MENTAL HEALTH IN INDIAN SCHOOLS

Malavika Kapur

Schools play a crucial and formative role in the development of children in every sense of the word. An important aspect that is often overlooked is that, in the process, schools can and do induce mental health problems. Recent studies show that nearly 20 per cent of all adolescents experience some form of emotional or behavioural disorder while 10 per cent of them suffer from serious mental ailments. Since schools have a profound influence on children, their families and the community, they are best placed to provide mental health services for children.

In this context, Malavika Kapur provides an experiential and interactive account of designing a mental health programme in a school setting in a developing country and despite the paucity of financial resources and trained personnel. She outlines strategies to sensitize teachers, provides a detailed account of training teachers to undertake counselling, and describes a successful school-based intervention. The approach evolved is holistic and culture-specific and includes both the child and the environment. It encompasses key issues of tools of assessment, process and content evaluation, and methodological problems across age, gender and socio-economic strata and in different school settings. The focus is not only on identification and referral but on intervention by trained teachers.

The book details intervention strategies to deal with specific problems such as emotional disorders, hyperkinetic conduct disorder and learning difficulties. An important feature is a descriptive account of an initiative to provide mental health services in a rural school. In conclusion, the author draws lessons for other developing countries from the work being done in India. She maintains that what is advocated in developed countries is often impractical in countries such as India.

Anecdotal, practical, simply written and based on the author's first-hand experience spanning twenty years, this book will be of considerable value to school teachers and administrators as well as to counsellors, child psychologists, those working in child guidance clinics, and those in the field of applied psychology in hospitals and universities.

Malavika Kapur is currently Additional Professor in the Department of Clinical Psychology at the National Institute of Mental Health and Neuro Sciences, Bangalore, where she has been since 1976. In the course of over three decades of clinical and teaching experience, she has been a clinical psychologist at the National Health Services, Scotland; Senior Research Associate at the University of Edinburgh; and on the Faculty at KMC Hospital, Manipal. Professor Kapur has undertaken various projects on behalf of organizations like the World Health Organization, the National Council of Educational Research and Training and the Indian Council of Social Science Research. She has contributed papers to various national and international journals, edited several books, and previously published *Mental Health of Indian Children*.

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BY THE SAME AUTHOR

MENTAL HEALTH OF INDIAN CHILDREN

■ Malavika Kapur ■

Despite the existence of sound policy guidelines, scant attention has been paid to the provision of services and funding or to setting up priorities for research and training for child mental health care in India. The aim of this book is to sensitize those who work with children to various aspects associated with child mental health. The book describes and evaluates the various assessment and therapeutic techniques used with troubled children; discusses the nature of some specific disorders in terms of phenomenology, aetiology and intervention; and elaborates on various aspects of the family, school and community in which such troubled children are brought up.

This comprehensive volume provides a culturally appropriate and holistic perspective as against the segmented approach followed by Western therapeutic models. Written in a simple style, this book will be of interest to a wide audience including those involved with child psychology, clinical psychology, education, social work, psychiatry, paediatrics and family studies.

> ...this pioneering work will go a long way in stimulating interest in developmental psychotherapy and thereby contribute to its advancement in the days ahead.
>
> *Deccan Herald*

> ...contribute(s) to child mental health knowledge overall...praiseworthy attempt at highlighting what is applicable...within established theory and practice...
>
> *European Child & Adolescent Psychiatry*

> ...interesting reading...fills the need for a book specific to the Indian situation...a must for any mental health professional dealing with children and should be a reference book in the library.
>
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To
the future citizens
of India

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Preface

The present work has the modest aim of providing an experiential account of mental health services in school settings in developing countries, despite the paucity of trained professionals and financial resources.

Several ways of reaching out to the school population have been evolved and evaluated with some degree of success. If this book encourages at least some child mental health professionals, school authorities and teachers to go beyond their limited roles and reach out to the ever-increasing school population, it will be a reward to the author for sharing her experiences.

The work described may appear chaotic as the emphasis shifts from the child as consumer of mental health services, to the teacher as consumer of the training programmes aimed at providing these services, and the professional as the trainer. These conceptual ambiguities will be resolved if one looks at the child as the real client and the teacher as the conduit for services which the child needs. The professional has the expertise to provide the services but cannot do it due to the sheer magnitude of the problem. The author's work reflects the variety of innovative approaches to provide help for troubled children.

Chapter 1 gives the background to the school mental health programme, as well as the people and organizations responsible for it. Schools are the strongest social and educational institution available for intervention. The school can also act as a 'safety net', protecting children from hazards which affect their learning, development and psychological well-being. The World Health Organization, in a document entitled *Mental Health Programmes in Schools* brought out in 1994, makes a strong case for school mental health programmes to be initiated all over the world, citing

some of the work already carried out in the most-developed to the least-developed countries.

The present book aims to reach out to the administrators in the education sector on one hand, and teachers at the grass-roots level on the other, so that mental health service delivery can be carried out in school settings, by teachers with appropriate training and support. It is envisaged that school mental health work will include both the child and the environment and the approach adopted will be holistic. A series of surveys conducted in the past two decades in school settings in India are reviewed, highlighting the key issues of tools of assessment and methodological problems, along with some major findings amongst children, across ages, gender, socio-economic strata and school settings. The surveys are conceptualized as passing through five phases. These are epidemiology of incidental, descriptive, phenomenological, aetiological and interventive nature. The interventive epidemiology is suggested as the most desirable as it upholds the ethics of applied research.

Chapter 2 describes the child mental health intervention programmes conducted in school settings by different workers. It also gives a detailed experiential account of the author's own work from 1976. It deals with her work with 300 teachers, covering approximately 20,000 children, and describes the evolution and evaluation of strategies to sensitize teachers to the mental health problems of children, identify those who need help and refer them to appropriate agencies.

Chapter 3 describes the training in counselling carried out as the follow-up phase of the orientation course. It gives a detailed account of four training courses in counselling carried out in urban schools in Bangalore, and the lessons learnt. Process and outcome evaluation focusing on quantitative analysis is described, using an anecdotal approach, to highlight the problems encountered in the training situations, and to describe actual casework done by the teachers. In addition, a successful school-based intervention is described, where the mental health component was integrated into an ongoing school health project.

Chapter 4 details the development of some of the intervention strategies by mental health professionals to deal with specific problems such as emotional disorder, hyperkinetic conduct disorder and scholastic backwardness in school settings. These strategies are evaluated to test their efficacy, and can be employed for

small groups of children in school settings. These strategies can be used effectively by interested teachers, with some training.

Chapter 5 deals with initial efforts at providing mental health services in schools in rural areas. It gives a descriptive account of the problems encountered and possible strategies to resolve them. The marked differences in the strategies required in the urban and rural settings become obvious in the course of the work in rural schools.

Chapter 6 is a reappraisal of the process of evaluation of service delivery systems. It reflects the author's growing disenchantment with elaborate assessment measures. The chapter highlights, with illustrations, the need for simple indices for the evaluation of service delivery.

Chapter 7 scans the various policy documents related to children in India. Against the background of the difficulties in translating policies into action at the grass-roots level, the various aspects of the work described in the earlier chapters are highlighted in order to clarify the implications of the present work in the context of the policies.

Chapter 8 deals with the implications of the work in India for developing countries and in the global contexts, against the background of the WHO document, *Mental Health Programmes in Schools*.

The appendices provide (*a*) manual for orientation programme and developmental psychopathology checklists for teachers to gain insights into child mental health problems; (*b*) manual for training in counselling for trainers; and (*c*) supporting tables for those interested in the scientific background of the work which is narrated in a simple manner in the text.

Malavika Kapur

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I am indebted to Professor R.L. Kapur, former Professor of Community Psychiatry, my husband, for introducing me to the world of school mental health, and to Dr Illana Cariapa for collaborating with me in the early stages of the work. I gratefully acknowledge the help given by all former and present colleagues in the child and adolescent mental health unit, and M.Phil. and Ph.D. scholars for their support in all the school health programmes. I am also grateful to the members of the departments of Psychiatry, Psychiatric Social Work, Speech Pathology and Neurology for the help rendered whenever requested.

The continued support given at different points of time by the directors of NIMHANS, Drs R.M. Varma, G.N.N. Reddy and S.M. Channabasavanna is gratefully acknowledged. Professor G.G. Prabhu, former head of the Department of Clinical Psychology had been a source of the encouragement for the school mental health programme.

I owe a deep debt of gratitude to the Rockefeller Foundation for sponsoring the residency, at the Bellagio Study and Conference Centre, Italy. Without their help this work may not have seen the light of day.

To my teacher–friend, Bulbul Benjamin, I owe an enormous debt of gratitude for her loving labour over the draft manuscript.

But most of all, I owe a great deal to M.C. Pankaja, a schoolteacher, who taught me that a teacher can be a far better counsellor than a psychologist. She demonstrated that caring for people was not confined to the hours between 9.00 A.M. to 5.00 P.M. She and other teachers gave me courage of conviction that school mental health programmes can be successful in this country.

Malavika Kapur

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Introduction

The school mental health programme, as described in this book, has evolved from a programme initiated in 1976 at the behest of a voluntary agency, Medico Pastoral Association (MPA), of Bangalore, India. The agency, concerned over the lack of awareness amongst schoolteachers about the mental health problems of children, requested Prof. R.L. Kapur, then head of the Community Psychiatry Unit, National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore, to sponsor a programme to remedy the situation. He deputed the author, a clinical psychologist, and Illana Cariapa, a child psychiatrist, both from the teaching faculty of their respective departments, to initiate such a programme.

The MPA arranged for 28 teachers from various private, fee-paying schools to be deputed to attend the course conducted by NIMHANS. They also provided a convenient venue in the city, for teachers to meet. Since then, there have been several such programmes. Many clinical psychologists, psychiatrist and psychiatric social-worker colleagues have participated in the various programmes over the years. To name a few from the faculty: Drs Shivaprakash, Shoba Srinath, Shekar Seshadri and Satish Girimaji from the Department of Psychiatry; Drs Parthasarathy, S. Rajaram and V. Indiramma from the Department of Psychiatric Social Work; and H. Uma and J. Rozario from the Department of Clinical Psychology. In addition, post-graduate trainees from all the three specialities have unstintingly supported the project. The departments of Neurology and Speech Pathology, too, have often

helped out. At present the school mental health project is run by the Child and Adolescent Mental Health Unit, with which the author is associated.

The directors of NIMHANS—at various periods of time, Drs R.M. Varma, G.N.N. Reddy and S.M. Channabasavanna—have been very supportive of the school mental health programme. The programme has been carried out with no budget, with only transport costs provided and the time spared for the faculty by NIMHANS.

What started initially as a programme to sensitize teachers about mental health problems, and identify and refer needy children to the appropriate agencies, has grown into a package of innovative strategies of self-contained outreach programmes for interventions, of a kind undreamt of by the author in the late 1970s. The author finds it puzzling that even in the 1990s a large number of proposed school mental health programmes are being conducted in a manner similar to what her team did in 1976–80. The possibility that teachers could do more, even better than mental health professionals, has not yet been properly understood or fully appreciated.

What needs to be conveyed to teachers is a philosophy of caring for children. It is not being claimed that all teachers can be effective as counsellors. But most of them can be sensitized to identify and refer, while a few can indeed function as counsellors to help children troubled by mental health or academic problems.

While government policies in India for children have been forward-looking, the translation of these into action has often not been attempted; or where attempted, has not been very successful. The present work hopes to provide an experiential account so as to encourage both policy-makers and activists at the grass-roots level to initiate such work—to reach out to troubled children in Indian schools.

Schools play a crucial and a formative role in the spheres of cognitive, language, emotional, social and moral development of children. The role of schools in the emergence of mental health problems has hitherto been generally overlooked. However, there is now a growing recognition that schools have a significant role in producing such problems, due to the formative influence of schools on normal as well as abnormal development.

The mental health and well-being of children require our attention. All young people today face significant stresses in their lives;

many make it through their youth without major problems. However, nearly one in five children and adolescents will have emotional and behavioural disorders at some time in their youth,[1] regardless of region or socioeconomic status. Even by conservative estimates, 10 per cent of the child population suffers from mental disturbances with serious associated impairments, including learning problems, health problems and drug abuse, at any given time.[2] At least 3 per cent of school-age children suffer from serious emotional disturbances such as severe depression and suicidal thoughts, psychoses, serious attention problems, or obsessive compulsive disorder.[3]

In many parts of the world, families and schools are the strongest institutions in the child's life. Schools have an unprecedented opportunity to improve the lives of young people. With nations moving towards a commitment to universal education, schools are finding it necessary to expand their roles by providing health services to deal with the factors interfering with schooling.[4] Schools are currently the best placed to develop mental health programmes for children[5] because:

- Almost all children attend school sometime during their lives.
- Schools are often the strongest social and educational institutions available for intervention.
- Schools have a profound influence on children, their families and the community.
- Young people's ability and motivation to stay in school, to learn and utilize what they learn, is affected by their mental well-being.
- Schools can act as a safety net, protecting children from hazards which affect their learning, development and psychological well-being.
- In addition to the family, schools are crucial in building or undermining self-esteem and a sense of competence.
- School mental health programmes are effective in improving learning and well-being, and in treating psychological disorders.

A mental health programme should be part of a comprehensive health programme, including health instruction to teachers at all levels from primary to high school, easily accessible health services, a healthful, nurturing and safe environment, and interaction with

family and community organizations. The aim of school-based intervention is to provide an experience that will strengthen children's coping abilities to counter the environmental stresses and disadvantages encountered in their growing years. Some of the available comprehensive health initiatives have resulted in higher school attendance, enhanced academic success, fewer school dropouts and reduced criminal behaviour. Mental health and life skills education have been demonstrated to reduce drug use, alcohol consumption and cigarette smoking in children and adolescents.[6]

School-based intervention may be environment-centred or child-centred, and one may lead to the other.[7] The school environment refers to the 'living and learning climate' of the school. Environmental approaches aim at improving the educational climate and providing an opportunity for children to interact with a healthy school programme where they can find health role models. This positive environment includes the structure of the school day, structuring of playground activities and the physical structure of the school and classrooms. An environment-centred programme may also strive to enhance the ability of administrators, teachers and support staff to deal with specific kinds of behaviour; and prepare them to make use of agencies serving children. The Yale model developed by Comer[8] provides a coordinated collaborative effort to improve communication, understanding and respect between staff, students and parents. This provides a sense of direction and involvement with the programme. It has also been found to improve students' academic and behavioural performance over a period of time. This work is worth special mention as it has been continuing since its inception in 1968, and has covered a high-risk population in the inner city schools in Connecticut, USA, for almost 25 years. The success of the programme is of relevance, even in the Indian context.

Child-centred activities on the other hand, include individual mental health problems, and focus on interventions as well as general classroom programmes to improve coping skills.[9] The WHO report entitled *Mental Health Programmes in Schools*[10] documents various strategies adopted across nations, from the least to the most developed.

In the present book, the main focus is on schools which cater to the lower middle-class population. The Indian school system flows

in two streams: one is that of 'elitist' schools, catering to the upper middle class and upper socioeconomic strata; the other is the 'indifferent' kind of schooling provided to the majority of underprivileged children in the urban slums, as well as rural, tribal and the other socioeconomically backward communities. In some states in India, elitist education is obtained by paying a large donation and high annual school fees, with parents suffering the unnecessary burden of paying for private 'tuitions' outside regular classroom teaching. The burden that adults bear by choice pales into insignificance when compared to the plight of the children who have to bear the burden of the elitist education. For example, at the age of three years a child has to start learning to count up to a thousand, and read and write the alphabet. He/she has to pass an entrance examination to be admitted to the first standard by the age of five years! The years of primary, secondary and high school education become increasingly burdensome and stressful with various languages that have to be learnt, and an increasingly heavy load of syllabus. An unrealistic syllabus is devised by policy-makers and handed down, to the consternation of teachers and pupils alike, to be taught and learnt and evaluated in the limited time of the academic year. This is compounded by parental anxiety and expectation that the child has to become either a doctor or an engineer when s/he grows up. The outcome is that with six hours of schooling and four to six hours of homework and tuitions, there is no time for play, peer-interaction, reading for pleasure, or creative pursuits and hobbies which lay the foundation for a healthy psychosocial development. The author strongly believes that the elitist schools in the country are actively engaged in 'child labour' in the name of education. The National Council of Educational Research and Training (NCERT), New Delhi, which plays a pivotal role in the Indian educational system has been actively striving to change the system through its publications and video documentaries.

This book is an experiential account of the author's work, which is at the same time child- and environment-centred. The work which spans the years from 1976 to 1996, adopts an anecdotal approach to drive home the following points.

- What is advocated for, or works in, developed countries may not be applicable, and may even be impossible to carry out, in the developing countries, such as India.

- Strategies developed need to be holistic, as well as culture-specific, with regard to the problems encountered in school settings.
- Teachers, if sensitized, can function effectively with not just one group of students, but many such groups every years, as long as they remain in the profession.
- Mental health service strategy must be seen as a part of the educational and health service delivery in the school setting.
- The strategies employed must aim to develop skills in those who are already working with children in some other capacity, such as teachers, and not require extra funds. The funds available in health and education sectors in developing countries is limited and likely to remain so, or dwindle even further.
- The focus should not only be on identification and referral but also on intervention by trained teachers.
- The strategies developed should be simple to work with and evaluate, as teachers would be expected to carry out the tasks alongside their normal duties.

Mental health knowledge, attitudes and related behaviour, affect students and teachers. Early identification and intervention may prevent more serious problems later on, such as drug and alcohol abuse, school failure, dropouts, delinquency and low-level adult learning. The cost of these problems to individuals, families and communities is extremely high.[11] Children who come to school from backgrounds of poverty, violence, hopelessness and mental illness in their families, may present disruptive behaviour in schools. Children who are neglected, have poor mental health, and are lacking in skills to cope with stress are unlikely to do well in school or, subsequently, later in life.

In India, for instance, NCERT, which is an apex body involved in educational research and training, has included in its curriculum, a mental health counselling course designed by the Indira Gandhi National Open University (IGNOU).[12] Thus, a pivotal body, in principle, has considered a mental health component as essential to its curriculum.

At the state level, Andhra Pradesh has initiated a school health project with funding by the Overseas Development Agency (ODA),

UK, in 1991.[13] It is expected to cover all the government schools in a phased manner over a period of five years. The focus is on:

(*i*) health promotion and disease prevention;
(*ii*) screening and surveillance;
(*iii*) treatment.

This ambitious project aims at covering nine districts in the first year, and seven each in the second, third and fourth years.

The author, who was invited to hold a seminar on incorporating a school mental health component within the available framework, found that the top functionaries were totally in the dark about such a possibility. However, at the end of the day, the example of the work done in Bangalore could convince them that a teacher can be trained in the delivery of mental health services.

Indian work in school settings

- adult-focused epidemiology of the 1970s wherein a child population was studied as a part of the adult population in the community;
- descriptive epidemiology of the early 1980s where surveys were conducted in the community as well as in school settings to study the demographic characteristics and prevalence of child psychiatric disorders;
- phenomenological epidemiology of the middle and late 1980s, when surveys changed from being single-phase to two-stage designs, the detailed stage using interviews and various specially devised tools to study a child population to elicit various aspects of phenomenology;
- aetiological epidemiology followed closely by the phenomenological approach, as a natural sequel to study the biopsychosocial correlates of various disorders;
- interventive epidemiology of the 1990s is just emerging as a much desired model of epidemiology, mainly in the context of ethical considerations of research for the sake of research. Interventive epidemiology thus seems to be the ideal to strive for, for service-oriented research, especially in school settings.

In their evolution of the epidemiological surveys, the earlier ones used a single phase of screening, while those which came later, included a second phase of detailed investigation. Screening tools were initially cursory and idiosyncratic, while later ones were well thought out, and based on well-known and internationally standardized tools, such as Rutter's Childrens' Behaviour Questionnaire (CBQ) for teachers,[14] Reporting Questionnaire for Children (RQC) by Giel et al.,[15] Child Behaviour Check List (CBCL)[16] for parents, Teacher Report Form (TRF),[17] Youth Self Report (YSR) by Achenbach and co-workers, and Goldberg Health Questionnaire (GHQ).[18] These tools are helpful for the detailed study of a child population and for the study of phenomenology. In order to explore the aetiology and to evaluate interventions, a different methodology and tools of assessment are required. Tables 1.1, 1.2 and 1.3 present in brief, some of the studies conducted in India, using Western and indigenous tools of assessment.

