvement in the situation of children by the end of the century may be envisaged" (p.10).

In a recent evaluation of the progress made in the field of mental health in India, Srinivasamurthy, R. and Wig, N.N. (1993) have recognized that there is plurality in approaches to health and disease, and gradually the masses are moving toward a medical model. Also they noted that this plurality involves overlap as well as contradictions. As a more viable framework to analyse health, the authors prefer the 'paradigm of field of health'. It has four components namely, human biology, environment, lifestyles and health-care organisations. Until recently, attention has been concentrated on the fourth component only and the environmental factors and lifestyle have been neglected. The situation in India is unique as it has a unique opportunity to maximise the incorporation of new mental health knowledge gained over the last century into social policy on mental health, so as to benefit its population by introducing a more holistic approach. It is felt that there is need to emphasise national as well as local realities. Indigenisation of mental health requires greater coordinated dialogue

among the different professionals working in this area (Rhode, J.; Chatterjee, M. and Morley, D. 1993).

With this context, there is today a need to revisit and re-examine, from a broader perspective, our notions of education and the role of the school in shaping the lives of students. There is a need to move beyond the narrow orientation of viewing education as a formal academic exercise, to recognise it as an important tool through which cultural processes are mediated and ideologies shaped. Education is the medium through which a society's philosophy of life is reflected. If health and illness have their genesis in larger socio-cultural processes, then a movement toward health would be the acknowledgement, that the school is the nurturant space; that the fertile soil on which matured and healthy minds could find a space to develop and express themselves. This has several important implications for the mental health of a society at large. Hence, research in the area of mental health also needs to direct itself towards the development of ideology based, socially responsible education.

EMERGING ISSUES AND AN AGENDA FOR FUTURE RESEARCH

The preceding review of studies in the field of mental health in the educational context reveals that the issues, findings and theoretical perspectives adopted in the available research studies present a mixed picture. While researchers have displayed continued interest and a tendency for fixation on certain topics, however, their scope has widened and some new problems have been explored. A critical appraisal of the available studies suggests the following trends:

1. At a paradigmatic level, the researchers have opted for an R-R type paradigm in which two response measures are assessed, usually through self-report instruments, and attempts are made to draw causal relationships between the two sets of variables. In most of these attempts the processes involved in the relationships are obscured. This limits the value of the findings.
2. Health is generally viewed as an individual-based phenomenon. In doing so, there is excessive reliance on treating the child and ignoring the context.
3. There is lack of clear recognition of health processes in the educational context. Barring a few studies on the environmental context, there is paucity of research on the processes underlying the health status.
4. The available researches are largely one-shot studies and no programatic and long-term efforts have been made to identify the trends in health-related variables and processes.
5. The issues of health in the different sections of society (e.g., disadvantaged, rural, tribal) have not yet been adequately crystallised. As a result, no concerted effort at health promotion has emerged.
6. The Indian society is currently undergoing large scale socio-cultural transformation owing to the introduction of effective mass media and increasing interaction with other cultures. Its effect, however, is being experienced differently in the diverse segments of the population. The changes in lifestyles, values and attitudes have serious implications for the health of adolescents and youth. This needs careful analysis. Infact, many of the school problems including adolescent school failure are symptomatic of social problems.
7. Schools need to be regarded as a social situation and interventions to help the adolescents have to adopt a multipronged strategy. The changes in socialisation (Sinha, D. 1988) under the influence of rearrangements in the family system and women's entry to employment outside the four walls of home have made new adaptational demands. The school

problems need to be viewed in this context.

8. There is need for educational provisions and policy initiatives for children with special needs.
9. So far the studies have been addressing the issue of well-being at theoretical levels and were confined to the analysis of variables and their relationships. We need greater focus on the practical aspects of health including training, study-skills training, awareness of mental health social-skills training, and enhancing the quality of teacher-student and parent-teacher interactions.
10. Intensive studies of adolescents and youth with a focus on lifestyle and its linkage with health and well-being are warranted.

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