Studies of different kinds of schools

In a series of studies[45] in 1983 on urban Karnataka, various kinds of school settings such as slum, corporation and convent schools were focused upon, using CBQ ratings by teachers. Neurotic trends were exhibited by children attending convent school while more antisocial traits were encountered in the slum schools. But when both kinds of problems, i.e., neurotic and antisocial traits, were combined together the prevalence rates remained similar. This seems to suggest that similar prevalence rates may not reflect the actual nature of problems in a particular school, unless they are specifically examined. In another study, a sample of 47 children in a certified school and 40 children in a child guidance clinic were compared. The extent of overall disturbance was highest in the certified school, followed by the child guidance clinic; the slum, convent and corporation schools had lower prevalence rates. Antisocial traits and neurotic problems were highest in the certified schools and the child guidance clinic. The study of child-rearing practices of the children from all the schools revealed that children from a higher social strata were overprotected and subjected to strict discipline, leading to neurotic problems. In contrast, the parents of the middle and lower strata ridiculed and rejected their

Table 1.1
Studies on Rural School Children

Investigator	*Year*	*Centre*	*Age Range*	*Population*	*Prevalence Rates*	*Tools*
Jiloha & Murthy[19]	1981	Raipur Rani (Haryana)	5–12	715	20% mental health problems 5.8% mental retardation 8.8% bed-wetting 2.1% stammering 1.6% epilepsy 2.23% disorders of emotion and conduct	RCQ
Parvathavardhini[20]	1983	Bannerghatta (Karnataka)	5–12	309	10.6% psychological disturbance 12.29% academic problems	CBQ
Mehta[21]	1993	Rural Delhi	6–12	2,055	12.38% psychiatric problems (14.53% in boys; 10.20% in girls) 22.23% academic problems	–
Smitha Ruckmini[22]	1994	Doddamalur (Karnataka)	5–12	271	13.6% (gender ratio being equal)	CBQ

Table 1.2
Studies on Urban School Children

Investigator	*Year*	*Centre*	*Age Range*	*Population*	*Prevalence in*		*Percentage T = Total*	*Tools*
					Boys	*Girls*		
Rao[23]	1978	Bangalore	13–16	428	18.80	22.80	19.92	GHQ (60 items)
John[24]	1980	Bangalore	9–12	98				
Rozario[25]	1988	Bangalore	12–16	1,371	11.27	1.47	6.42	CBQ
Dalal[26]	1989	Bangalore	12–16	665	–	–	50.68	GHQ (30 items)
Sarkar[27]	1990	Bangalore	8–11	408	8.96	12.43	10.54	CBQ
								CBCL (Parents)
Deivasigamani[28]	1990	Madurai	8–11	755	–	–	33.7	CBQ
Shenoy[29]	1992	Bangalore	5–8	1,535	–	–	18.31	CBQ
							19.80	(Teachers) CBCL
							27.17	(Parents)
Sood[30]	1993	Urban Delhi	6–11	375				CBCL

Table 1.3
Studies on Specific Disorders in Schools

Investigator	*Year*	*Centre*	*Disorder*	*Age Range*	*Population*	*Prevalence*	*Tool*
Khurana[31]	1980	Gujarat	Scholastic problems	4–14	100	–	–
Chawla et al.[32]	1981	Urban Delhi	Hyperkinesis	6–12	2,160	4.67	Author developed checklist
Chawla et al.[33]	1981	Urban Delhi	Conduct disorder	6–12	2,160	4.67	–
Chandrashekhar et al.[34]	1982	Rural Karnataka	Hysteria	–	134	18.6	–
John & Kapur[35]	1986	Urban Karnataka	Scholastic problems	8–12	–	–	Author developed battery
Gada[36]	1987	Urban Bombay	Hyperkinesis	5–10	321	8.1	–
Oommen et al.[37]	1987	Urban Karnataka	Hyperkinesis	4–10	400	4	Connor's Rating Scale
Nathawat & Bordia[38]	1988	Rajasthan	Hyperkinesis/ Impulsivity	9–11	100	–	Connor's Rating Scale Porteus Maze[39]
Venugopal & Prabhakar[40]	1988	Pondicherry	Scholastic problems	9–12	137	26.61	Myklebust rating scale[41]
John[42]	1989	Urban Karnataka	Scholastic problems	8–12	100	–	Author developed battery
Jandhyala[43]	1991	Andhra Pradesh	Scholastic problems	–	206	–	–
Sitholey[44]	1992	Uttar Pradesh	Hysteria	–	206	–	–

children and were harsh with them, suggesting that antisocial behaviour could thus be a product of a harsh upbringing.

In 1985, a study of 353 residential school children in the age range of 10 to 16 years in Karnataka,[46] reported a prevalence rate of 25 per cent on CBQ. The most frequently reported symptoms were irritability (71 per cent), telling lies (65 per cent), fearful and fussy (40 per cent each) aloof and withdrawn (39 per cent). A significantly greater extent of psychological disturbance was reported in the 11- to 12-year-olds and scholastic problems in 11- to 13-year-olds. Only 40 per cent had average or above average scholastic performance.

The above studies highlight some salient points, as seen in the school population.

- The symptoms manifested vary across age, from preschool years to adolescence.
- There is gender difference in the symptoms manifested, i.e., boys tend to have externalizing problems while girls have internalizing problems.
- Symptoms vary with the different kinds of schools, such as slum, rural, certified, fee-paying and non-fee-paying—in the overall prevalence rates and in the nature of symptoms manifested.
- The fewer the number of symptoms the less likely is the significant disturbance, with the exception of an occasional symptom which may be considered severe, such as running away or violent acts.
- The two major problems in the school setting are scholastic and mental health problems.
- Symptoms elicited from a single source may not give a comprehensive picture about the child. A teacher may be better informed about externalizing or scholastic problems, while parents may be more sensitive to internalizing and problems such as sleep disturbance or bed-wetting.
- Parents and teachers may be good informants for preschool, primary and middle school children, but in adolescents self-report is the main source of information.
- Family relationships, illnesses, stressors and temperament have significant protective or adverse influence on scholastic performance and mental health status of the children and adolescents.

Thus, there is a need to study all these complex relationships in the school setting in order to help troubled children.

Having made a case that the school mental health programme should be an essential component of the school system, the question is how to convince those within the school system at the various levels, especially the top level, to accept the programme.

The book has the following aims:

- to demonstrate to the top level policy-makers and administrators in the *education* and *health* sectors that a mental health component can effectively be incorporated into the existing healthcare and education systems, with the available financial and manpower resources.
- to persuade individual school authorities and teachers that this has been done, and that there are benefits to them, apart from the obvious benefits to the children.
- to provide a framework which can be used in other developing countries, where manpower and financial resources are scarce.

The book does not propose to offer ready-made packages applicable to different school settings in India or other countries, as each setting has a unique set of problems. It portrays a philosophy of evolving strategies for identification, referral, management and follow-up, suitable for each setting, using the available infrastructure at a low cost. The attempt is to describe an array of strategies which are not universally applicable, but are created to develop appropriate interventions at the grass-roots level. These are innovative approaches, with cultural sensitivity to the needs of children and their families, teachers and the community in general.

NOTES

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Interventions in school settings

The studies reported in this chapter do not deal with schools where mental health services and remediation for scholastic problems are provided by school psychologists, counsellors and remedial teachers, as in Western countries. The present chapter will briefly focus on the work undertaken in school settings in India, before giving a description of the work carried out by the author and her colleagues since 1976.

Bombay experience: Direct consultancy in collaboration with parents and teachers

In 1979, H.S. Dhavale of the Department of Psychiatry, B.Y.L. Nair Children's Hospital, Bombay, started a child mental health programme[1] with the aims of early identification, treatment, assessment of causative contributors of mental health problems and screening of a large number of school children. Schools were taken as the bases of operations, and the programme catered to children from the lower socioeconomic strata, who could not afford to seek help. Initially, groups of teachers and parents were met and the purpose of the project, the nature and management of child mental health problems were discussed. A team of psychiatric social workers, a clinical psychologist and a psychiatrist visited the schools, for the assessment of the children who has been referred.

From four schools 980 children were assessed. In 73.06 per cent of the children, problems such as enuresis, mental retardation, behavioural problems and hyperactivity were identified. A number

of recommendations were made to the education department, and initiatives such as starting special classes for mentally retarded children in specific localities, were taken.

The team found during the course of their work that the parents and teachers had no idea about mental health, and despite the orientation provided, they continued to refer children with physical problems.

In 1982, a school mental health clinic was set up in B.Y.L. Nair Children's Hospital to deal with child mental health problems in a more comprehensive manner, on a long-term basis. The clinic adopted a two-pronged approach. The team had discussions with, and gave lectures to, teachers and parents in different regional languages, using audio–visual aids in schools. The team also offered long-term therapy for the referred children, consisting of various models of therapy such as behaviour and family, on an individual basis and in group settings, in addition to drug management. The referrals came from the detection team at the schools, other out-patient facilities, teachers, social workers, self-referrals and from other organizations. The clinic was also made available to public schools.

In the course of 12 years, more than 15,000 children have been seen in the school mental health clinic. Nearly 70 per cent came with complaints of scholastic backwardness, and 50 per cent of these were found on evaluation to be mentally retarded. This necessitated screening of all the children in Class I. A workshop was conducted for providing guidance and counselling to the parents, paving the way to an active parents' self-help group. In addition, seminars and workshops on different aspects of therapy and recreational programmes for the children attending the clinic have been organized. Increased awareness has led to increased referrals, and teachers and parents are now more receptive to mental health initiatives, and cooperative.

The school mental health clinic also initiated an enrichment programme for one section of higher secondary students, i.e., for children with above-average intelligence, but who were academically backward. Various activities, projects, discussions, stimulation workshops and creativity camps were conducted. The programme was time-bound and lasted for three years. The evaluation showed that adolescents benefited from the programme.

In 1989, a study[2] among 42 teachers of their perception of the behaviour problems of a primary school population of 1,522 children, revealed the following: apart from scholastic problems, 72 children were considered as problem children, as against 229 who were considered non-problematic children. Interaction between parents and teachers was greater in the case of the problem children. A total of 110 people were addressed by the team—68 parents, 36 teachers and 4 administrative staff members. The interaction and discussions were healthy and cooperative. Frequent meetings of teachers and parents were suggested as the main method of solving several problems. The issues that emerged out of the study were: children from the lower socioeconomic strata, whose parents were less concerned about their children's education, had more problems in the classroom; children who were happy at home had fewer problems at school than those who were not.

Delhi experience

A study[3] of the perception among 75 primary schoolteachers in Delhi of childhood psychiatric problems was conducted. Case vignettes of four disorders, i.e., hyperkinetic syndrome, overanxiety, somatoform and learning disorders were used. Teachers were able to identify hyperkinesis but not the others. They also had a poor knowledge about their role in dealing with the problems. It was suggested that it was essential to enhance the ability of teachers *to identify and facilitate early intervention*.

Bangalore experience: Direct work with high school children

A student enrichment programme, suitable for rural and tribal high school students was developed in rural Karnataka.[4] In this programme the following inputs were given:

- how to study effectively;
- causes of and remedies for failures in examinations;
- characteristics of efficient students;
- preparing for examinations;
- prevention of health problems;

- knowing about self and others;
- causes of interpersonal difficulties;
- orientation to the future;
- pupil–teacher expectations;
- principles of mental health.

The programmes were classroom- as well as group-oriented, conducted over 25 sessions, and were time- and personnel-intensive. Teacher involvement in such enrichment programmes was considered as crucial by the mental health professionals who conducted the programme.

Evolution and evaluation of orientation programmes in school mental health[5]

In 1976, the first orientation programme for teachers on child mental health was conducted at the behest of the MPA in Bangalore.[6] The MPA arranged the venue for the orientation course, and 28 teachers deputed from different schools participated in the programme. The course was conducted in 13 sessions of lectures, case discussion, role play and summarized handouts of the lectures. Each session lasted two hours and was conducted once a week. Segmental inputs were given by several experts, though the main team consisted of a clinical psychologist (Malavika Kapur) and a child psychiatrist (Illana Cariapa). The participants were also given information about where to refer the identified cases of epilepsy, speech, language or psychiatric problems.

Out of 28 teachers, 18 attended the orientation course regularly, i.e., for more than eight sessions and were present for the evaluation *before* and *after* the course. At the end of the course, evaluation of three kinds was carried out.

The first was about the knowledge and attitudes of the participants before and after the course. A 20-item questionnaire revealed that *before* the orientation programme, 40 to 50 per cent of the teachers believed that corporal punishment was good, masturbation was bad for health, and that epilepsy could be controlled; 23 per cent each believed that quiet children learned better, and that asthma could be caused by emotional distress; teachers had a progressive attitude towards the nature of emotional and speech

problems, physical handicap, sex education and coeducational schooling, but many believed that quiet children learned better and children should be persuaded to write with the right hand even when they preferred to use the left hand. (For details see Appendix I, Table A1.)

These attitudes may vary amongst teachers from different schools. An assessment before the course would enable the supervisors to tailor the content of the orientation programme and their misconceptions could be clarified. One way of doing it is to actually read out the right answers soon after the initial assessment, and discuss the pros and cons openly with the participants. It is important to make the participants feel that their role in the process of evaluation is to enable the supervisors to communicate better with them. Teachers should never be made to feel that they are being examined.

The second kind of evaluation was of the various methods of teaching used in the programme. The trainee teachers were asked to rank the five techniques which had been adopted. These were lectures, handouts/summaries, case discussion, general discussion and role play. The ranking was done on two parameters of 'understandibility' and of being of interest. For example, the most understandable and interesting technique was ranked first, while the least understandable and interesting was ranked fifth. On the 'interest' parameter, lectures were given the highest rank, followed by case discussion and general discussion. Summaries and role play were assigned the last two ranks. (Appendix I, Table A2).

The third method of evaluation was that of the trainee teachers:

(*i*) The teachers were asked about the problems they thought they could deal with, within the school setting. The teachers felt confident about handling the problems of children and their peers two-thirds of the time, while they felt diffident most often with regards to problems of a financial nature or those involving parents and the fellow teachers.

(*ii*) The teachers had completed six fictitious case vignettes on handling some of the problems. Each of these was assessed independently by two supervisors. A score of 0 was allotted when the counselling potential was 'poor', 1 for 'mediocre' and 2 for 'good'. The two supervisors had an agreement percentage

of 94.4 (when the rating 0 and 1 were combined), which dropped to 66 (when 0 and 1 were rated separately), indicating that a more global evaluation of good potential can be done with a fair amount of reliability. The evaluation supports the contention that non-specialists, such as teachers, do possess counselling potential.

Evaluation of orientation courses in different schools

An important experiment was conducted in one of the schools catering to the slums of Shriramapuram.[7] The school had 6,230 students and 138 teachers on its rolls, but no counsellors.

The school was housed in temporary structures, had overcrowded classes and scarce teaching aids. It typified the learning environment available to most school children in India.

Since the number of teachers was large, and the problems of normal and abnormal development varied across the ages, the orientation courses were conducted separately for primary, middle school and high school teachers. In addition, an effort was made to deliver jargon-free lectures and discussions. This was facilitated by speaking in the local language. Earlier experience had revealed that experts tended to contradict themselves and there was a good deal of overlapping in what was being communicated. The team thus consisted of only the two supervisors. The topics focused upon in the primary school was different from that of middle and high school.

The technique consisted of brief lectures with case illustrations, followed by discussion by the group. Discussion was considered the most important aspect of learning and was encouraged greatly by the supervisors. It was observed that instead of dwelling on elusive aspects of personality and motivation of the teachers, it was more practical to rely on concrete responses to observations and situations.

A group of 111 teachers participated in the orientation programme which was conducted in three batches. Participation was voluntary. Though the school had 138 teachers nearly one-fourth of them did not choose to participate, due to a variety of reasons; because they were close to retirement or on leave, were assigned

other duties, or were simply not interested. The evaluation tools given in the manual, will enable the reader to follow the details of the orientation course, which formed the prototype for future orientation courses.

There were 45 male and 66 female teachers in the group, 92 were married and 19 were single. 37 teachers were in the 21–30-year age range, 17 in the 41–45-year age range. There were 81 teachers who had high school education and taught primary school. There were 30 who had university education and taught high school. The average teaching experience of the group was 12½ years. Out of the 111 teachers, 80 participated in the evaluation before and after the course and both groups were comparable in the various sociodemographic characteristics.

After the course, the performance of the teachers improved substantially on several parameters. There was (Appendix I, Table A3) significant increase in the concurrence with the supervisors in seven out of 11 items. These items were: children too can become mentally ill, poor performance at school may be due to defective vision or hearing, epilepsy can be controlled by medicines, asthma may be due to emotional disturbance, emotional disturbance can cause stammering, poor intelligence can be improved with drugs (with no as the answer) and a child with epilepsy can do as well in studies as other children.

The assessment of group performance showed significant improvement on the group average score before and after the course. The analysis of individual performance revealed that out of the 80 teachers, 65 per cent showed improvement and 35 per cent showed deterioration.

The counselling potential was measured through vignettes. Based on responses to the 10 vignettes before and after the orientation course, the trainee teachers were asked to describe how they would deal with children with the following problems:

(*i*) a child who is fearful of examinations;
(*ii*) a bright child who is inattentive in class;
(*iii*) a dull child who is inattentive;
(*iv*) a delinquent with a problem family;
(*v*) a child who is anxious because of an unreasonable teacher;
(*vi*) an unmarried pregnant girl;
(*vii*) a child who clings;

(*viii*) an adolescent who is unable to appear for examinations because of an unreasonable father;
(*ix*) a physically handicapped child;
(*x*) a child getting epileptic fits in class.

Of the above 10 vignettes, only the last three appeared to show improvement in the counselling potential, though there was overall improvement for all the 10 vignettes. (Appendix I, Table A4). However, as the recording of lengthy responses was cumbersome and time-consuming, it was decided to retain only the three vignettes that were most sensitive. As most of the children came from very deprived socioeconomic backgrounds, a vignette such as that of a bright and distractible child may have been an unfamiliar problem in that school. The vignette of an unreasonable teacher may have provoked personal anxieties in the teacher. The responses to the vignettes could be used to explore why a teacher had responded the way he/she did.

The method of examining counsellor potential through vignettes proved to be reliable, obviously because the teachers worked together as a team. What was more heartening was the finding that two other mental health professionals, who were not involved in the study, had high reliability in their rating of the counselling potential. An analysis of variance techniques demonstrated the correlation amongst the four raters: before the course—0.99, and after the course—0.88.

The above results may be stated simply, in a different manner. When an orientation course of the kind just described above, is conducted in any school, one-fourth of the teachers may not attend at all, while of those who attend only two-thirds would show improved performance, with 10 per cent exceptionally so. But one-third would not show improvement but may deteriorate. This is a pattern to be expected in most schools. It is the 66 per cent who improve, who will be relied upon to identify and refer the children with problems; and the 10 per cent with top performance, if trained adequately, will be able to manage the children with problems. *The expectation of mental health professionals and educationists that all teachers should be interested in mental health problems, can prove to be counterproductive in the long run.* Between 5 and 10 teachers in a school who are interested and motivated, in a group of 100 teachers, can take care of the problems of the children in the school setting.

An analysis of those who improved and those who did not, revealed certain interesting associations. University education had an inverse relationship with improvement. The explanation may lie not in the educational level, but the minimal contact that high school teachers with university education had with their adolescent students. They were also subject teachers and not class teachers. While in the primary school, the teachers were class teachers and had good and consistent contact with the children. Perhaps in order to know their pupils better, high schoolteachers might have to work hard at it, while such a close interaction would occur spontaneously and naturally between children and teachers in the primary school setting. It is also possible that adolescents may prefer to distance themselves from teachers due to peer pressure. This has important implications in working with adolescent groups and special efforts may be required to break the barrier. The need for use of self reports among adolescents to elicit distress (described in Chapter 2), reiterates the notion that adolescents need to be approached in a specially sensitive manner.

The foregoing analysis appears to suggest that it is easy to provide orientation courses in mental health problems in the school setting. Unfortunately, the two decades of experience in this field has not always been easy or encouraging. Several practical and problematic issues have emerged in the course of our work with approximately 350 teachers, covering a population of 25,000 children in the school setting.

Not all school authorities and management are interested in such programmes whether the schools concerned are aided, partly aided or fee-paying. The principal of a central school, when approached, said,'we have no problems at all. We don't need such a programme!' There have been schools which invited us, but failed to provide space to conduct the course, or inform teachers or encourage them to attend. We have had representatives of the school management or headmasters sitting through the sessions, not because they were interested, but to check whether any subversive activities were being encouraged by the visiting team. In such cases, it has been necessary to alleviate their anxieties by demonstrating how the visiting team had only the children's best interests at heart. We have had principals who participated fully, as against those in whose absence the teachers became spontaneous, interested and involved in the programme. Some authorities remained inflexible about the timing, sparing teachers to participate

and other practical issues. Often, they held that such programmes could be accommodated only if they did not cut into the teachers' regular teaching schedules and responsibilities.

It must be made clear that for the orientation programme to succeed, the school has to cooperate and be accommodating, which in turn is reciprocated by the visiting team. By yielding to inflexibility, the orientation programme may become totally marginalized and ineffective. These issues should be negotiated with both frankness and diplomacy, to lead to a mutually beneficial endeavour and not a one-sided affair. The above-mentioned problems indicate that sufficient ground work has to be done with the school management. The school authorities should feel that the programme is to their benefit, and the programme should be accommodated in a reasonable manner, *within* the working hours of school and teachers freed from their duties to *attend* six to seven sessions. The content of the course should be explained and it should be highlighted that the programme would benefit the school.

In addition, we have always offered consultancy services during the period of the orientation course, once a week, over a period of six to seven weeks, by asking the authorities and teachers to refer children with problems and arrange parents to meet the team. This not only helps the children, it also convinces the school authorities that the visiting team is sufficiently concerned to offer professional services. This also opens the door to future referrals. The visibility index of the team helps in setting up a liaison between schools and child guidance services, which would otherwise fail to be effective.

Teacher resistance

When a group of teachers in any school are met for the first time, they often come with several apprehensions about the programme. The first and foremost apprehension is that a lot of extra work is going to be foisted on them, with the authorities colluding with the outside team. The second is that they would be required to attend the programme, whether they like it or not. It is a good practice to bring out these fears, anxieties and resentments into the open freely, in the first meeting with the teachers. The first session may be exclusively devoted to a free discussion about the issues the teachers are justifiably concerned over, such as being overburdened by extra duties. At this point some negotiation with the authorities

too may be required. The timing of the sessions should be scheduled so as to be mutually convenient. Genuine appreciation should be shown where teachers are overworked and trying to do their best under very difficult circumstances. It must be made abundantly clear that they should attend the programme out of their own choice and not under pressure or compulsion.

Often, the first session starts with a sense of foreboding and pessimism. By using the group process skilfully, it is possible to get interested and optimistic teachers to be involved in the orientation programme. It is advisable to describe the content of the programme in brief, and leave the teachers to suggest in what ways it could benefit them. Unless there is a shift from a pessimistic to an optimistic response by the majority of the group, the programme is doomed to fail. An aggressive stance by the teachers should be countered by a non-confrontationist approach. It must be highlighted that 'caring for others' is a difficult job and that it has to be done voluntarily and not for any rewards, financial or otherwise. This process involves genuine respect for teachers, their integrity and concern, and this should be conveyed to them. The teachers must be portrayed as caring adults who will decide for themselves whether they will put in the little extra effort to help troubled children.

In addition, examples could be given of how overactive or scholastically backward children can be helped, and how it would make the management of the class easier for teachers. At the end of such, often stormy sessions, if the resistance does not melt away, one may have to abandon the programme. However, we have never had an encounter where teachers remained resistant. Thus, the first session of dealing effectively with teacher resistance is an important one. At the end of the session the pre-assessment questionnaire may be given, with the explanation that it enables the team to tailor the programme to suit the needs of the teachers. They will also be told that only group responses will be discussed and not individual ones. Some teachers, who are very diffident, may copy what their neighbour writes or request that the questionnaire could be taken home and filled up. A very rigid stance about filling the questionnaire may be counterproductive. It is better to lose a questionnaire than a teacher!

Parent resistance

As the goal of the programme is to reach out to children, the authorities and teachers should be requested to take parents into confidence, and information about consultancy services should be given to them. In addition, parent–teacher meetings may be arranged and the issues which surface during the orientation programme may be discussed. In schools catering to the upper strata of society, issues of overexpectation, overburdening through tuitions, absence of play and aspects of normal development could be discussed. With parents from poor socioeconomic backgrounds, issues of absence of play, understimulation, child labour, alcoholism at home and their impact on childrens' emotional well-being, and scholastic performance could be focused on. These should be tailored to suit the needs of the particular school and problems which occur in that community setting.

Other orientation programmes

Between 1976 and 1977, several orientation programmes have been conducted in public schools, rural schools, institutions for the deaf, for the orthopaedically handicapped, residential schools, and for the staff of orphanages and certified schools. It is often necessary to add extra components to suit the setting from which the teachers come. The following description is from one of the most comprehensive programmes, and its mental health component was integrated into the school health project. Details are provided to demonstrate the aspects which make a programme successful. In the present chapter, only the aspects of the orientation programme are described, while the training in counselling is given in the next chapter.

The orientation programme was conducted in the Sevashrama High School located in the slums of Shriramapuram, Bangalore, where an orientation programme was conducted for the entire school.[8] In 1988 the school health project sponsored a team from NIMHANS to add a mental health component. The project covered the primary school population and monitored the health and academic status of all the children, on a longitudinal basis. It was funded by voluntary agencies at different phases of the work. Of the 42 primary schoolteachers 21 were recruited to the school

health project. They had already attended several lectures by the school health team, on hygiene, nutrition, common illnesses, first aid, etc., over 20 sessions. The coordinator also maintained a file on each child identified as having problems, from the time of joining the school till he/she completed Class IV.

The 21 teachers attended the orientation programme over six sessions. Subsequently they were trained in the use of Kannada and Tamil versions of CBQ for screening the children. The data revealed that of the 1,735 children (from nursery to Class IV), 481 children were screened, of which 199 children (nearly 40 per cent) had mental health problems. Of the 199, 84 had scholastic problems. Of this group, 251 children had irregular school attendance. However, there was an interesting relationship between teacher expectation and rating on scholastic performance. Teachers who did not expect their students to do well did not rate them as having a poor scholastic performance. This trend has been witnessed in many of the slum and rural schools.

To sum up, orientation programmes can be conducted in a large number of schools. These need to be tailored to suit the needs of the school community. Such programmes can successfully sensitize teachers to the mental health and scholastic problems of children, and train them to identify and refer them to appropriate agencies. The manual of the orientation programmes along with the tools of evaluation are given in Appendix II. The manual can be used by teachers to understand child mental health problems. It can also be used by the trainers to provide the content of the orientation course.

NOTES

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three

Training in counselling

The idea that teachers can be trained in the management of mental health problems has been met with incredulity from mental health professionals, school administrators and even by teachers themselves. This is not to claim that training in counselling is an easy task and has always been successful. An attempt is made to demonstrate, through the experiential account in this chapter, that it is possible to do so, at least with some teachers. We do not claim that all teachers can be trained to do counselling.

Though several schools had requested for our orientation programmes, which is the first phase of our work, the offer of training in counselling (the second phase) free of cost within the school premises, had very few takers. To be precise, only four schools opted for training, which was to be spread over an entire academic year.

First encounter

After the orientation programme described in Chapter 2, the first batch of trainees were given training in counselling.[1] The training in counselling consisted of a series of lectures on how to formulate and manage the cases. Of the 28 teachers who were deputed from various schools for the orientation programme, nine opted for the second phase of training in counselling. The content of the course and the working up of cases and the evaluation component is described in the form of a manual entitled 'Process in Counselling' (Appendix III).

The training process

The training involved the simple method of assessing the extent to which trainees evaluate their own performance against the standards set by supervisors. This self-training was an essential part of the training process. In practice, even in higher centres of learning, this is often neglected. There were no formal lectures and the document, 'Process in Counselling' formed the basis for initial discussion. The teacher trainees were expected to present cases on the format given. Of the nine teachers, two were males. Their average age was 40 years, and they had an average teaching experience of 14 years. All of them were trained teachers and seven of them had university degrees. All of them had adequate verbal proficiency in English to present and discuss the cases.

The training was conducted over 12 sessions, of 90 minutes duration each. During each of these sessions, one of the trainees would describe a real-life problem she/he had encountered in the school setting. In addition, she/he described what has been done about the problem or what one could do to resolve it. The presentation was followed by a discussion among the group members. The presentation was first examined in a constructively critical manner, focusing on issues such as additional information required and possible interpretations; in short, whatever was required for a better understanding of the child. Second, the management of the case was discussed, as a joint effort between the group members and supervisors.

The process of monitoring individual and group contribution was discussed in an open and candid manner in the very first session. A relaxed interaction was the main feature of these sessions. For example, one teacher laughingly told fellow trainees,'I will buy you all *masala dosa* if you give me high ratings for my presentation'. The group became a gathering of friends and not of critics, and there was an easy camaradarie among members. Four basic rules were followed by the group members and supervisors.

First, individual members were not to bring into the focus personal issues or problems, as these could raise anxieties and hostilities among other members. If there was a personal problem a teacher was anxious to talk about, it could be taken up in confidence with the supervisors but not in the group.

Second, group evaluation did not permit unbridled criticism. Direct criticism of individual members or their actions was to be

avoided. Suggestions were welcome with regard to what more could be done about the cases presented. Direct and confrontationist statements were discouraged. The group was also encouraged to function in a creative manner. Monopolizing of discussion by a few members was discouraged, in order to enable all the members to function with ease.

Third, the members were made to feel that they had the potential for the creativity required to be effective counsellors. Monitoring was carried out to enhance creativity. For example, the group participation score would not be rated as high, if one merely asked for information which had already been given by the presenter, or asked a question which had already been asked. Adding any new information, observation, clarification or suggestion rated higher scores. This encouraged group members to be attentive and to contribute in a creative manner. These three points were observed in a stringent manner, in all the sessions.

Fourth, the members were told that the eventual aim was to enable them to function independently of the supervisors. Though the supervisors participated very actively initially, they expected the group to take over their function. Thus, in the later sessions, the supervisors would wait till everyone had contributed, and would present their observations only if it was absolutely essential. This enabled the group to develop a sense of independence, and the confidence that supervisors considered the group members to be mature individuals, capable of handling situations encountered in the school setting.

Two kinds of evaluation were carried out. One on the quality of presentation and the other on that of discussion by the group. The evaluation was made on a four-point scale, with 0 for poor performance, 1 for adequate performance, 2 for good performance and 3 for excellent performance.

(*i*) Evaluation of quality of the case presentation of the trainees by the self, others and the supervisors was carried out on the following four parameters (Appendix I, Table A5)
  (*a*) ability to collect historical information;
  (*b*) ability to observe the child;
  (*c*) ability to formulate the case;
  (*d*) ability to plan a course of management.

The trainees found historical information and observation easier to comprehend than formulation and management. Subsequently extra efforts were made to explain these further.

(*ii*) Evaluation was carried out of the contribution to the discussion by self, others and the supervisors.

The three kinds of evaluation made were:

(*a*) trainee's self-evaluation
(*b*) group evaluation
(*c*) supervisor evaluation

An analysis of the discrepancy ratings by individual trainees, the group as a whole and the supervisors, over the 12 sessions, was carried out (Appendix I, Table A6). It revealed significant correlation between self and supervisors, group and supervisors but not self and group (which was basically the same). There was a negative correlation between the discrepancy ratings and the number of sessions. This meant that the discrepancy in the ratings made by self, group and supervisors decreased as the sessions progressed. In other words, the group members approximated the supervisors' assessment, indicating that the group was ready to take over the function of the supervisors by the end of the 12th session.

Each member of the group as well as the supervisors assessed the participation of each of the members, including the two supervisors. The rating was done on a three-point scale, with 0 for poor, 1 for moderate and 2 for good participation. Over the sessions there was a positive correlation indicating increased group participation over the session.

At the end of this particular training programme, the supervisors were satisfied that the group could function independently as counsellors in their own schools. On completion of the course, the trainees were told that they could meet the supervisors once a month. However, a year passed with no contact between the trainee teachers and supervisors. At the end of the year the supervisors arranged to meet the group for a feedback. This was an eyeopener for the supervisors. The trainee teachers were satisfied with the training they had received and felt that they were competent to deal with children in their schools. Unfortunately no one recognized them as counsellors. Nor did the headmaster and other

teachers know how to identify and refer the cases to them. In reality the trainee teachers had the expertise, but no clients! Some of them had taken up problem children in their own classes and managed them, but could not do anything for the rest of the children in their schools.

Second encounter

At this point of time (in 1978) came the request from Sevashrama High School for an orientation programme for the entire school, the details of which are given in Chapter 2. The headmaster himself was trained as a counsellor in the first batch. The following is the account of the second phase in the above school, where the programme (1978) was carried out with better results.

The Training in Counselling Programme began in August 1979. By this time the assessment tools described in the foregoing analysis were used routinely during the sessions and further statistical analysis was not carried out. The following account is a descriptive one, illustrating the manner in which the course was conducted and the kinds of cases presented, based on the log entries made at that time.

In the first session, 13 teachers were present. The discussion focused upon the difficulties of accommodating their regular classwork with the training programme. It was pointed out that commitment and regularity of attendance was essential. Those who found it hard to accommodate themselves to these requirements were encouraged to withdraw from the group.

The second session dealt with the four components of case presentation, which have already been described. During the discussion the following clarifications were sought by the trainee teachers:

- Was information about heredity required? Would only the details of the family background suffice? It was conveyed that family history of illness such as mental illness, mental retardation, alcoholism or epilepsy was necessary only if it had a bearing on the child's current problem.
- Would changes in the environment cause problems in children? They would, if they were factors such as sickness, or desertion by a parent, death in the family, birth of a sibling, change of school or neighbourhood and so on.

- How would one observe the child? This was illustrated in the class on interview techniques and through some role play activities.
- What would one do if the versions about the child's problem varied between the parents themselves? This was often the case—not only between the parents, but also between the teacher and the parents, and amongst the teachers themselves. In the case of marked differences, one would have to judge and rely on the account of the person who had spent the most time with the child and had observed the child more closely. However, each person's account would add a new dimension to the child's problem and give a better overall picture.

In the third session, the interviewing techniques were described. It was highlighted that if a child could develop a good relationship with the teacher, the child would freely express his/her problems. The session focused on methods of establishing a good relationship. One teacher suggested that one could take the child to see a film, so that he/she would develop more confidence in the teacher. Other teachers pointed out that the next day the child might brag to other children that he/she had gone to see a film with the teacher. Perhaps with such an intense relationship with the teacher, the child might develop hatred towards his parents who gave him nothing. Another teacher pointed out there were better ways of establishing a good relationship, which did not involve offering such 'bribes'. It was pointed out that a course of action taken with one child should be applicable also to other children, otherwise it would be an unrealistic solution. The teachers had a discussion on how to establish good relationships without going overboard and creating needless problems.

In the fourth session, a case of an orphaned child was presented by Mr P. The format was discussed and a rota for presentation for the entire group was drawn up. The next 25 sessions, consisted mostly of case presentations, and the follow-up of the cases presented at different points of time, in addition to occasional role play and feedback sessions.

A description of seven of the cases presented during the training sessions is provided, to give an idea of the kind of problems presented and the nature of work carried out by the teachers.

Case 1

Mrs K. presented a case of a 15-year-old girl who had developed episodes of fainting spells, followed by chest pain and also 'possession states', when she claimed that she was a goddess. She usually had these attacks at around 4.30 P.M. when she was about to return home from school.

She was the youngest of three children. Her elder brother and sister were married and lived separately with their respective spouses. Her father worked as an attender in an office, in a distant part of the city and came home only during the weekends.

When Mrs K. asked the girl about her problems, she burst into tears and wept for a long time and eventually revealed the source of her conflict. She wished to avoid going home, as her mother was having an affair with a man, who visited their home in the evenings. The girl was upset about her mother's behaviour, but was afraid to tell her father as she was fearful of the consequences. In recent weeks, the man had started making passes at her. Consequently, she was afraid of going home. It was clear that her fear and anxiety affected her mind, to produce spells of unconsciousness. This in turn, enabled her to delay going home. It was highlighted that such symptoms were not deliberately produced, but came up in the face of unbearable stressors—often without solutions. These kinds of physical manifestation of stress are fairly common in children and adolescents.

The girl talked to Mrs K. about the problem over several sessions. This resulted in the disappearance of the symptoms. Mrs K. was asked to continue to work with the girl as the solution to the problem was not found during the sessions. Mrs K. reported that she has persuaded the family to be together by telling the father that he was needed at home every day, so that their teenaged daughter had adequate supervision and protection, without bringing out the mother's 'affair' into the open. This case was used to demonstrate how hysterical symptoms were produced in relation to stressors and how they could be removed by relieving the cause of distress and bringing about changes in the environment. The case exemplified a sensitive management of a potentially explosive social problem. In addition, Mrs K. subsequently involved the girl in various cultural activities in the school, to give creative expression

to her flair for dramatization. Some teachers even thought that she should be married early, as is customary in her community, in order to avoid such problems in the future.

Case 2

Mr R.P. presented the case of a 16-year-old boy, who missed classes regularly in order to go to the movies, and persistently failed to do his homework assignments. He played truant along with a group of friends. The problems started when he was 12-years-old and changed his school in Class VIII. He was a resident in the orphanage attached to the school, where Mr R.P. was a warden. The boy had no father; his mother was sick, and lived in a destitute home in Tamil Nadu. She had pinned all her hopes on him, believing that when he grew up, he would take care of her. The boy spent his days fooling around, singing film songs, mimicking film stars and generally entertaining his friends. His scrapbooks were filled with pictures of film stars. He would sell his school books to see films. When given money to hire a bicycle to go to the market to fetch vegetables for the orphanage, he would walk and save the money to go to the movies. When confronted by Mr R.P., he would weep and promise that he would correct himself. Neither advice nor punishment had any effect on him.

Mr R.P., decided that something had to be done to remedy the situation, to shift the boy's focus from the world of fantasy to reality. Mr R.P. took him through a series of real-life situations in order to introduce him to reality. First, he introduced him to the secretary of a film fan association of a particularly popular film star. The secretary revealed that he was not genuine fan, but a paid employee, who had to put up posters, garland the large billboard cutouts with the star's picture on them, arrange processions to celebrate film premiere shows and so on. Next, Mr R.P. took the boy to the modest home of a film extra in their neighbourhood. The film extra was dressed in ordinary clothes and lived in an ordinary tenement flat. He talked to the boy about the hard life led by most people in the film industry, where big money and status were mere illusions. Subsequently, Mr R.P. took the boy to a film shoot of a stunt scene starring his favourite star. As the boy watched the shooting with great excitement, he discovered that his hero was not doing any of the stunt scenes himself!

Following these experiences, the boy gradually settled down to study and matriculated that year and went on to become an apprentice in a factory. The casework illustrates a very innovative yet caring approach to bring to earth an adolescent with a rich fantasy life. It is a sad yet realistic solution. One wonders what would have happened if the adolescent had stayed on in his unreal world.

Case 3

Mrs T. presented a case of an 11-year-old child who had become extremely withdrawn, stopped wearing clothes and going to school three years earlier. His father was a factory worker, the mother a schoolteacher who was also Mrs T.'s colleague. The child had an 8-year-old sister and a 3-year-old brother.

Three years earlier, when the child was studying in Class II his academic performance was average. His younger brother was also born around that time. His mother was very ambitious about his studies. He could not achieve what his mother expected of him. He used to get headaches often. His mother felt that being a teacher's son, he should top the class. On a particular day, three years ago, his mother had discovered that he had failed in mathematics. She was very upset and angry. She had removed his clothes, beat him mercilessly in the presence of neighbours, and locked him in a room at night without dinner. From the next day he refused to go out, wear clothes or talk to anyone.

This had unpleasant repercussions on the mother's life. Others around her called her the mother of a mad child. She stopped socializing because of such humiliating experiences. Mrs T. noticed that the mother herself had become quiet and withdrawn. She invited the mother to a function at her house, and got her to talk about the problem. The mother felt guilty about having driven her son to madness. Mrs T. sought the mother's permission to help the child and offered to help her overcome her guilt.

Mrs T. went to the child's home, physically carried the skinny, silent and naked child in her arms and brought him to her own home. She had many picture books and magazines in her living room. She took the child on her lap and started showing him the pictures. The child, who initially avoided both eye and body contact, soon became quite comfortable with her. She continued to bring him to her home for a couple of hours each day, all through

the summer. She went on with her chores, talking to him about stories, pictures, etc. She also sewed a pair of pyjamas and a top, which he agreed to wear, by the end of the month. By the end of that summer she was able to get him to go back to school and join the class where she was a class teacher. She also encouraged other children to play with him. She helped him with his studies. Meanwhile, the mother had learnt the hard way that humiliation and punishment were not the methods to be used with a sensitive child. Subsequently, the family moved to another state. A follow-up report revealed that the child was doing very well in his new school and was well adjusted. Mrs T.'s approach to the management of a psychotic child can be considered truly remarkable, from a mental health professional's viewpoint. Mrs T. had been able to bring the child out of his psychotic world in a most sensitive manner, without resorting to expert advice. This has been one of the most humbling experiences for the author.

Case 4

Mr P. presented the case of a 13-year-old boy studying in Class VIII who came with complaints of headache, irregular school attendance and poor performance in studies. His mother was chronically mentally ill, had had to be locked up in a room, and had eventually run away when he was a year old. Her whereabouts were never discovered. The father, a carpenter in a factory, remarried when the boy was 4-years old. The boy had an elder brother and three stepbrothers and sisters. The father worked long hours and had no time for the children. The background information revealed that the boy had never seen a film, was not allowed to play and was given a great many household chores to do. Consequently he had no time at all to study. He firmly believed that no one in the whole world cared about him. Once he even ran away from home, to escape this. His headache, depression, concerns about his mother and stepmother, and running away were seen indicators of a serious problem by the supervisors.

The teacher established a trusting relationship with the boy, where he could talk freely about his sadness, fears and anxieties. Mr P. also helped him with his studies. He explained to the parents the need for the boy to study more, and asked them to reduce the burden of household chores and permit him to play for relaxation.

They were also told that his headaches were the signs of his distress and not of physical illness. They were told it would help greatly if they talked to the boy about his school friends and made him feel wanted. In addition, it was also decided that he should have a medical check-up to be sure that he had no physical problem, in addition to emotional problems. The case highlighted the fact that physical symptoms and scholastic problems are often caused by an unhappy home life and lack of emotional support. In this case, provision of a trusting relationship, help in studies and improving the family environment went a long way in resolving the situation.

Case 5

Mr P.S. presented the case of an 18-year-old boy, studying in Class X. He was very disobedient, disruptive, aggressive, and bullied other children and teachers alike. He was living in an orphanage. His father had deserted the family when he was 9-years old. His sister was in another residential home, studying in Class X. His mother eked out her livelihood, working on a daily wage basis with a road construction gang, and had no permanent home.

Up to the age of 15 he was quiet and obedient, stayed with his mother whenever he could and was no trouble at all. The teachers observed that gradually he had become irritable and disobedient and bullied other children in the classroom. In the orphanage he would beat other boys, and bully them to do his chores for him, especially when the wardens were absent. He did not comply with the instructions of elders. When asked why he did this, he said he had a headache. He was particularly aggressive with a boy of his own age, whom he suspected that the warden was partial to. When Mr P.S. approached him sympathetically, the boy spoke about his mother and wanting to be with the family, and the lack of justice that existed in the orphanage and school. Subsequently Mr P.S. allotted tasks to both the boys, after discussing with them whether the responsibilities were fairly allocated. He also praised him openly for his good behaviour and simply ignored his disruptive behaviour, instead of punishing him, as had been done earlier. Gradually, his aggressive behaviour became manageable. The case illustrates the feelings of insecurity and strong sense of justice which cause adolescents to be defiant and angry with the world. By

allowing the expression of negative emotions and providing a role model of a just person, the teacher was able to bring about a change in the boy. A good prognostic sign was that the boy was not an aggressive child up to the age of 15 years, as chronically aggressive and disruptive children usually do not respond well to counselling.

Case 6

Ms K. presented a case of a 16-year-old girl, who had irregular attendance at school, performed poorly and had been irritable in over the past two years. Her father was a government servant, a strict disciplinarian, and the mother was weak and passive. The girl was one of four children. She had done well at studies, till Class VIII. When the teacher was able to get her to confide in her, the problem was revealed. She had fallen in love with a man and then discovered that he was married and had a child, a fact that he had concealed from her. The girl had not discussed the matter with anyone. The teacher was rather direct in her approach, though very sympathetic to her predicament. Ms K. also talked to the girl and her mother about a caring and confiding relationship between the two. The father was not informed as both the mother and daughter feared his anger. In a 'closed society' of the kind the girl lived, it was the teacher's warmth and compassion that made the girl confide in her. The solution in such situations would have to take into account what the family would expect the girl to do, and not just the ideas of an 'enlightened' outsider. The teacher can be accepting, but not permissive, about crossing the bounds of 'propriety' in a particular community. 'Love affairs' are considered normal in many societies and cultures, but teachers should function within the constraints of the social setting, otherwise they may not be able to deal with the families in an effective manner.

Case 7

Mr R., a shy and quiet member of the group, presented the case of a 5-year-old withdrawn child. The boy was described to be shy and fearful, who sat with his head buried in his arms from the day he joined school. No request from the teacher would make him look up. Mr R. decided to handle the situation in an unorthodox and

innovative manner. He began to tell an adventure story to the class, in which the hero's name and the little boy's name were the same! When he came to the end of the story the little boy was peeking between his fingers, intently listening to the story. The next day, the story had more adventures built into it, with the hero doing fantastic stunts. Slowly the little boy was found sitting up and listening. At the end of the week he was paying rapt attention and making eye contact. Over the weeks, the adventure story included the hero and his classmates. The little boy started answering questions about the story as it progressed. In a short while, the child had completely settled into the school routine. The case illustrates a method of drawing out a shy child in an exceptionally imaginative manner by a teacher who himself was shy.

Evaluation of the training course

Over the 20 sessions, several interesting cases were presented and formal rating was carried out as part of evaluation. Case presentations were supplemented with follow-up, feedback and role play sessions. Parent–teacher meetings were also conducted twice, to discuss some problems faced commonly. In an informal session, the teachers had two questions: *whether such a course had brought about any change in the way of their thinking, and whether such a training should have been given earlier, when they were undergoing teachers' training. Would it then have been more effective?*

The answer can be best illustrated by the story that one of the teachers narrated. He said, 'Earlier if a child did something wrong I would hit him. Now I pause to think why the child did that.' He went on to narrate that there was a boy in the orphanage where he, the teacher, was the warden. The boy hid in his pocket an apple given to him by a visitor, instead of sharing it with other children. The teacher was about to punish him, but stopped himself in time, to ask the boy why he was not sharing it with the other children as was expected. The boy said meekly, 'My mother is coming to visit me today with my little brother. I wanted to give the apple to him, because he has never eaten one'. The teacher was chastened. How hasty he had been in attributing a selfish motive to the little child. He would even have acted on his belief, had he not bothered to explore the reasons for the child's behaviour or problems. This

approach of looking for reasons for problem behaviours had indeed broadened the understanding of the teacher–counsellors, and permitting them to manage these problems more effectively.

As for the second question, the teachers felt that they did have some courses in psychology at the teachers' training stage, but these remained at the level of theoretical knowledge. The practical applications could only emerge when teachers experienced real-life problems. 'In-service' training made the applications clear and understandable. One learns better when one knows where the shoe pinches!

At the end of two years, when the course finished, the 12 teachers had between them managed 112 children with mental health problems. The programme was gradually discontinued as the supervisors had other schools to attend to, and they had only one afternoon at their disposal.

Third encounter

Between 1981 and 1985 several schools were offered the orientation programmes. These programmes covered 250 teachers and a child population of approximately 25,000. In 1984, the third school, after the orientation, opted for the training course for eight teachers. The training was conducted satisfactorily. Yet on completion of the course the school failed to sustain the momentum, as the teachers were drawn into different programmes which the school authorities considered more important. This was a fee-paying school, with a heavy premium on a strict and disciplined approach to education.

Fourth encounter

The fourth course in training in counselling was once again conducted in the Sevashrama High School in Sriramapuram, in 1988, after a gap of nearly 10 years. This was done as a part of school health project described in Chapter 2. Of the 21 teachers who participated in the orientation programme, four volunteered for the course in counselling. This particular course went beyond the limited aim of offering training in counselling. This was because of the emergence of certain problems which could not be resolved by the teachers through their counselling skills. The following is a descriptive account of what followed.

Step 1

The four teachers were trained as described earlier. Following the epidemiological survey in 1989 by the 21 teachers, of the 1,484 children, 97 were seen to have scholastic/mental health problems. These children were screened by mental health professionals, i.e., post-graduate trainees from NIMHANS. Suitable cases were referred to the teachers who had observed the screening of the children allotted to them. The teachers had managed about 80 such cases.

Step 2

A large number of children were scholastically backward. Psychological testing revealed them to be of average intelligence. The reason for scholastic backwardness appeared to be understimulation, poverty and neglect at home. Counselling was not likely to be the solution. Thus, a resource corner was created in the main hall, where the school health project was housed. The corner was furnished with toys, art and craft and other materials to facilitate cognitive stimulation. These activities were provided for the identified children in small groups of five. They were supervised by a person with some child development background, who was paid out of the project funds. Each day 2–3 groups were exposed to the stimulation classroom for a period of two hours, over 20 sessions. In addition, they were given snacks. About 80 per cent of them showed improvement. In the regular classrooms they became more attentive and interested in their classwork, according to their class teachers. Those who did not improve were given yet another run of 20 sessions. Some of them also had individual counselling by the teachers.

Step 3

During the survey, nine children were found to be mentally retarded (MR). Attempts were made to find them placements in special schools, free of cost. To our utter surprise, none of the parents availed themselves of these facilities. We discovered to our dismay that the parents, being daily wage earners, could neither afford the transport nor the time to take them to and from the special school. The parents told the school health project staff that the children

would have to remain in the school as they could not be managed anywhere else. This indeed was a challenge. Thus was created yet another resource corner in the same hall for the MR children. A teacher trained in teaching MR children was hired for the purpose. There is a provision that if such a school is registered and runs for three consecutive years, the salary of the teacher would be subsequently paid by the welfare ministry. This could be a model strategy for schools with MR children who cannot go to special schools. At present this school has 12 MR children and two trained teachers. The management of these children has had to be modified over time, as the children are growing older and require vocational skills in addition to self-help skills.

The account in the preceding paragraphs indicates that in a given school there may be problems which cannot be handled by a teacher on a one-to-one basis. There is a need to develop suitable strategies for the problems that emerge in a particular school setting. For example, in the Sevashrama High School, individual counselling, stimulation and MR resources met the needs of the school, to certain extent. There are other dimensions which can be added, such as: child-to-child programme to deal with health education; skills training; vocational counselling for older children; parent–teacher meetings to deal with social issues such as poverty, child labour and alcoholism. Neither the mental health professional nor the teacher can limit his or her role. One has to go beyond limited roles to be effective in a school setting. One has to be a counsellor, an education reformist and eventually a social activist committed to helping troubled children.

NOTE

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four

Specific strategies to help children with problems

The three major problems encountered in primary school settings are: (*a*) emotional disorders characterized by social withdrawal, timidity, anxiety and fearfulness; (*b*) hyperkinetic conduct disorders characterized by overactivity, attentional problem, impulsiveness and disruptive behaviour of all kinds; and (*c*) scholastic problems characterized by problems in reading, writing and arithmetic, along with perceptual motor difficulties.

All these problems call for counselling or remedial work. In addition, there is need for support through some changes in the attitudes and behaviour of the adults in the child's home and school environments. Some strategies for use in the school setting have been attempted and evaluated by mental health professionals. These can be adapted by teachers, or teachers can be trained in the use of these techniques.

Play therapy for children with emotional disorders[1]

Using Virginia Axline's model of non-directive play therapy[2] the study was conducted in the school setting, on a one-to-one basis, with children who had emotional problems. Play therapy has the advantage of being conducted in a small group setting.

In the present study five children were treated with play therapy. They were assessed before and after the completion of all the sessions. This group was compared to another group of five children with similar problems, but which was not exposed to play therapy.

The children were matched for age and intelligence. Nine of the children had alcoholic fathers, which was typical of the slum background from which the children came. The children were in the age range of 5–6 years and were studying in Class I. The difference on the CBQ scores in the play therapy group before and after the intervention showed a reduction in psychological disturbance, while in the untreated group the difference was not significant (Appendix I, Tables A7 and A8). During the play sessions, the interaction with the therapist and verbalization increased. As regards story completion tasks, the stories became longer and aggression was toned down. The aggression shown towards family members decreased, as these conflicts were acted out in the play sessions. The class teachers reported increased interaction with peers and greater responsiveness towards classwork. With 10–15 sessions with two sessions a week of 45 minutes duration, the improvement was considerable. In addition, one could gradually introduce these children to a small group to facilitate interaction with their peers. However, it must be pointed out that at least five sessions were required before a child felt secure with the therapist.

A case illustration of play therapy

M.K. was a 5-year-old boy from a poor socioeconomic background. His parents reported that he was withdrawn, cried easily, was fearful, and had minimal interaction with peers, preferring to play alone. He had had nightmares, almost every night, for the last two years.

The family history revealed a non-consanguinous union between the parents. The father worked as a part-time driver and coolie. The mother was a housewife. They had been married for eight years. The boy was the older of two siblings, a younger sister being 3-years-old. His interaction with his parents was minimal; practically not at all with the father. The father was an alcohol dependent, and has been so for the last six years. He frequently beat the children, but had no interaction with them at all. The mother alone took care of most of their needs. The boy's relationship with his younger sister was also not very cordial, in the sense that he almost never interacted with her, and when he did he hit her.

The teachers reported that he preferred being alone in class, did not participate in any of the class activities and cried when called to do so.

On examination the child was seen to be withdrawn, talking only in monosyllables. Crying spells were seen intermittently.

Summary of 12 therapy sessions with highlights

Session 1

As an introduction to the play situation, the child was asked to accompany the therapist to the playroom. He was extremely reluctant and stood in the classroom unsure of what to do. After persistent coaxing, he agreed to come to the playroom.

Again in the playroom, he stood motionless and was led to see the play materials. He looked at the materials and stood to one side. He was asked to sit down and the therapist explained the characteristics of each of the toys and then asked if he would like to play with them. He touched the gun and the crayons, but did nothing else.

Session 2

The child willingly accompanied the therapist to the playroom. He sat down and began playing with the toy buses and a car. He pretended he was on a road and imitated the sound of, and enacted, an accident.

He looked at the therapist, who did not say anything then. He picked up the gun, saw that some sparrows had entered the room and took aim at them. He laughed aloud and looked at the therapist. He then took the gun and began pulling the trigger over and over again.

He then picked up the buses and the car and began playing with them. After this he picked up the dolls, examined their clothes and put them back.

Session 3

The child was seen to be crying in the classroom when the therapist went there. But he got up willingly when called and came to the therapy room. He took the gun and then looked at the therapist and smiled. He then examined the gun, tried the trigger and smiled to himself.

He took the bus and held it up close to his eyes for inspection. He then pointed to the chairs inside the bus and said 'chairs'. He then placed the bus on the floor, picked up a donkey and put it on the bus. He moved it around the floor for some time.

He then picked up the telephone and took the receiver to his ear and held it for a little while and then kept it down. He then looked at his school bag, picked it up and was ready to go.

He looked at the play materials once again. He then picked up the animals and made them stand. He put the dog in front of the elephant.

C — 'The dog is fighting with the elephant and will kill it.'
T — 'You feel the dog will win the fight with the elephant?'
C — 'He may be small but he will.'

Session 4

The child accompanied the therapist willingly. He ran into the playroom and picked up the bus. He pointed to it said 'bus'.

C — 'Daddy is sitting here.'
T — 'You feel your father is sitting here.'
C — 'Yes, here is my mother and here I am sitting.'
T — 'It looks to you as if your parents and you are sitting in the bus.'
C — 'Yes.'
The child then picked up the animals. He made them all stand next to each other.

He picked up the female doll, pulled off her hair and said, 'See, she is bald' and began laughing. He then spread out all the utensils.

C — 'We will eat, I have cooked a grand lunch.'
T — 'You want me to join you for lunch.'
C — 'Yes.'

The child then started filling a plate with sand and water. Abruptly he stopped, picked up the car and began moving it around the room, then stood up and made noises with his mouth and ran with the car in his hands. 'This is a plane,'he said.

Session 5

The child willingly accompanied the therapist to the playroom. He ran in as soon as he saw the door open and sat in front of the play materials. He first picked up a few utensils and placed them in front of the therapist.

C — 'Let's eat first and then play.'
T — 'You would like to eat first and then you would like to play.'
C — 'What shall I play first?'
T — 'You cannot decide what to play with first.'
C — 'Yes, I think I will start with this.'
The child pointing to the feeding bottle. He picked up the feeding bottle and shook it several times, then put it to his mouth, made a face and put it down.
He picked up the dolls, and looked at the therapist.

C — 'I want to keep the dolls leaning against your leg.'
T — 'You would like to keep them here.'
C — 'Yes, I will.'
The child then picked up the dolls in twos and placed them against the leg of the therapist.

He then took each of the animals by turn and made them stand in threes. He put a plate in front of the dog. He hit the dog with another animal and threw it away.

He went to the family of dolls. He picked up the baby doll and said, 'She's so small, like my little sister.'

T — 'She looks as small as your little sister.'
C — 'Yes.'
He then knocked her off and yanked at her hair.
C — 'Yes, I want to hit her.'
T — 'You feel like hitting her.'
C — 'Yes, I do.'

Sessions 6,7 and 8 followed along similar lines.

Session 9

The child came willingly for threapy. He took the feeding bottle and sucked at it for some time. After this, he took the father and mother dolls and kept them side by side. He then rode the bus over them. He did not look at the therapist, nor did he say anything.

He then picked up the baby doll and kept her on a car and pushed very hard.

C — 'They are all gone.'
T — 'You feel they are all gone.'
C — 'Yes, my family, I sent them away.'
T — 'You appear angry with them, so much that you sent them away.'
C — 'I am.'
He did not elaborate further.

Session 10

The child repeated what he had done in the previous session, but this time, he took the dolls from under the bus and buried them in the sand.

Session 11

He took the mother and father dolls from under the sand and took care to clean them properly with water.

C — 'Now, they have come back, see. They were dead and now they are back.'
T — 'You feel they have come back from the dead.'
C — 'Yes, now they will be good people.'
T — 'You feel that now that they have come from the dead, they will be good people.'

Session 12

The final session was a re-enactment of the previous session, but the child verbalized more about future goals for the family.

Discussion

The child came to the therapy situation very reluctantly and appeared fearful in the initial two sessions. It can be seen from the description of the sessions that the child felt more comfortable as the sessions progressed. During the course of the sessions the following major points were observed:

Attitude towards play situation

Although negative in the first session and neutral in the next two sessions, the child began to react more favourably in the later sessions, to the extent that he would request the teacher for permission to come to the playroom even at other times.

Amount of time spent in active play

In the initial two sessions, the child would sit and observe the play materials and tentatively touch them. By the fifth session, he would be active most of the time with minimum pauses before switching to different play materials and different activities. By the last session, he would run into the playroom and begin playing with no discomfort at all.

Attitude towards therapist

Initially the attitude of the child to the therapist was neutral and the therapist actually did not exist for the child. He would play by himself. By the third session, he had begun speaking to the therapist more and seeking her opinion.

Involvement of the therapist

An indicator of the therapeutic milieu being comfortable and anxiety-free is the child's attempt at involving the therapist both in conversation and in the play activity itself. This child, by the second session itself, had begun involving the therapist in conversation and by the fourth session had begun involving the therapist in the play activity itself, by deciding to cook a meal for the therapist.

Acting out conflicts

Perhaps the best indicator of play therapy having a therapeutic effect is when the conflict situations are played out in the playroom. The child's conflict appeared to centre on sibling rivalry, as seen by his play in the fifth session when he hit the baby doll and pulled off her hair, after having identified the doll as his little sister. He also appeared to have some conflict with his family as seen in the session when he said, 'I've sent my family away,' and a lot of aggression also came through in the ninth and 10th sessions when he ran a bus over the mother and father dolls (ninth session) and buried them under the sand (10th session). There was a tendency to regress, as a method of seeking attention, as seen clearly by his sucking at the feeding bottle in three of the sessions.

A good deal of the conflict appeared to have been resolved after the playing out, as seen in the 11th session, when he brought the family back from the dead, hoping that 'they'll be good people' from then on.

Management of hyperkinetic conduct disorder in a small group setting

The study[3] to develop an intervention strategy for hyperkinetic conduct disorder and evaluation of its efficacy was conducted on 10 primary school children, in a small group setting. The management was carried out over 15 sessions.

Developmental and family history, school performance and temperament

Out of the 10, five children were delivered by caesarean section indicating possibility of damage to the brain. Developmental problems in terms of clumsiness were reported in three of them. Two had articulatory difficulties, another three were identified as having feeding problems, primary enuresis was present in two, whereas sleep-related disturbances were recorded for three of them.

Psychological disturbances such as crying easily, clinging to parents and shyness were recorded for two children. All of them were reported to be overactive with short attention spans, seven of them were distractible, and five impulsive and stubborn. Disobedience was a complaint about three children. Seven of them were

aggressive (on provocation) and three had temper tantrums and fought with peers.

One child had a positive family history of mental illness; another one had history of parental alcoholism and one child's father had been hyperactive in his childhood.

Six of the children had problems in their interactions with parents, parents of four were punitive, and of two overexpectant and overindulgent. Inconsistent disciplining was present for eight of the children. Multiple parenting and sibling rivalry were present in two cases each. Serious parental disharmony was reported in the cases of two children.

Poor school performance was observed in four of them, with two each having reading and writing problems, and one having problems in arithemetic. Two had poor memory and were forgetful. Six of the 10 children had difficulty in getting along with their peers, whereas one child had problems with his teachers as well.

Seven of the parents reported their children to be temperamentally difficult to manage, with three of the children considered to be emotionally reactive; nine to be having high activity levels; three to be having poor appetite; two to be shy; and five regarded as aggressive, by their parents. The development of sensitivity was lately emerging, in the case of seven children.

All the children on CBCL had high externalizing scores while one child also had high internalizing score.

The case descriptions of three children who formed the first group are illustrated below. The other seven children formed two more groups.

Case I

V.K. was a 9-year-old boy, studying in Class III, from a middle-class family. His maternal grandfather (who was the child's main caretaker) reported him to be clumsy, inattentive, impulsive and stubborn, from early infancy. The child would begin tasks, hurry through them and leave them half finished. Frequently he would mishandle and break things at home. For the past two years, on various occasions, he was talking back to his grandfather; hitting other children and getting into frequent fights.

His teacher found him to be a definitely bright student, who in the past had helped to carry her books. However, she reported him to be inattentive, easily distractible, fidgety and extremely

restless. Often he would shout in class and disturb his peers. He was usually reprimanded for showing 'out of seat behaviour' (not being able to sit in one place) or for answering before his turn. His peers refused to play with him, and the senior school boys teased him.

Temperamentally, though affectionate and sensitive, the child had a low frustration tolerance and a markedly increased activity level, which made him difficult to manage. He was the only child born of a non-consanguinous union. The father, an electrical computer engineer, had died in 1991 after a prolonged illness. Since infancy, the child had been entrusted to the care of his maternal grandparents as his parents usually remained busy with their professions. The grandparents were overinvolved and over-indulgent in their interaction with this child. The child showed dependence on his grandparents and would frequently ask questions about his father's death.

Behavioural observations during pre-intervention assessment revealed him to be restless and overactive. His responses on different tests were ill-planned and hurried; his manner of attempting the tasks was haphazard, and despite comprehending the test instructions correctly he made several errors. He also demonstrated a need for approval and reassurance from the examiner, several times, during the assessment period.

Case 2

S.S. was an 8-year-old boy, studying in Class III, from a lower–middle socioeconomic background.

His parents reported that the child's problems had increased after his admission into school. The problems were: inability to pay attention or concentrate on his work; motoric overactivity like climbing chairs, tables and windows, jumping and running excessively; inability to sit quietly for a reasonable period of time; generally being distructive; being stubborn and crying easily.

According to the teacher S.S., functioning at a below average level, was a 'problem child'. He demonstrated little interest in studies. He was unable to pay attention in class and he frequently disturbed other children. On several occasions he would be beaten up by the teacher for disrupting the class discipline. The teacher felt that he had specific problems in reading and arithmetic.

His temperamental profile revealed him to be a sensitive and trusting child but one who was stubborn and aggressive (on provocation). The family history showed that he was the elder of two siblings, born of a non-consanguinous union. The father was a 40-year-old factory worker, educated up to Class X. His mother was a 32-year-old housewife. Parental disciplining was inconsistent, with the father being punitive and the mother feeling incompetent to handle him. His restlessness would become more obvious in the father's presence, which, in turn, further made the father angry and intolerant. The child feared his father as well as his class teacher.

During pre-intervention assessment, though initially restless, he would subsequently settle down and work on the tests in an orderly manner. However, after 15 minutes, he repeatedly expressed the desire to go back to the classroom and hence the assessment had to be continued the next day.

Case 3

S.K. was a 9-year-old boy, studying in Class III, from a middle-class family. His father reported that from infancy, the child had an unusually high activity level; he would be constantly breaking and throwing things; tearing paper; running and jumping around and was unable to complete any task. The child was impulsive, demanded money in excessive sums, threw frequent temper tantrums, got into fights and was non-compliant.

His teacher was exasperated. His impulsive, inattentive, aggressive and disruptive behaviour often brought him into conflict with school authorities. Branded as a 'trouble maker' has was nicknamed 'loafer' and 'useless fellow' by his peers. In the previous school, due to the above-mentioned problems, he had been detained twice in Class II, and the parents had been asked by the principal to change the school.

Temperamentally he was sensitive but a difficult child to manage and had an increased activity level.

Born of a non-consanguinous union, he was the elder of two siblings. In the presence of severe marital disharmony, disciplining at home was inconsistent. His father was overindulgent; his mother was a suspicious person who was punitive towards the boy. Due to the child's problems, there were frequent quarrels between the

parents. The child, himself, expressed anger towards people around him, was conscious of not being looked after and said that he 'hated the world'.

Behaviour observations during testing revealed him to be well-mannered and it was easy to develop a rapport with him. However, after the first five minutes, his restlessness became obvious. He responded to the test tasks in a hurried, ill-planned, haphazard and thoughtless manner.

Therapy sessions for group I

The three children (Cases I, II and III, i.e., V.K., S.S. and S.K.) formed the first group. The main characteristics of this group were:

- The boys were between the ages of 8 to 9 years.
- They were all studying in Class III.
- They all had a core attentional deficit.
- They were motorically overactive.
- They had moderate to severe degree of behaviour problems and were aggressive.
- They had significant difficulties in interpersonal situations and often got into conflict with their environment, especially with parents, teachers and peers.
- They were rated by their teachers to be doing poorly (Cases II and III).

Though the severity of problems varied across groups yet attentional deficits, interactional difficulties and behavioural problems were present in all the three groups. As these were the target areas that intervention aimed to handle, an essentially uniform intervention programme was developed and implemented for all the groups. Thus, the process of therapy as presented below, can be considered as a representative account of how intervention progressed in the other two groups as well. The qualitative differences between groups will be dealt with later.

Initial phase—sessions I to V

A brief, 30-minute introductory meeting was held, with the purpose of introducing the children to each other and to the therapist, and

also to inform them about the broad outlines of the programme. The children were encouraged to talk about their likes and dislikes, following which a general outline of the programme was given. They were made to understand that each day all three of them and the therapist would involve themselves in a number of tasks and games. To complete these, it was essential to be attentive, friendly, and cooperative. They were asked if they could think of any reason why they had been selected for the programmes? S.S. responded by saying that it was to play and to improve on their intelligence. None of the children could, however, understand that they were in anyway more problematic than their peers. This point was not stressed by the therapist at this stage. After playing snakes and ladders for 10 minutes, they were informed about the date and timings of the next sessions and were then sent back to their respective classrooms. All three children were observed to be distractible, restless and inattentive.

The major focus of sessions I to V was to help the children to understand and recognize the nature of their deficits and also to help them to make the association between their problematic behaviour and the negative consequences that they repeatedly experienced, both at school and at home. Such an understanding would convince them of the need for modifying their behaviour, so they would participate in the sessions with involvement and interest.

In the first session, the children and the therapist sat in a circle on the floor. All three children began complaining simultaneously about their reading test, about each other and how they were shouted at by the teacher. It was stressed that they should speak one at a time and by turns. V.K. hit S.K. This was discouraged immediately and they were reminded of the need to be cooperative and helpful. It was emphasized that during group sessions, complaining, abusing or hitting one another was to be avoided, but that apart from this they could feel free to communicate any of their problems as the group was a platform where they were to share their experiences, problems and difficulties. They were reassured that attempts would be made to find answers for these problems. A few other rules to be followed during sessions were introduced. The agenda for the day's sessions was provided and the children were told that everyday tasks such as colouring, beading and scanning would be undertaken. After this the tasks were actually begun, with the therapist introducing and verbalizing aloud the strategies for planning and executing them.

In the colouring task, they drew lines all over the page without considering the boundaries of the sketched figures; on a wooden cube they could not even replicate simple sequential tapping; on visual scanning, the maximum numbers scanned were 12 in five minutes.

Before ending the session, the therapist briefly highlighted the need for cooperative work.

In the second session, the discussion revolved around why it was essential to follow certain norms and rules of behaviour, both at school and at home, and how disturbing, inattentive behaviour disrupted the total classroom functioning. The need for rules such as sitting in the seat, answering by turn, paying attention and not hitting or disturbing other classmates was explained.

The children were restless, unsettled, distractible and unable to participate much in group activities. No improvement on task performance was observed. To raise their interest, they were allowed to go out and play for 15 minutes. Following this, their participation in the scanning activity was again poor. The session concluded with each child summarizing the behaviour expected from him in the classroom.

In the third session, the therapist once again asked the children why they, amongst all their peers, had been chosen for the daily sessions. As the children did not respond, the therapist made an attempt to link up their behaviour to the negative consequences that they faced both at home and at school. It was explained how an improvement in behaviour was likely to facilitate their acceptance in both these situations. At that moment, S.S. said that his parents, especially his father,, were punitive; and S.K. said that all his schoolmates hit him and teased him.

After providing the children a chance to ventilate freely, attempts were made to help them realize how they were partially responsible for the negative consequences that they experienced. After a detailed explanation, reassurance was provided that this state of affairs could definitely be modified if they too made consistent efforts.

The techniques of 'time out' and 'response cost', and their necessity in times of severe misconduct were explained to the group. They were clearly made to understand how and when these techniques would be used for their benefit, i.e., to help them gain control over their behaviour. They were asked for suggestions

whether there were any other methods to deal with their misbehaviour, but none of them made any spontaneous contribution.

A motivational chart, stating problem behaviour in positive statements (e.g., did not disturb), was shown to the children and they were clearly explained which kind of behaviour would help them earn stars, both from the therapist as well as the teacher.

In the daily tasks, though still distractible, they showed more interest. They were able to colour together for 12 minutes and could undertake scanning for 10 minutes. Though they showed an interest in the cube task, yet they could not imitate the tapping sequences accurately.

In the fourth session, the issues raised the previous day was discussed further. The children were directly asked to find links between their disturbing behaviour and its consequences. S.K. immediately responded by saying that he was the naughtiest boy in class but felt angry as everyone called him 'bad'. The child was allowed to ventilate freely and each of his peers was asked to describe his positive qualities. Moreover he was made to understand that he was not the only one to face these difficulties but the other group members did too, and this was precisely the reason why they were attending the group sessions. This opportunity was also used to reassure the children that there were various ways in which they could overcome their problems, and learn to control themselves in difficult situations where they tended to become restless, inattentive and impulsive. V.K. said he was more talkative and 'played mischief' in class but that the previous day he had tried to be quiet and had earned two stars. This was reinforced, and the example set before the other children that they too could begin working in a similar manner. S.S. said that he also wanted to be attentive but could not. Once again the group was reassured that the purpose of these meetings was to help them achieve these skills. A qualitative differences in their performance was observed; in contrast to the earlier days they showed some interest in repeating the verbal self-instructions after the therapist, before beginning the tasks. They also finished all tasks with less errors and better cooperation.

In the fifth session, it was observed that the children were restless, distractible and were talking out of turn. They were reminded of the group norms but for the first 15 minutes, no order could be maintained. During colouring, they were observed to be

pushing each other and not sharing the colours. S.K. hit V.K. on the eye. 'Time out' was used, and later when S.K. was asked what he should have done instead, he voluntarily apologized to the other child. All were given a feedback regarding their behaviour during the session. When this was being done, each one began shouting and complaining about the others. They were warned that if such behaviour continued, they would be sent back to their respective classes and the session would be discontinued. After this, though they were disturbed, they gradually settled enough to attempt the attentional tasks. Before closing the session, the children were themselves asked the reason for the impulsivity and excitement. A few suggestions were volunteered by them, following which the therapist introduced certain self-control strategies that they could make use of, during such times.

By the end of the first five sessions, one session with each child's teacher had also been held in which the teacher had been sensitized to the child's limitations; the use of positive instead of negative reinforcement was discussed and a motivational chart was handed over to the teacher, which she had to fill up and send home with the child so that parents could review and reinforce the child's positive efforts each day.

Likewise, one or two sessions had been held with each child's parents/caretakers. They were given detailed information regarding the nature of the child's problems. Parents were made to see how typical coercive interaction with children hindered progress, and how such exchanges become more frequent if the child is even partially successful at avoiding comments or undesirable situations. They were helped to realize why they often reacted to their child with increased control. Parents were asked to employ the better methods of commenting upon, praising and noticing the child's positive behaviour, while ignoring his less acceptable behaviour.

Middle phase—sessions VI to X

The format followed in these sessions was similar to the one described for the first five sessions. The major emphasis of intervention in this phase was on strengthening the children's motivation to overcome problems of inattention and overactivity. This was done in several ways. First, the complexity level of the tasks was common for all the children. This meant that the complexity level of the tasks matched the average capacity of the group. The fact

that teachers and parents were reinforcing the children both at school and home, further strengthened their motivation to continue approaching different situations and specific tasks positively. Instead of following the therapist's instructions blindly at this stage, they were encouraged to think for themselves the different strategies involving planning, and employ a systematic manner to approach tasks. Answering out of turn and complaining about each other (which frequently occurred) were discouraged. The various kinds of problem behaviour that had been reported earlier were taken up for discussion, and a more acceptable way of responding in specific situations was discussed. Though the participation of the children was minimal, when the therapist offered suggestions they showed interest and made efforts to contribute to the discussions.

From the eighth session onwards role-playing was introduced into the daily agenda. A few situations which all children found difficult to handle were chosen, and role-playing attempted. However, the involvement of the children was minimal, as they hesitated to participate in this activity. Hence from the 11th session onwards it was decided to discontinue its use, as the children's interest in this activity could not be generated.

Storytelling was introduced as a regular feature from the ninth session onwards. Initially brief and easy stories were chosen and general questions about these stories were asked. The children's attention was ill-sustained and they were unable to answer even simple questions, following the completion of the stories.

However, improvements in other attentional tasks were gradually being observed. Almost everyday they were regularly and cooperatively completing the colouring exercise in 12 to 15 minutes, except in the seventh session when they tore the paper. On that day the positive reinforcements were withheld and the reason for this was clearly explained to them. Beading was progressing well and by the end of the 10th session, the children were, on an average, threading 46 beads each, within the standard time limit of 10 minutes. Likewise, improvements in scanning were evident. With verbal self-instruction, the children were making efforts to scan more systematically, up to 40 numbers in seven to 10 minutes. Though the tapping task was still able to hold their interest, yet minimal improvement on this activity was observed.

By this time, the children were relatively more settled and comfortable. As the sessions progressed, they were earning more stars, both from the therapist as well as from their teachers.

Despite this, fluctuations in level of performance continued. There were times when they suddenly become excitable and impulsive, and sometimes even hit each other or entered into fights with their peers in school.

Regular contact with their teachers was maintained. The feedback that the teachers gave regarding the children's behaviour in the classroom each day, was later given to the children during the sessions. In this way the programme's continuity and linkage extended from the classroom to the therapy sessions and in the home setting as well.

Final phase—sessions X to XV

During these sessions, the work initiated in the previous days was continued, with added emphasis on teaching the children to improve their attention by organizing and focusing it on every task that they attempted. They were encouraged to check and go over their work, before finally handing it over to the therapist during the sessions, to the teacher in class, or to parents at home. To improve their organizational skills, they were asked to make lists of daily activities that they had to do, and to check every night the books that they had to carry to school the next day. Various other simple activities which called for planning before their actual implementation, were initiated.

Initially, the parents were assigned the supervisory role, to help their children attain these skills that cooperative play and team work resulted in.

Discussions during these sessions focused upon providing the children with the rationale behind cooperative play and team work, and explaining to them the benefits that resulted. The instances when they had worked cooperatively were highlighted, and these were contrasted with the negative consequences of fighting, hitting or beating. Their role as responsible students was stressed and they were entrusted daily with small tasks that required them to share their belongings (such as pencils, erasers, playthings, etc.) with their peers in school. Likewise, their role as an important growing member in the family was discussed with them.

By the time the intervention programme was concluded, the children were regularly colouring complex pictures of landscapes, scenery, buildings, and models of their school. During the 13th session, they resorted to their haphazard manner of colouring.

Feedback was given immediately, but that day it was not possible to alter their style of functioning. Otherwise, everyday they regularly did the colouring exercise for 15 minutes. The average number of beads threaded steadily increased to 67, and by the last session they were able to scan up to 80 numbers in 10 minutes (even though the size and boldness of the numbers had been reduced by this time).

On the cube, the replication of the more complex tappings was still not possible. But the children could reproduce simple tapping sequences correctly. Their efficiency on the storytelling task improved gradually as was evidenced by the fact that two out of three children were able to give most of the details of the stories.

While improvements were being observed, two of the children, S.K. and V.K., expressed feelings of low self-esteem during the 11th session. V.K. said that everyone around him called him a naughty boy and the bus driver also threatened to beat and fine him. This meant that he actually was a 'bad child'. S.K., on the other hand, expressed his distress in the form of aggression, anger and hostility towards all adults and other children. During the sessions, attempts were made to elevate their self-esteem, but as the problems were serious they were taken up in individual sessions with both the children.

A finding worth mentioning here is that though individual differences in performance persisted all through the intervention programme, the children were actively making efforts to match their speed with that of the other group members. Moreover, the children were more settled and appeared happier because of the positive reinforcements and attention that was being given by several adults around them.

Before concluding the programme, responsibility for continuing the attentional tasks at home was entrusted to the parents. The teachers were praised for their efforts and were asked to continue them in the future as well. The children were prepared for the termination of the programme and were promised that the therapist would occasionally keep in touch with them.

The above programme had focused on the three targets: enhancement of attentional skills, prosocial behaviour and elimination of problematic behaviour. The termination of the intervention with the three groups coincided with the summer vacation. On assessment after the intervention the teacher ratings on Conner Rating Scale revealed a significant reduction in the mean scores

from 18.2 to 7.5. Parents too reported a significant reduction in the extent of misbehaviour. On assessment of actual performance of these 10 children on psychological tests, the maturational age on a visuomotor copying task improved significantly in all the groups, with the exception of one child. There was improvement in attentional functioning on a simple colour cancellation task. The methodical and sequential handling of complex cancellation tasks showed only a marginal improvement. This indicated that further training was required in stabilizing the gains on the attentional tasks. Their performance on a test of intelligence, which was average before the intervention, showed significant gains in terms of time taken. The group also showed significant reduction in impulsivity on a maze test (Appendix I, Tables A9 and A10).

After the summer vacation, the follow-up showed that nine children had maintained the improvement. The child who did not improve had been referred earlier to a child psychiatric clinic, because of the severity of the problems.

Strategies for the management of scholastic backwardness[4]

One hundred and five children studying in Class IV were rated by their class teachers as having significant problems in reading, writing and arithmetic. Of the 32 students who were identified as having problems, 25 children were taken up for remediation. The remedial work was carried out for batches of five children. They were asked to read selected passages from Class I to IV text books. The deficits in reading, writing and comprehension were noted down carefully. On assessment all the children were found to have average intelligence. The children were often found to have difficulties in more than one area, i.e., reading, writing, or arithmetic. The remedial package consisted of graded tasks in all the areas where the individual child had deficits. The main areas were language, arithmetic and perceptual motor skills.

Language

Reading, writing and comprehension abilities were evaluated carefully. Assessment revealed that poor readers lack two important

skills, i.e., the ability to recognize simple common words and to exploit the system of phonics. Remedial education for reading problems consisted of improving reading and phonic skills. A list of basic sight words were prepared, using commonly used words from the children's text books. Flash cards were prepared for each word. Each child was taught four to five words in each session. Decoding skills were taught using sets of words arranged at four levels of increasing difficulty. Each child was taught two to three units in each session. The child was also given exercises for reading aloud for five to seven minutes each day; mistakes were noted down and corrected at the end of the session. The children were asked the meaning of what was read. Add-a-word programme was used to improve spelling skills—the child was given a list of words whose spelling he had to learn; as he mastered the words, new ones are added to the list. To improve writing skills, charts were maintained with the date, time, number and types of mistakes committed. The length of the passage given for copying was kept constant. The children were encouraged to monitor their own progress by keeping a diary. They were praised even for the smallest gain. Children were encouraged to read high-interest and low-vocabulary story books independently.

Arithmetic

Four basic operations, i.e., addition, multiplication, subtraction and division were taken up for remediation. First, the concepts were taught at a concrete level, using beads and sticks. Second, at a semiconcrete level, the beads and sticks were removed and lines were drawn on the blackboard or paper to teach the basics. Third, at an abstract level, the problem was presented without any aids. When the problem was presented at the abstract level, the children were also taught the method of addition. They were taught to add up numbers on the extreme right, write the 'unit' in the respective answer column and to carry the 'ten' to the next line.

Similarly other operations like subtraction, multiplication and division were taught, using concrete and semiconcrete operations before proceeding to the abstract level.

Briefly the strategy consisted of the following:

- Students were given exercises in each operation.

- Weekly targets were set for each student.
- Assessment–teaching–assessment method was planned.
- Students were encouraged to monitor their own progress.
- Praise was freely given for the smallest gains.
- Parents were also involved in motivating them in the same manner, instead of being critical about the child's inability to do arithmetic at the age-appropriate level.

Perceptual motor skills

To improve perceptual motor skills, training was given in drawing straight lines, curves, circles, angles and three-dimensional figures first with appropriate aids (such as bangles, sticks, etc.), and later on without them. Simple jigsaw puzzles, prepared by the children by cutting pictures into pieces, were often helpful in learning how different shapes can be put together.

The results indicated that the performance after the intervention of 25 sessions, showed significant gains in language, arithmetic and perceptual motor skills (Appendix I, Table A11). The speed of performance too had improved. Since they were more than two to three years behind in their scholastic skills, the gains were not as yet equal to what is expected of the Class IV level. To bring them up to the level expected to function adequately in their class, further training would have been needed.

However, it must be noted that schools vary in their expectation regarding academic performance of the children. Some children may have average ability and the school may have higher expectations, while in schools where the expectations are low, the child's genuine learning problems may go unnoticed (as in slum or rural schools). It has been observed that between different kinds of schools, teachers have reported scholastic problems in students in a wide range between 10 to 60 per cent.

In the absence of elaborate assessment used in the above study, the teacher may use a common-sense approach. The child's real level of functioning in reading, comprehension, arithmetic, writing and copying of simple shapes such as squares, triangles or circles could be assessed. Whatever the age of the child, the assessment must begin at the Class III level. Remedial work should also start at the basic and simple level, where tasks are simplified to such an extent that the child feels confident about doing them. The exercises

should be devised in such a way that their level of difficulty is graded and the child is not overwhelmed by it. Small gains should be praised.

The child should not be criticized by the parents and teachers. Minor setbacks should be ignored. Parents and teachers should be made to recognize that the child's difficulty is genuine. Adults often believe that the child's behaviour is deliberate. These children most often have average intelligence and only have problems in executing the 3 R's.

Remediation of academic and pre-academic skills in time, may prevent school dropouts and more serious problems later on. However, the learning-disabled at the high school level are harder to manage. Careful examination has to go into identification of the pattern of deficits. At high school level, one has to develop appropriate learning strategies with adolescents in order to effect remediation.

In addition to working with the children, it is essential that the parents understand the genuine nature of the difficulties of the child. They should be involved in helping the child overcome them by using the strategies evolved specially for that child. Parents should approach the child's problems realistically and with understanding. They should not be overambitious and punish the child for his/her disabilities. Similarly, teachers also need to know about the nature of the child's learning problems in order to help him/her. The best results are obtained when remedial work is carried out with the child with full support from the parents and the school.

The above three studies highlight the potential for working with primary school children. Problems of high school children may be dealt with similarly.

Working with adolescents in groups

This is one of the fascinating areas of work which could be taken up in the school setting. The WHO document[5] highlights the following for inclusion in mental health education as part of health education or life skills education.

The life skills education consists of:

- decision-making and problem-solving
- critical and creative thinking

- communication and interpersonal skills
- self-awareness and empathy
- skills for coping with emotions and stressors

Life skills of this nature in a wide variety of school-based interventions including health education, peace education, drug abuse prevention, prevention of adolescent pregnancy and HIV/AIDS, prevention of bullying as well as promotion of scholastic performance, self-confidence and self-esteem.

Life skills need to be defined in the context of appropriate situations and cultures within which they are required.

Mental health education consists of:

- brain and behaviour
- psychological and emotional development
- effects of stress
- successful coping strategies (ideally linked to life skills classes)
- common psychological problems in youths and families
- risk factors
- how and where to seek assistance
- healthy relationships between sexes (including sex education)

These aspects can be dealt with effectively in a group setting with adolescents. A teacher who has been trained and also has the skills to relate to adolescents can conduct the groups. Or some among the adolescents can model and create self-help groups. For groups with specific needs such as career counselling, an outside expert can help out.

In the Indian setting, groups may have to be formed separately for adolescent boys and girls, otherwise it may become counter-productive. Sensitivity in handling a group is a skill to be acquired, as leadership qualities may be inborn only in some. However, working with adolescents requires a very special talent as they are a very difficult group to work with.

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five

School mental health in rural areas

Epidemiological surveys of mental health problems in rural schools have been scarce. Actual training of schoolteachers in mental health services delivery was initiated by the author in 1993, although without much success. The author, being an optimist, hopes that her future endeavours will lead her to effective strategies of management of mental health problems in rural areas. The first part of the chapter describes the trials and tribulations of a rural mental health programme. It is not a success story, but indicates the need for some very pragmatic approaches at the grass-roots levels.

In contrast to the urban projects described in the earlier chapters, the rural schools seemed to call for very different strategies, because of the very nature of problems, and paucity of manpower resources available in a rural setting. The following is an account of the author's attempt at exploring some possibilities. These ideas germinated in the beginning of 1990. The exploration was begun only after 18 years of work in urban areas due to practical problems of logistics and paucity of manpower and financial resources.

The school mental health programme was initiated in the Doddamalur village in Channapatna taluk, about 95 km from Bangalore. Channapatna, the district headquarters, is 3 km away from the village. The area is famed for its exquisite spun, crêpe and printed silks, lacquer work toys and terracotta pottery. In the village, the children who belong to the upper castes go to private convent school in Channapatna, while those from the poorer and backward castes study in the rural primary school. There is an

invisible but strong divide between the upper and lower classes, as elsewhere in the country. The present description pertains only to the children of the rural primary school.

The little village of Doddamalur, a place of pilgrimage, is famous for its beautiful 15th century temple dedicated to the infant Lord Krishna. The temple is situated right next to the school. The shrine is filled with little silver cradles dedicated to the temple by women seeking to be blessed with children. The village is also famous for a subsect of Brahmins, whose achievements include excellence in science, mathematics and languages. These achievements are in stark contrast to the little school community.

The infant Lord Krishna was once supposed to have picked some dirt and put it in his mouth. His foster mother saw him and forced him to open his mouth wide so that she could remove it. When he opened his mouth—lo and behold! It was not dirt that she saw, but the whole universe! Perhaps here in this little school of Doddamalur one can see an entire universe of a rural setting of teachers and children.

First session: September 1994

The school has a kindergarten section, and Classes I to VII. The kindergarten has one teacher and the primary school has six teachers for the seven classes, and six classrooms. The school had 300 children on its rolls. It is a government-aided school and the medium of instruction is Kannada. Except for blackboards, there are no other teaching aids. The school has no amenities like a playground, toilets or drinking water.

When a survey was conducted in the school, 38 children were identified as having mental health problems. In addition, 12 children had physical complaints, which needed a paediatrician's attention.

The second session: November 1993

The three investigators, including the author, discussed the project with the teachers and sought their help in filling in the CBQ forms. One teacher was absent and the other two teachers wanted to do it on another day.

Mr T.M. the headmaster was a strict disciplinarian and was not psychologically attuned to the needs of the children. However he

was very interested, motivated and cooperative about the programme, as he saw that it would be beneficial for the school. In addition, he was enterprising and always had good suggestions about how our mutual aims could be achieved, in a pragmatic and effective manner. In the latter part of the year a headmistress was posted, but she never showed up, claiming she had health problems and could not live in the village. Mr T.M. continued to function as headmaster.

Mrs R. was a good teacher, a disciplinarian and an organizer. She was most knowledgeable about the children in the school, including those who were not in her class. She was seen as an ideal candidate for the training programme.

Mr S., a young man who was away on the first day, turned out to be an enthusiastic and good teacher, but did not have the sensitivity of the kind Mrs R. had, which came with experience.

Mrs A. was an elderly teacher, due for retirement in a year's time. She had a lisp and was child-like in her simplicity. She was the most ineffectual of the teachers and the children were totally out of control in her class. She did not seem to have the potential to be a counsellor.

Mrs L., a nursery teacher, was very bright, interested and knowledgeable about the children in her class.

Mr R. was most taciturn and difficult to relate to. He was very strict and pessimistic, and believed that nothing was worth trying in the school. He was totally uninterested in teaching, wanted to take early retirement, and practice full time as an ayurvedic physician, which he was already doing outside school hours. He was most unwilling to fill up questionnaires. Mrs R., Mrs L. and Mr R. showed sensitivity and the required understanding in the knowledge and attitude questionnaires and vignettes, while Mr T.M., Mr R. and Mrs A. marked the forms indiscriminately, indicating all the items as very harmful and giving 'no' or a similar answer to the vignettes. The assessment on schedules and our observation of the teachers during the interaction appeared to match closely.

An open discussion regarding the problems faced by the teachers was discussed first. These were: extreme overcrowding, and absence of teaching aids, play and sports facilities. When asked how these problems could be resolved the following suggestions were brought forth.

- creation of posters and teaching aids using locally available material;
- creating a resource corner with games and art/craft work materials;
- provision of drinking water, toilets, playground.

The strategies which could lead to securing these facilities were discussed.

The survey revealed that 38 children had problems, with one each in Classes I, II and VII, three in Class IV, five in Class VI and 14 in Class V. The caste distribution revealed that 193 were Vokkaliga (farmers); 93, Scheduled Castes; 16, Oil Presser Caste; two, Shepherd; two, Washerman; two, Trumpet Player; five, Smith; and five of other castes. Though there were no Brahmin children, three of the teachers were Brahmins.

Of the 38 children identified, 30 were examined. Sixteen were girls and 14 were boys. Ten children had family histories of mental illness/alcoholism/epilepsy. The developmental history revealed birth complications in seven and specific delays in 12. The following kinds of problem behaviour were noted: 10 children had hyperkinesis, 18 children had conduct problems, 16 had emotional problems. Of the 30 children 25 suffered from stress. The boys had more hyperkinesis and conduct disorders while the girls had more emotional disorders. Both groups had learning problems to the same extent. This group of children needed intervention at the community level for the stressors, and at the school level for learning and mental health problems.

Third session: December 1993

The meeting with the six teachers was in the small Hanuman temple next door, as the classrooms were extremely noisy, having been left unattended. The session was brief. In this session Mr T.M., Mr R. and Mrs A. sounded very pessimistic and tired. An open discussion revealed their preoccupation. They were concerned with the scholastic problems of the children.

The children were reported to have poor memory, and lacked interest in studies. They spent a lot of their time viewing television and seeing films. In the past five or six years television sets had

invaded the community centres and neighbourhoods of even remote villages. Consequently there had been a dramatic drop in interest in school work. Parents contributed to it by not controlling television-viewing hours. As they themselves were illiterate, they did not consider their children's schooling as important. Some parents drank, gambled and smoked, and sometimes sent their children out to shops to fetch cigarettes/*beedies* and liquor for them. Some parents, though poor, would buy the school books, while others would fail to pay the nominal fees that were charged. But all of them expected the teachers to be responsible for their children's performance in school.

In addition, some children were made to join the school at too early an age, as some mothers wanted them out of home. Some were sent because they were given free milk under a special programme. They were too young for their classes and had trouble acquiring skills.

Regarding scholastic backwardness, the teachers were pessimistic about what could be done to overcome it. The teachers were assured that such problems occurred even in urban schools and that it was possible to do something, even under dire circumstances. The session gave the teachers the opportunity to ventilate their grievances about the problems they faced with the children and their parents.

The rationale for a school mental health programme was explained, albeit briefly, at this point of time. Mrs R. spoke about her experience with a child with a drunkard father, and how she had spoken directly to him (the father) and brought about a change in the situation. Mr S. said he had spoken to a group of children and their parents about selective television viewing, and found that it did improve the situation. Mrs A. complained that children had become particularly precocious in their sexual awareness because of the films that they watched. Unsuitable television programmes appeared to be a matter of great concern to the teachers.

The session especially focused on issues which needed social action. The teachers appeared to be quite sensitive and willing to act. Mr S., Mrs L. and Mrs R. were quite willing to talk to the parents regarding excessive television viewing, drunkenness and underage children being sent to school, and to explain about the consequences of such problems. The logistics of 'how', 'when' and

'where' the interventions could be carried out was also discussed, so that practical issues could be thought out well before embarking on a course of action.

The possible course of action could be:

- to convince parents that the teachers were concerned about the children;
- to discuss the problem of television viewing and the absence of stimulating alternatives in the child's environment;
- to discuss with the children what they liked doing best;
- to provide a more stimulating classroom setting.

Fourth session: February 1994

Following the Christmas holidays, the teachers were met in February 1994. A lecture was held on hyperactivity, conduct disorder, speech and language problems, and scholastic backwardness. Details regarding the causes of disorders were discussed. The nature of normal development in physical, cognitive, language, emotional, social and moral realms were dealt with, too. The role of play was especially highlighted.

The major problem of seven classes with six teachers was focused upon. It was suggested that some play activities could be organized for the classes which were unsupervised and this could even be monitored by children themselves. Play is considered essential for a child's development, and it would not only keep children happily engaged but help teachers, too, to achieve some degree of control over the unsupervised classes. This would help in the overall development of the children with very little effort by the teacher.

This approach could be described as a universal intervention to benefit all the children, in contrast to situations where teachers work with disturbed children individually. At this stage the author felt that such universal intervention may have to be carried out in most rural schools, as a good number of them were single- (or two-) teacher schools, with four to five classes.

Three teachers were identified, to manage the 30 children who were identified during the survey. The teachers were requested to volunteer their services, not forced to take on the work either by

the investigating team or the headmaster. The other three teachers, who had not volunteered, also wanted to continue to attend the sessions, when the option to withdraw was offered.

More topics from the orientation course were taken up. Except for Mr R. everyone evinced keen interest. At this juncture, an attempt was made to draw Mr R. out, to talk about what was upsetting and disturbing him, as he seemed to be highly disruptive to an effective group functioning. He revealed that he had had enough of the school and of teaching. He also complained how commuting by bicycle left him exhausted and irritable. The other teachers were silent, but supportive. He even declared that he was not interested in our programme. When all of us accepted that his feelings were understandable, he became pleasantly accommodating, and even offered some good suggestions. He had probably wanted reassurance that no one would force him to do something he did not want to do, and that every one understood and appreciated the hardships he faced. (However he died in an unforeseen and tragic road accident later in the year, very close to the school, on the main highway.)

The district assistant education officer was met and he evinced keen interest in the programme and offered to involve all the schools under his jurisdiction, for our work. However, follow-up action on that promise is yet to materialize, despite two meetings and some correspondence.

Fifth session: March 1994

Before the start of the fifth session it was decided to collect material for sports, art and craft to keep children, in classes with no teachers, occupied. The materials costing Rs 500 were donated to the school. Additionally, the following steps were taken:

- A list of children who gambled was to be drawn up, and their parents to be met.
- Eleven children were identified as requiring immediate attention, and were to be managed by the three trainee teachers.
- Seven children were identified as having a problem with stammering, were to be referred to a speech therapist.
- Ms S., who conducted the survey as part of her M.Phil requirement, took the play and art materials to those classrooms where there were no teachers, and devised strategies to keep the children busy. It was discovered that the class became quiet and very happy, being involved in interesting activities. The children would vie with each other to start new tasks. They became involved with outdoor and indoor activities.
- Mrs L., the nursery schoolteacher, described the progress she had made with the four children in her charge. The other three teachers had taken up eight children between them, and briefly described the cases.
- The parents of children who gambled were called to the school to meet the team and the teachers. The parents of five children came. The mothers pleaded helplessness and blamed television viewing and films for the problem. It was also discovered that there were three small gangs of children who gambled, in the village. It was pointed out to the parents that beating the children was not a solution. The children neeeded more supervision, so that they did not have an opportunity to gamble. Other parents, too, were given permission to stop any of the children if they (the parents) saw them (the children) gambling. The parents were also requested to maintain a study schedule at home, and to make sure that it was followed. Mrs R. described the case of a child who had improved at his studies, with strict supervision by his sisters. Controlled television viewing, not being given money, and punishment by his father, too, had helped. It was explained that punishment was not a good idea. It was decided that the sixth session would be held after the summer vacation.

Meanwhile it was decided that the assistant education officer and the primary healthcare personnel would establish some kind of a network, so that all teachers and primary healthcare personnel could be made aware of child mental health problems. In addition, more efforts would be made towards reducing preventing underage school enrolment and gambling. Efforts would also be made to provide more play materials to the school.

Sixth session: August 1994

Three teachers briefly reported on the progress they had made. Three cases handled by Mrs R. were doing well. Two children

handled by Mr S. were better, while one had died of some serious medical problem, which was unrelated to his mental health problem. Mrs A. claimed that the children she had taken up were better, while the other teacher said that the children were much the same as before.

Seventh session: September 1994

The materials for play were bought. It was decided by the teachers that they would also get some inexpensive, locally-made material, such as skipping ropes and *kolattam* sticks, as the district was known for woodcraft. Children could be taught group dance if *kolattam* sticks were obtained.

Children identified as suffering from epilepsy were referred to the district mission hospital. Unfortunately, speech therapy could not be arranged. Some other cases were evaluated and their management discussed.

What can be done—lessons from the seven-day sessions

Targeted intervention

- Teachers from one or more rural schools can be invited to attend eight to 10 sessions in a year. The needs of children with problems can be assessed, and a suitable course of action planned.
- Schools can tie up with the medical services available in the catchment areas.
- Targets can be identified for social action, such as excessive television viewing, gambling, alcoholism, early school enrolment and other such problems.

Universal intervention

- Adequate play and study material can be provided for the enhancement of physical, cognitive, language, social, emotional and moral development.

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Evaluation of service research

It may be noted that in evolving school mental health programmes, the author had incorporated, to a larger extent, evaluatory components in the initial phases of various programmes. Over the years, the research components have gradually diminished. The reasons are many.

An extensive database, which requires filling up elaborate forms, does not appeal to teachers. They do not, and rightly so, think that it is relevant to their work. They may, however, be persuaded to fill up, brief and clearly-stated questionnaires with very few scaling components. They prefer to answer simply 'yes', 'no' and 'I do not know'. In addition, it is often necessary to explain to them, even the simple words used in the questionnaires, be it in English or a regional language. The investigator's presence is often necessary for completing the assessment, whether it is a part of process or outcome evaluation. Thus, to expect overworked teachers to carry out research on behalf of the investigators is not only unrealistic, but also unreasonable. The best possible solution is to have an item pool, which is considered absolutely essential and get oral information from teachers. The forms should be completed by the investigators. This can result in considerable loss of detail, but one may be able to rescue at least some crucial data, which may otherwise be lost in the wilderness of incomplete information.

Following the first set of orientation courses between 1976 and 1980, the number of items and vignettes in the assessment questionnaires was drastically reduced. An enormous amount of collected data was never analyzed, because of paucity of financial and

manpower resources and time constraints. While researchers, with unlimited funds and manpower resources at their disposal, may carry out detailed assessments, the data should eventually be reduced to a simple format which can be used by any investigator. For example, putting together a machine such as a refrigerator is a complex task, but the user needs to know only a few simple operational routines. Efficient evaluation of data calls for simple indices which are easily handled.

There are, of course, valid reasons as to why evaluation of service delivery should be carried out. This could be to determine the quality of service, or carry out a cost–benefit analysis of the different kinds of service delivery; (service delivery essentially involves the use of funds and it is necessary to ensure that there will not be excess cash flow). There is a need to carry out evaluatory research services even when it is impossible to collect elaborate data due to a resource crunch. Some simple indices to determine the success of service delivery can be developed at the grass-roots level, on the basis of experiential data. The four indices are: attendance, follow-up, disruption and accommodation. These can be used as fair indicators of the possible success of the orientation or training programme, and to ensure that an interventive programme can be introduced in such a school.

Attendance index

Attendance in an orientation or a training-in-counselling programme has proved to be a sensitive index, not only in the author's work in schools, but also in her training programmes for lay volunteers in the delivery of mental health work. Teachers who attend atleast two-thirds or more sessions are likely to be genuinely interested in a programme. If one plans five to 10 sessions with a group of participants, a dramatic reduction in the number of participants occurs initially in one-third of the sessions. It is important that the worker or the investigator has realistic expectations about participation in voluntary mental health service delivery efforts. The following are some illustrations of our experiences in schools, where 'attendance' was the key index of interest.

In 1980, in a central school (these schools are considered to be among the best educational institutions in the country), of the 80 teachers on the staff only 12 attended the first session of the

orientation course, and only seven remained to attend the rest of the four sessions. Among the reasons were, overburdening of teachers with academic work and transfer of teachers. In a fee-paying school the teachers were interested in the programme, although the principal was not. Of the 29 teachers, 25 teachers on an average attended each of the five sessions. In a residential school, of the 16 teachers, five attended all the five sessions, nine attended four sessions, one attended three sessions, while one was on leave and was away from the school during this period.

Before planning a major intervention programme in schools, simple orientation courses consisting of four to six sessions and focusing on child mental health education may be carried out. This can be done on a weekly basis in urban schools, while in less easily accessible rural schools, two to three sessions can be arranged in a single day, perhaps for the whole day, once in a month or two months. The attendance index would give sufficient indication whether one should continue to work in a particular school or not. Schools often show initial interest in consultancy programme, but when the teachers themselves are expected to participate, they fail to be supportive.

Follow-up indices

After having achieved a satisfactory attendance index, the following activities may be undertaken to determine the follow-up index.

- encourage the teachers to read the manuals (and not just assume that they have read up what was given to them) and seek clarifications, and check in each of the sessions if they have indeed done their reading.
- ascertain if the group still harbours any of the misconceptions it may have had earlier, bring the issues out into the open for discussion, and assess whether group members have understood what was discussed. To illustrate, a discussion to clear misconceptions about adolescent sexuality is a good exercise for a group of high-school teachers.
- get the teachers to supply additional details about cases they may have described or brought up for discussion, and recheck that such details have been supplied.

- encourage the teachers to summarize what was discussed, especially on crucial and sensitive issues and thereby get a feedback on how well they have understood the issues.

In all the above components of follow-up indices, it is the investigator who records the observations and monitors them.

Disruption index

One has to watch out for people who are disruptive or negative in their approach to the programme. They could undermine the entire programme, unless they are tackled at the first possible instance. As soon as disruptive behaviour is noticed, it should be tackled in a non-confrontational and diplomatic manner, and by skilfully getting the support of other teachers in the group. This wins the confidence of group members and earns their respect. If disruptive individuals cannot be made part of the group, they may be encouraged to leave the group. They should not be permitted to disrupt the on-going group process. A 'convert or exit' policy should be adopted.

Accommodation index

In contrast to the disruption index, accommodation indices, such as the following, facilitate the group process:

- advance arrangements to enable teachers to attend sessions;
- provision of a comfortable and undisturbed place, with chairs, blackboard and other necessary facilities;
- provision of water and refreshments for the participants;
- arranging consultancy appointments efficiently by getting in touch with parents and teachers;
- involving heads of the institutions in the sessions, not to direct or supervise, but so that they may also learn;
- advance information to participants regarding changes, due to unavoidable reasons, in the schedules, and alternative arrangements.

Evaluation of interventive research

The evaluation of mental health service is beset with the problem of conflict of interest between the research and service components, especially in the school setting where teachers are expected to provide mental health service. The higher the component of research the lesser is the attention paid to the provision of actual service. The time at the disposal of the teachers to participate in these programmes is very limited. The longer the time taken for the research component, lesser time will be available for actual work. If a strong research component is to be included, funding and personnel resources should be made available and carried out by an outside team.

The following are some of the simple tasks which can be carried out by teachers with the help of the investigator. These can be used as simple indices of process and outcome evaluation, in addition to the four indices already described.

- A simple epidemiological survey of the school population can be supplemented by greater details obtained about those identified as needing help. Tools such as CBQ for screening CBCL/TRF for detailed study have been found to be time-consuming by the teachers—and have often to be read out and filled up by the investigator. The special tools to identify specific disorders are cumbersome for teachers to manage; teachers may overrate or underrate the symptoms unless supervised by the investigator. A simple and understandable tool which gives the 'symptom cluster' and can be verbally administered is particularly suitable in the Indian setting. The Developmental Psychopathology Check List (DPCL) (Appendix IV) developed by the author[1] can be used for the first level of screening and a second level of detailed work, to plan intervention strategy and possibly to monitor the outcome of interventions. For the first level of screening, there are 36 items, including components of hyperkinesis, conduct, learning, emotion and somatic/hysterical disorders, with 15 additional items, if required, to detect psychoses. For the children who are identified as disturbed, additional items from 79 to 124 can be used to explore into the nature of the family interactions, stressors,

social supports, and temperament. These would enable one to plan an appropriate treatment strategy for the child (Appendix IV).

- The teacher can meet the child/parents. The number of times the teacher meets the child/parents is a fair index of the commitment of the teacher to the case under her/his care.
- The teacher can record the sessions.

The recording of one's actual work is often avoided by post-graduate trainees at higher institutions of learning and healthcare workers at the grass-roots level. Recording should be kept to the minimum and should appear simple and non-threatening. It should elicit information on what has to be done, and what has been carried out. Details of what actually transpired could be narrated by the teacher and recorded by the investigator. Sometimes, such a description can reveal much about the effectiveness of intervention, in addition to the simple indices (such as how often the teacher has met the child and the family) described above. For example, one of the subjects was withdrawn and sad, following her father's death. The teacher spoke to the mother and discovered that the mother herself was depressed. In addition, the mother had had to assume the role of breadwinner. Consequently she (the mother) had no time, energy or the frame of mind to help her little daughter. The teacher understood that the child needed emotional support and security. She pursuaded the little girl that before going to her own class each day, she (the girl) should tell the teacher (counsellor) how she was getting on each day. During the next few weeks the teacher established communication with the child. She would smile at the child, pat her and ask her how things were, whether there were any problems and so on. Dramatic recovery occurred in a fairly short period of time in this briefest of brief innovative therapies. The crucial factor was not the duration or length of communication, but the emotional contact. Here the descriptive account conveys the essence of what transpired. More such accounts would help therapists to understand the essence of good counselling.

Index of improvement

An index of improvement seems simple and yet is hard to obtain. For example, one teacher may claim improvement in a child, while

another may deny it. Thus, reports of improvement from multiple sources may provide a better index. Are the child's problems the same as ever, worse or better than before? A parent too could be asked similar questions. Even illiterate parents can give an estimate of improvement in terms of paise in a rupee instead of percentage. The complexity of a measuring instrument and the data obtained from it, does not necessarily mean that the information obtained is superior to that obtained from simple measures. Crude measures can often be very sensitive indicators of the status of mental health in an individual child, as well as in the community. Simple impressionistic and global evaluation can be valid indicators. However, it is necessary to cross-check, follow up and confirm these findings.

In the preceding section, the nature of evaluation with individual children is described, while in the following section, evaluation at family, group and community intervention is briefly dealt with. This consists of:

(*a*) Following any community intervention, a study of a crude chain of action and reaction and analysis of reasons for inaction can be unearthed as a part of evaluation. Follow-up of failures is an important step. In any group or community, the nature of the problems and suitable solutions for them vary, as they are determined by a multiplicity of unknown forces. While this approach may appear ambiguous and crude for evaluation of community interventions it is almost impossible and unrealistic to hope that intervention can be scientifically assesed. A successful outcome evaluation does not necessarily bring about the desired changes. Bringing about actual change involves a series of steps to be negotiated successfully in a given situation. This could involve working separately with individuals to achieve something on a collective basis. For example, to stop a group of people from drinking alcohol, the ways of going about it may be complex, such as meeting the toddy seller, the employer, the wife and neighbours and the drinking companions.

(*b*) Identification of catalysts in the community who will enable the investigator to translate ideas into action is also essential. Not all individuals in a community can become change agents. There are no precise ways of carrying out community intervention. To be successful, school mental health

programmes have to be linked up with community action. Thus, the ideal approach needs acquisition of required skills by some people, social activism of a catalyst to establish a network of help, and these have to be carried out at different levels such as individual, school, family and the community at large.

The school mental health projects described above could be replicated across the country, if administrators in the education and health sectors set up systems of training the trainers. The trainers could be identified amongst the teachers in the school settings. In the rural areas, briefer training programmes could be carried out by training the schoolteachers and primary healthcare workers.

To sum up, the philosophy is to reach out to those catalysts who are about children and the community and want to seek solutions, however complex the problems might appear, with persistence and determination. That kind of spirit is reflected in a statement by a teacher who worked wonders under very difficult circumstances in a slum school. When asked what kept him going he simply smiled and said, 'If I do not do it, who else will?'

NOTE

1. S. Phadke: 'Child Welfare with Focus on Policy Issues', in T.S. Saraswathi and B. Kaur (eds), *Human Development and Family Studies in India*, New Delhi, Sage Publications, 1993; NCERT, *Integrated Education for Disabled Children*. New Delhi, 1988.

seven

Policy perspectives and child mental health in India

In India, children constitute nearly 40 per cent of the 900 million population. Although, the setting up of priorities for research and service in the area of mental health has been long overdue, a good deal of attention is being paid to research and training in mental health service for mentally-retarded children and adults under different ministries and specialized centres of higher learning. It is heartening to know that the government policies concerning children are forward-looking. However, the national policies have not all been translated into practice. The book describes some attempts to translate some components of these policies into action, especially in the school setting.

National Policy for Children[1]

Under this policy, several important policy statements were made. These were;

- All children shall be covered by a comprehensive health programme.
- Programmes shall be implemented to provide nutrition services with the object of removing deficiencies in the diet of children.
- Programmes will be undertaken for the general improvement of the health, nutrition and education of expectant and nursing mothers.

- The state shall take steps to provide free and compulsory education for all children up to the age of 14, for which a time-bound programme will be drawn up consistent with the availability of resources. Special efforts will be made to reduce the prevailing wastage and stagnation in schools, particularly in the case of girls and children of the weaker sections of society. The programme of informal education for preschool children from such sections will also be taken up.
- Children who are not able to take full advantage of formal school education shall be provided other forms of education suited to their requirements.
- Physical education, games, sports and other types of recreational, cultural and scientific activities shall be promoted in schools, community centres and such other institutions.
- To ensure equality of opportunity, special assistance shall be provided to all children belonging to the weaker sections of the society (such as Scheduled Castes and Scheduled Tribes), and those belonging to the economically weaker sections, both in urban and rural areas.
- Children who are socially handicapped, who have become delinquent or have been forced to take to begging or are otherwise in distress, shall be provided facilities for education, training and rehabilitation and will be helped to become useful citizens.
- Children shall be protected against neglect, cruelty and exploitation.

Preventive and promotive aspects of healthcare, particularly for preschool children, education for other groups of children at risk, and training and rehabilitation of handicapped children were considered to be the priority programmes. National Children's Boards were constituted at the central and the state levels, for planning, review and coordination of all the essential services. The role of the voluntary sector in this effort was recognized. In addition, the need for effective legislative and administrative backing, and the importance of community participation was highlighted.

Integrated Child Development Services (ICDS)[2]

A special programme for children under the welfare sector, with emphasis on early intervention, the Integrated Child Development

Services programme has been in operation for nearly two decades. It covers children under the age of 14 years, both in urban and rural areas.
The objectives of the programme are:

- to improve the nutritional and health status of children in the age group 0–6 years;
- to lay the foundations for proper psychological, physical and social development of the child;
- to reduce the incidence of mortality, morbidity, malnutrition and school dropout;
- to achieve effective coordination of policy and implementation amongst the various departments; and
- to enhance the capability of the mother to look after the normal health and nutritional needs of the child through proper nutrition and health education.

The programme offers day care facility (*anganwadi*) for every 1,000 persons, and covers preschool children in the urban slums, as well as those in tribal and other economically backward areas. The programme provides supplementary food, immunization, health checkup, referral services, along with information on nutrition and education in child care for mothers. Preschool education is one of the priorities. Some studies have been conducted to evaluate the actual impact of the programmes (NIPCCD 1978, NIPCCD 1979, Gopala Das).[3]

As pointed out by Phadke[4] despite many problems, the ICDS programme remains the most viable approach to protect children from major developmental hazards and give them a fair start in life. All the possible strategies to strengthen the resources of the families and communities should be deployed in the interests of the children by suitably trained community volunteers; and motivation, education of the parents and local communities can do a lot more for the children than they were given credit for. While ICDS represented a step in the right direction, it would be disastrous to be complacent about the prospect of its countrywide coverage. The task begun could not be imagined to be the task completed, and many complex problems of its implementation have to be squarely faced.

In future the ICDS workers could be given mental health and normal child development inputs especially for preschool age range.

Integrated Education for Disabled Children (IEDC)[15]

The objective of the programme of Integrated Education for Disabled Children is to integrate the physically and mentally handicapped into the community. It also aims to provide educational opportunities for disabled children in regular schools. Disabled children include those who are orthopedically-handicapped, mildly hearing-impaired, partially sighted, mildly mentally-retarded, or those with multiple handicaps and learning disability. A special teacher would take care of the children with special needs in a regular school. The evaluation of these schemes is awaited.

In the majority of urban schools, where the teacher–pupil ratio is poor, the integration of the mentally disabled into the school setting poses a number of problems. As part of the school mental health project in Sriramapuram, described in Chapter 3, an attempt was made to develop an integrated strategy, as the parents of mentally retarded children were unable to make use of the free facilities offered outside the school setting. The creation of a resource facility, with a specially trained teacher paid by the welfare ministry, seems to be the practical way of translating the policy into practice. The task of integrating the physically handicapped requires attitudinal changes in the teachers and this, in fact, formed part of the orientation course for the teachers described in Chapter 2.

National Health Policy[6]

The National Health Policy envisaged as the starting point of a planned health policy gives special attention to the physical, mental and social health aspects of the physically disabled and mentally handicapped. The policy envisages, apart from decentralized healthcare, the provision of maternal, child and school health services as important tasks ahead. The curative and preventive aspects of health are equally emphasized.

In addition to other aspects of healthcare, decentralized school healthcare is considered as an important objective. In the Sriramapuram experiment, mental healthcare as a component of total

healthcare is being run in a decentralized manner, through primary health care staff, teachers and through child to child programmes. In short, it represents a working model of what is being proposed in the health policy document.

The National Mental Health Programme for India[7]

The National Mental Health Programme for India seeks to achieve the following objectives:

- to ensure availability and accessibility of minimum mental healthcare for all in the foreseeable future, particularly those belonging to the most vulnerable and underprivileged sections of the population;
- to encourage the application of mental health knowledge in general healthcare and psychosocial development;
- to promote community participation in developing mental health service and to stimulate efforts towards self-help in the community.

The programme will have three components, namely, treatment, rehabilitation and prevention of illness and promotion of positive mental health. The recommendations for further action are:

- Mental health must form an integral part of the total health programmes and as such be included in all national policies and programmes in the field of health, education and social welfare.
- Considering the importance of mental health in the total development of society, mental health aspects should be kept in view in the planning of activities for national development.
- Appreciating the importance of mental health in the training curricula for various levels of health professionals, suitable action should be taken with the appropriate authorities to strengthen the mental health educational component.

The programme covers adults and children alike, with special emphasis on mental health programmes being included in the health, welfare and education sectors.

The National Mental Health Programme for India was an effort to develop future mental health services in the country. The programme envisages mental health to be a part of the existing total health programme. Within this framework, the recognition and management of epilepsy, and liaison with schoolteachers and parents by multipurpose workers for the management of children with mental retardation and delinquency were also included as targets.

The policy, however, emphasizes the education sector's role in mental healthcare regarding social, behavioural and learning problems, and suggests that teachers should be given adequate orientation in early diagnosis. The programmes developed by the author go beyond these limited aims of sensitization and deal with training in *the actual management of mental health problems and the promotion of healthy psychosocial development in the school setting*.

National Policy on Education[8]

The National Policy on Education states that early childhood care and education (ECCE) will receive high priority. It recognizes the holistic nature of child development, viz., nutrition and health, and social, mental, physical, moral and emotional development. Daycare centres will be provided as a support service for universalization of primary education. The programmes will be child-oriented and focus around play and individuality of the child with effective community participation. Integrated child care and pre-primary education will be integrated to strengthen primary education. Elementary education will aim at universal enrolment and retention of children below 14 years of age in schools, and at improving the quality of education; school facilities will be improved. Non-formal education will be launched for school dropouts. The policy aims at free as well as compulsory education up to 14 years of age by 1995. Secondary education and vocationalization are aimed for at higher levels of education.

Child Labour (Prohibition and Regulation) Act[9]

The National Policy on Child Labour (1995) aims to encourage excellence without losing out on social justice. The Child Labour (Prohibition and Regulation) Act of 1986, clearly states that child

labour is prohibited in specified situations for children below 14 years of age. However, there is no universal prohibition and children are employed subject to certain strict rules regarding safety, number of hours of work, minimal wages and so on. Also, erring employers who do not follow the above rules could be legally prosecuted. In addition, attempts at combining aspects of non-formal education to enable the working children to benefit from the policy are being carried out.

The major criticisms of the Child Labour Act are that no minimum age has been set for occupations permitted to children and that no provision exists for the education of working children. Another problem is that children working for their families continue to be outside the scope of legislation, which leaves a dangerous loophole in the law as employers can try to pass off workers as family members.[10]

The magnitude of the problem of child labour in the country should be of special concern to mental health professionals. Yet, if universal education becomes a reality, the problem will disappear as a natural consequence. In turn, mental health work in the schools will have larger populations to deal with, and will have greater challenges to face in the national context.

The translation of national policies into practical strategies for the provision of mental healthcare requires that mental health professionals establish effective networks of research and services, both in hospitals and in the community.

The above description of various policy documents highlight what needs to be done in the Indian context. The present efforts focuses not only on what has been done, but also what could be done in future, based on the experience over several years and in different settings. Chapter 8 will demonstrate how the policy documents have been or can be translated, at low cost, by volunteers (schoolteachers and non-governmental organizations) in liaison with the health sector and with community participation.

The implementation of these policies into reality is naturally been beset with problems. This is especially so with child mental health problems, which, though of a serious magnitude, have been understood the least and are coupled with the paucity of trained personnel to deal with them. How mental health professionals could help to translate the policies so as to reach the child population at risk, should be a matter of concern for them. The magnitude

of the problem should make the child mental health professional tread with caution and with due care in evaluating the services in terms of efficacy, manpower, and economic cost-effectiveness.

NOTES

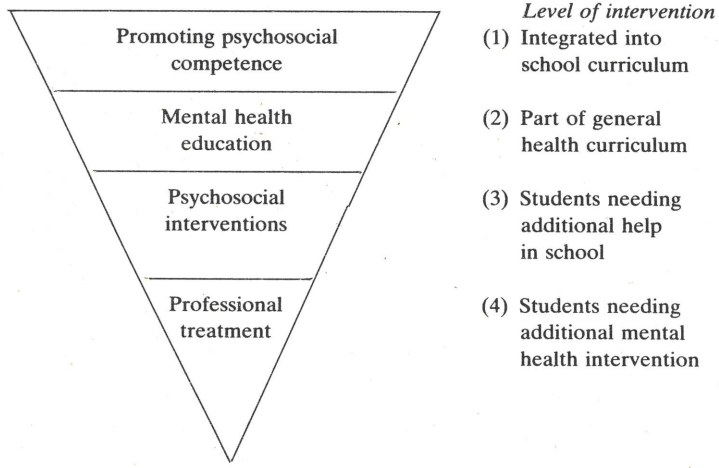
1. Government of India, *National Policy for Children*, Department of Social Welfare, New Delhi, 1974.
2. Government of India, *Integrated Child Development Services (ICDS)*, Planning Commission, 1972.
3. National Institute of Public Cooperation and Child Development, *The Working Mother and Early Childhood Education*, New Delhi, 1978; National Institute of Public Cooperation and Child Development, *Some Facets of Child Development*, New Delhi, 1979; T. Gopala Das: 'An Early Evaluation of Integrated Child Development Services (ICDS) Programme in India', *The Baroda Journal of Nutrition*, 9, 396–401, 1982.
4. S. Phadke : 'Child Welfare with Focus on Policy Issues', in T.S. Saraswathi and B. Kaur (eds), *Human Development and Family Studies in India*, New Delhi, Sage Publications, 1993.
5. NCERT, *Integrated Education for Disabled Children*, New Delhi, 1988.
6. Government of India, *National Health Policy*, Ministry of Health and Family Welfare, New Delhi, 1993.
7. Government of India, *National Mental Health Programme for India*, Ministry of Health and Family Welfare, New Delhi, 1984.
8. National Policy and Education University, News, July 1, 1986.
9. Government of India, *Child Labour (Prohibition and Regulation) Act*, Registered No. D-(D)-72. The Gazette of India, extraordinary Part II, 1, New Delhi, 1986.
10. M. Bose: 'Child Labour Legislation in India', *The Lawyers*, 6–11, 1988.

eight

Implications of the work in India for developing countries and in the global context

The document entitled *Mental Health Programmes in Schools*[1] addresses workers at the grass-roots levels, and school settings, across the world. The document scans 77 reports from different parts of the world, from the most developed countries to the least, with regard to provision of mental healthcare for children in the school setting. The document strongly recommends that school is the strongest institution in the child's life and schools have unprecendented opportunities to improve the lives of children. The intervention model proposed is at four levels (Figure 8.1).

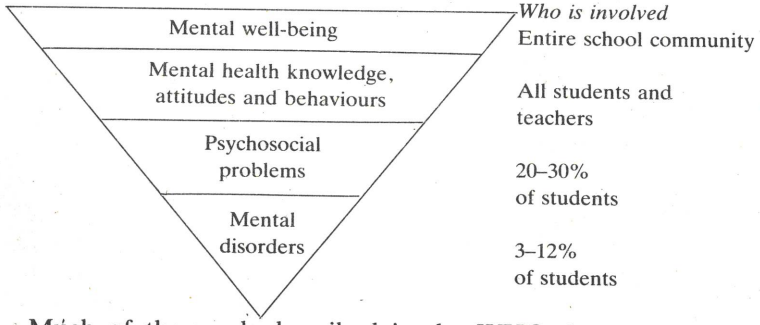
Figure 8.1
Comprehensive School Mental Health Programme



In the regions where mental health has not received much attention, a mental health programme may focus on only one or two levels initially. However, to be maximally effective, an integrated programme at all four levels is required. Levels (1) to (4) can be respectively likened to primary (1–2), secondary (3) and teritiary (4) prevention efforts.

The WHO document[2] aptly describes the structure of a model framework for a school mental health programme (Figure 8.2).

Figure 8.2
Psychological Issues in Schools



Much of the work described in the WHO document can be successfully adapted in elitist schools in India. The programmes which directly intervene at the various levels, require higher manpower and financial resources.

In addition the document focuses on *promoting psychosocial competence, mental health education and instruction, and the identification of and intervention in and psychosocial and mental health problems*.

The following section focuses on psychosocial mental health problems, their identification and intervention.

Identification of psychosocial problems and high-risk populations

Risk-taking behaviour such as smoking, substance abuse, too-early sexual activity and life-endangering adventures (such as driving recklessly) may be an early indication that a young person is in danger of succumbing to more serious problems. Early intervention may prevent serious consequences. Psychosocial problems become

evident through changes or deviations in emotions and/or behaviour. This may include aggressiveness, excessive shyness, the worsening of interpersonal relationships, poor school attendance, a decline in academic performance, widely fluctuating moods, changes in peer group, recourse to risk-taking behaviour, obsessive and compulsive behaviour, and unusually exaggerated or repressed feelings associated with physical illness. Learning problems can also lead to behavioural problems and school failure, a very significant life stress.

Risk factors affecting a child can include developmental delay (late walking and talking), difficult temperament, history of physical or sexual abuse, chronic illness and disability, scholastic underachievement and being forced stay out of the home. It should also be recognized that children with visual and hearing problems, as well as those with specific learning problems (e.g., dyslexia) are at special risk of also having mental health problems. Extra care needs to be taken by health professionals in screening for these disorders.

The disorders mentioned above are: substance abuse (drugs/alcohol), conduct disorder, post-traumatic disorder, and disorders such as depression, attentional problems, psychoses, anxiety, and eating disorder.

In the context of developing countries, perhaps the most common problems may be risk-taking behaviour such as drug and/or alcohol abuse, recklessness and gambling; conduct disorder; attentional and learning problems; emotional and somatic problems; and psychoses in children from psychosocially deprived backgrounds. Child labourers and street children are at special risk, and require intervention at the community level.

The WHO document (Section 6.3) describes some of the commonly used tools of assessment. The ones used in the Indian context are mentioned in Chapter 1. The author, in addition to using these, has developed a special checklist suitable for developing countries with an illiterate population. It can also be used for detailed investigation by teachers in developing countries.

Section 6.4 of the WHO document described the following steps:

- identification of the student who requires help;
- understanding the problem;

- intervention in school, and an out-of-school treatment plan; and
- follow-up.

The WHO document implies that the identified population can only be treated by counsellors or mental health professionals in a school-based mental health centre, or crises intervention and referral centres. Direct consultancy of the kind described in the WHO document is not a feasible model in developing countries, where there are very few mental health professionals and counsellors. Trained teachers can manage most disorders, and cases of serious mental health problems could be referred to specialists. It is important to highlight where such services are available, and also how the available resources in the community, i.e., in schools and primary healthcare centres, can be utilized. In fact, a WHO document prepared earlier in 1982, had envisaged this possibility and prepared manuals on child mental health and psychosocial development for primary healthcare physicians, primary healthcare workers, teachers and workers in children's homes. *The author's work actually demonstrates how a mental healthcare programme can be implemented with the help of trained teachers.*

Steps for programme development and implementation

The combination of methods chosen to develop a mental health programme is likely to vary from country to country and must be tailored to the needs and strengths of the particular region where the programme will be implemented. Recognizing that there will be individual variations, the following steps for programme development and implementation are suggested:

Step 1: Establishment of a team

The planning for a comprehensive school mental health programme begins with collaboration among school personnel, family members, community members, mental health professionals, and students to create an environment that is productive, positive and supportive.

The family

The fundamental unit in all societies is the family. Thus, the key factor in the success of any school mental health programme is the degree of family commitment to a programme.[3] The importance of the family environment to a child's school performance and mental health has been widely recognized and efforts are increasingly being made to involve family members, as active partners with the school.

The most important place for a child's development is the home, under the guidance of the family. It is important that parents and other family members are appreciated for the powerful influence they have on their children in the teachings of attitudes, values and beliefs. With better understanding of their role, parents and families can better appreciate their complementary role in mental health education and promotion of their children.[4] Parent–teacher associations, for e.g., offer the potential of creating an environment of collaboration and cooperation.

The community

A healthy school is an important part of the community that surrounds it. Community members should feel that their neighbourhood school is open and receptive to their ideas and participation. Schools, in turn, should be supported by community members through their participation in school programme development and through their support for adequate financial backing to carry out the school's mission. It is very important that any school mental health programme has the support of the governing board of the school and the head of the school.

Teachers

Teachers are the key to the successful implementation of a comprehensive school mental health programme. Teachers' perceptions are essential in planning and implementing life skills education, mental health education, psychosocial interventions and professional referral, when necessary. It is important to understand their perspectives and support their needs.[5]

Mental health professionals

Mental health professionals can have a variety of environment-centred and child-centred roles in a comprehensive school mental health team, and in many cases may have more than one role.

The mental health professional may serve as a consultant for teachers in programme development and implementation and for parents in their relationships with their child and their child's teacher. The role of the consultant focuses not only on providing mental health expertise during the direct evaluation of the student and the family, but also on serving as a resource person to the teacher, counsellors, and the parents, to establish procedures for dealing with potential problems.[6]

The mental health professional can be of benefit as a consultant to a school, a school district, educational administrators, and educational commissions. This consultation can help schools provide the best mental health programmes within their budget, help interpersonal relationships within the school system to function more effectively and increase the awareness of the mental health issues of children, families, teachers and among people who may be removed from daily contact with these groups.

The mental health professional can also serve as a consultant member of the school team, where the specific needs of individual children, families and teachers are met by mental health staff members within the system. The mental health professional is available for individual consultation, group discussions, or in-service teaching sessions. For example, seminars in behavioural management for school staff, rather than direct work with referred children, provides them with skills they can use with subsequent groups of children.

Step 2: Assessment of school and community environment

Basic information regarding regional demographics, health risks, and resources should be available for the team to consider. When possible, an assessment focusing on community strengths, available resources and needs, should be made to provide the planning team with the information they require to develop objectives.

When considering the various options for implementation, an important one is that the effectiveness of a preventive intervention requires a good match between intervention and the cultural, geographic and social–political characteristics of the region.[7] The most appropriate choice within the model framework presented in this book depends on the culture of the region, the resources available, the educational system, the political will, the interests of the school administration and teachers, and the point of entry available into the educational system.

Step 3: Development of a plan

Once the needs and potential for school health programmes are assessed and appreciated, and ideas for the most suitable elements of the model framework are discussed among parents, educators, students, community members, and mental health professionals, the next task is to develop a specific plan of action, including clearly stated objectives, assignment of responsibilities, a time frame and a coordinating mechanism for agency (sectorial) linkage.

To be successful, programmes must be based on the recognition of needs that are perceived to be important to the people in charge (for example, teachers, principals, public officials, community leaders). Local leaders must develop and/or adapt a programme so that it fits with their own strengths and needs. If a programme is adapted from another culture, it is important to understand which elements of the programme are not culturally limited and can remain unchanged, and which portions must be changed to make them culturally relevant.[8]

The most accessible and appropriate point of entry into the educational system should be determined in order to introduce, develop and maintain a comprehensive approach to mental health programmes. Mental health interventions may be accepted most readily if they are:

- part of the general educational system;
- implemented through routine healthcare in school;
- supported and developed by families and parent groups;
- brought in through the support of school counsellors and/or teachers who recognize that poor social functioning interferes with learning; and

- brought in through a commission or board of education who recognize schools as the best setting to improve the functioning of children in their country and thus to improve their children's and their country's future.

The biggest task in developing a comprehensive school mental health programme often is the establishment of stable financial support for such a programme. Collaboration with other community and governmental agencies may lead to a pooling of resources directed towards the mental health of young people. However, in many communities, additional financial resources may be necessary.

To take an example, a comprehensive school health programme in the slums of Bangalore, India, is run on a 'shoestring budget' and is successful thanks to the efforts of voluntary agencies, teachers and other health professionals[9]. In this project, mental health is one component of the total school health project.

Step 4: Monitoring and evaluation

All programmes require thoughtful evaluation including the measurement of outcome. This is important not only to determine whether or not a particular programme is effective but also because good research helps to improve already effective programmes and retain support for existing programmes. In addition, it is important to disseminate those aspects of a programme that are effective, to other communities.

When designing a mental health programme, the evaluative outcome study should be designed at the same time. Baseline data on the mental health of the children, the quality of school health services, the environment of the school and the health knowledge, skills and practices of students, are all essential for evaluating the effectiveness of a planned intervention.

The methods used to measure the effectiveness of the intervention, research design, and type of statistical analysis used, may influence the evaluation of a variable as a potential risk factor, an important mediating factor, or a measure of outcome.

- Meaningful outcome research should look not only at changes in attitudes and values as expressed before and after intervention, but also at changes in actual behaviour.

- Programme objectives, interventions to be assessed, outcome measurements as well as plans for data collection, analysis and dissemination should be specified during the planning stage.
- Rating scales chosen to evaluate outcome must be easy to administer and score, and deal with relevant and important areas for teachers, students, parents and funding agencies.
- Descriptive indicators of outcome such as positive written and verbal feedback from the participants should also be collected.

One approach to measuring outcomes, which may be particularly applicable to school-based mental health programmes, utilizes goal attainment changes as the unit of measurement. Initially the team of school professionals, students, parents and community members meet with a professional skilled in outcome research, to determine how successful outcomes will be defined in a way that can be measured reliably. The evaluation process is then planned, implemented and the outcome data analyzed and disseminated. The initial planning team meets again and discusses whether or not the goals were met and makes appropriate modifications.

A well-designed outcome study is not possible in every community. However, it is possible to collect information that will help in the evaluation of programme effectiveness such as parent, pupil and teacher satisfaction questionnaires, testimonials, criticisms from people involved, and a careful recording of the process of implementation for later review.

Step 5: Coordination and modification of programmes

Developing a comprehensive, integrated mental health programme in schools is an on-going process, that requires constant attention, evaluation and adaptation. Successful programmes are rewarding for all who are involved with them, as they lead to healthier and more productive children and adults.

In addition to the work with the children, it is essential that the parents are made to understand the genuine nature of the difficulties of the child. They should be involved in helping the child overcome them by using the strategies especially evolved for that child. Parents should approach the child's problems realistically and with

understanding. They should not be overambitious and punish the child. Similarly, teachers also need to know about the nature of the child's learning problems in order to help her/him. The best results are obtained when the remedial work is carried out with the child, with full support from the parents and the school.

An effective school mental health programme:

- takes into account the relationship between the school and community environment, as well as any unique cultural values and identities;
- identifies the sociopolitical conditions and processes likely to be associated with the establishment and survival of a comprehensive mental health programme in the school;
- involves families and community members as active partners in planning, implementation and on-going evaluation;
- utilizes the skills of school and community mental health professionals;
- intervenes at multiple levels;
- has a coordinating mechanism;
- focuses on teacher and parent training;
- evaluates its effectiveness and utilizes this information in programme modification.

The author has developed a programme for mental health delivery in rural areas, which can be attempted at different centres across the nation. The first objective is to identify psychiatric conditions, through epidemiological surveys, and the second is to evolve strategies for delivery of mental health services in rural areas, utilizing the services of teachers, *anganwadi* workers and primary healthcare personnel. The priority conditions for identification, referral and management are:

- impairment and delay in language development;
- impairment and delay in normal development (mental retardation) and other pervasive developmental disorders;
- specific learning disabilities/academic problems;
- attentional deficit disorders;
- sensory handicaps;
- serious psychiatric disorders;
- epilepsy and other chronically disabling illnesses;

- emotional and behavioural problems (internalizing and externalizing disorders).

The above conditions will be identified on the basis of cut-off points provided by the various tools (such as CBQ, Developmental Psychopathology Check List and developmental screening).

The study will be conducted on a population of 3,000 rural children below the age of 16 years. An economically backward area of rural Karnataka will be identified. A primary health centre (PHC) covers a population of 15,000–20,000. Nearly 40 per cent of the population are children. Thus, a population of 3,000 children forms 50 per cent of the population covered by a single PHC. In a small village with a population of less than 1,000, 80 per cent belong to the poorer classes while in the villages with a population more than 2,500 nearly 50 per cent are poor.

An attempt would be made to take an equal number of large and small villages. All the families within the village would be surveyed and all the children below the age of 16 would form the sample. School-going and non-school-going children, in the ratio 2:1, and boys and girls, in equal ratio, are likely to be represented.

The survey and the intervention will be carried out in a staggered manner. The entire sample will be divided into self-contained, conveniently located geographic units, consisting of a village or two. The period of the survey is divided into six time blocks of three months each. For example, in the timespan of three months, a sample of 400–600 children will be surveyed. This would be followed immediately by intervention. Similarly, all the six blocks will be covered in 18 months' time. This procedure has several advantages. First, it provides immediate intervention to the population surveyed; second, after identification it permits a longer period of follow-up for children seen in the initial phase of the survey; third, based on experience it provides a chance for the team to evolve better strategies, in each of the blocks as time progresses. The intervention will consist of establishment of a network of mental health service directly involving the parents, PHC and school personnel.

Recommendations

Now is the ideal time for families, communities, and young people to rally around their schools to develop and support a comprehensive

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Appendix I

Statistical data

Table A1
Percentage of Teachers Who Answered the 20 Statements in the Affirmative (N = 22)

Sl No.	*Items*	*Percentage*
1.	Mental illness is mostly hereditary	32
2.	Some degree of corporal punishment is good for children	52
3.	Stammering is due to brain disorder	13
4.	Epilepsy can be completely controlled	41
5.	Epilepsy is contagious	5
6.	Coeducation is good for children	86
7.	Sex education is necessary for high school children	90
8.	Quiet children learn better	23
9.	If children are free with teachers, it is a sign of indiscipline	0
10.	Headaches amongst children are often due to emotional stress	63
11.	All children must be persuaded to write with their right hand	23
12.	Asthma in children is often due to emotional stress	23
13.	Stammering is curable	90
14.	Emotional disturbances are common among children	90
15.	Emotional problems may cause failures in exams	100
16.	Masturbation is bad for health	41
17.	Inability to read, in an apparently average child, could only be due to intellectual backwardness	32
18.	Inability to do 'sums', in an apparently average child, could only be due to intellectual backwardness	23
19.	Defective hearing and vision can affect scholastic performance	90
20.	A physically handicapped child, given due consideration, is capable of benefiting from normal school	95

Table A2

Ranks Assigned by Trainees to Five Techniques on Two Parameters

	Understanding				*Interesting*			
	Total Ranks	*Mean Ranks*	*S.D.*	*Medians*	*Total Ranks*	*Mean Ranks*	*S.D.*	*Medians*
Lectures	40.00	2.22	1.50	1.50	49.50	2.75	1.47	2.75
Summaries	64.00	3.56	0.89	4.00	54.00	3.00	1.28	3.00
General discussion	49.50	2.75	1.10	2.50	53.00	2.94	1.21	3.00
Case discussion	43.50	2.42	0.97	2.25	47.00	2.61	1.17	2.00
Role play	73.00	4.06	1.36	5.00	66.50	3.69	1.47	4.00

$r = 17.5$ (df: 4), $P < 0.05$.
$r = 5.03$ (df: 4), $P > 0.10$.

Table A3

Changes in 'Knowledge' Items Towards the Problems of Children Before and After the Course (N = 80)

	Supervisors' Opinion	*Agreement with Supervisors*		X^2	*Level of Significance*
		Before (%)	*After (%)*		
1. Children, like adults, can also become mentally ill	Agree	70	84	5.26	$p < 0.05$
2. Poor performance at school may be due to defective vision and hearing	Agree	74	85	4.26	$p < 0.05$
3. Epilepsy can be almost completely controlled by medicines	Agree	34	68	20.09	$p < 0.00$
4. Poor performance in school is often due to emotional problems	Agree	81	72	1.82	$p < 0.05$
5. A child with paralysis of the legs can do as well as studies as any other child	Agree	13	13	0.00	$p < 0.05$
6. Asthma may be due to emotional disturbance	Agree	30	62.5	16.12	$p < 0.001$
7. Emotional disturbance can cause stammering	Agree	48	83	21.78	$p < 0.001$
8. Poor intelligence can be improved with medicine	Disagree	43	71.5	17.07	$p < 0.001$
9. Tuberculosis is often due to emotional disturbances*	Disagree	31	62.5	18.94	$p < 0.001$
10. A child whose epilepsy is under control may do as well at studies as any other child	Agree	46	64	4.67	$p < 0.05$
11. Headaches may often be due to emotional disturbances	Agree	82	73	1.82	$p < 0.05$
12. A child may miss classes may due to emotional disturbances	Agree	68	57	2.08	$p < 0.05$

* The item was introduced to check indiscriminate answering.

Table A4

Relationship between Some Hypothetical Situations and Counselling Potential Elicited by Them (N: 80)

	Scores Obtained		*Difference*	*t Value*
	Before	*After*		
1. Child fearful of examinations	73.50	74.13	0.66	0.52 (N.S.)
2. Bright child being inattentive	68.04	67.42	−0.62	0.14 (N.S.)
3. Dull child being inattentive	64.63	80.09	15.46	0.60 (N.S.)
4. Delinquent with problem family	101.05	107.96	6.91	0.99 (N.S.)
5. Child getting anxious because of an unreasonable teacher	74.01	74.09	0.08	0.33 (N.S.)
6. Unmarried pregnant girl	85.46	101.99	16.49	1.78 (N.S.)
7. Clinging child	125.40	128.31	2.91	0.19 (N.S.)
8. Child unable to take examinations because of unreasonable father	77.10	116.98	39.88	5.39 ($p < 0.001$)
9. Physically handicapped child	97.68	136.80	39.12	4.08 ($p < 0.001$)
10. Child getting fits in class	71.00	103.84	32.84	5.47 ($p < 0.001$)
Mean	83.79	99.17	15.39	2.98 ($p < 0.052$)

Table A5

Extent to which Trainees had Difficulty in Understanding the Four Sub-categories of Case Presentation

	Mean	*Standard Error*
1. Historical information	1.08	0.19
2. Observation	1.33	0.19
3. Formulation	0.83	0.17
4. Management	0.92	0.15

$F = 3.6594$

$P < .05$ (df. 3.33)

Table A5 (Continued)

i. When b and c are compared $t = 3.0677$ (df. 33) $p < 0.01$

ii. When b and d are compared $t = 2.5564$ (df. 33) $p < 0.05$

iii. Other differences were not significant

Table A6

Correlation between Rating Discrepancies and Progress of the Training Programme

Discrepancy Rating	*Correlation with the Progress of Training*	
1. Between self and group	$r = -0.53$	$p < 0.10$
2. Between self and supervisors	$r = -0.71$	$p < 0.05$
3. Between group and supervisors	$r = -0.65$	$p < 0.05$

The table shows the discrepancies in the ratings between self and supervisor, self and group and group and supervisor over 12 sessions. A Pearson Product Moment Correlation Coefficient for the groups of ratings was carried out. The negative correlation indicates that the discrepancies between the ratings decrease as the sessions progress. In other words, the assessment by the trainee starts approximating to the assessment made by the supervisors as the course progresses.

Table A7

Age, Intelligence Quotient, CBQ Score and Stressors for 10 Children

	Child	*Age*	*IQ*	*Psychosocial Stressors*
Play therapy group	1	5	97	Alcohol dependence in father;
	2	5	105	Alcohol dependence in father;
	3	5	91	Alcohol dependence in father; punitive parents
	4	6	97	Alcohol dependence in father;
	5	6	90	Inconsistent disciplining
I.Q. Mean 96; s.d.5.37				
Control group	6	5	93	Intrafamilial discord; alcohol dependence in father
	7	5	86	Alcohol dependence in father
	8	5	89	Financial pressures
	9	6	97	Alcohol dependence in father; financial problems

Table A7 (contd.)

	Child	Age	IQ	Psychosocial Stressors
	10	6	86	Alcohol dependence in father; financial problems
	I.Q. Mean 90.2; s.d. 4.15			

Table A8
Number of Sessions, Pre- and Post-CBQ Scores

Child	No. of Sessions of Play Therapy	Pre-Rutter's Score	Post-Rutter's Score	Difference in Pre- and Post-Intervention Scores
1	12	16	4	12
2.	15	23	5	18
3	11	15	10	5
4	15	17	6	11
5	13	18	8	10
	Mean	18	5.6*	
	Control Group			
6	0	22	18	4
7	0	20	18	2
8	0	17	12	5
9	0	15	14	1
10	0	16	15	1
	Mean	18	15.4	N.Sig

* Significant at 0.001 level.

Table A9
Differences in Ratings on Overactivity Before and After Intervention

Assessment Tools	Before Intervention	After Intervention	't'
Conner's Rating Scale (rated by teachers)	18.2	7.5	8.02*
Barkley School situation (rated by teachers)	34.8	25.6	8.26*

Table A9 (contd.)

Assessment Tools	Before Intervention	After Intervention	't'
Barkley Home situation (rated by teachers)	28.1	21.7	8.91*

* Significant at .001 level.

Table A10
Differences in Scores on Tests Before and After Intervention

Tests	Before Intervention	After Intervention	't'
B.G.T. Koppitz (errors)	5.8	3.6	5.28*
Colour cancellation (single correct)	23.2	27.2	4.17*
Missed	3.0	1.5	1.89
Colour cancellation (double correct)	34.2	37.3	0.99
Missed	4.7	2.9	1.96
S.F.B.	19.3	18.5	1.27
Shortest trial	79.2	64.7	4.19*
Porteus maze	4.4	3.6	2.45**

* Significant at .001 level.
** Significant at 0.005 level.

Table A11
Scores Obtained Before and After Remediation for Scholastic Problems After 25 Sessions (N = 25)

Areas	Before Remediation Scores Mean	After Remediation Scores Mean	't' Value
Language:			
Reading (errors)	58.60	4.80	15.49*
Comprehension	7.92	13.44	11.75*
Spelling	6.08	8.76	6.39*
Writing (errors)	10.48	7.16	16.12*
Writing (time)	20.28	18.92	9.61*
Arithmetic	20.28	33.36	12.38*
B.G.T. (errors)	4.56	2.80	5.21*

* Significant at 0.001 level.

Appendix II

Child mental health problems: Guide to schoolteachers

Section 1: Causes of disturbed behaviour amongst children

All children face some problems as they grow up. A problem becomes something for a teacher to worry about, and requires to be dealt with, only if it is severe and lasts a long time or if it adversely affects the child's school performance.

Problems in the child

Why do serious problems arise? The reasons may have to do with inherited factors, like poor intelligence, sensory defects, mild brain damage, or acquired defects due to serious illness. A child may not have inherited any particular observable defect but may have inherited a vulnerability which could cause problems. For example, s/he may have a slightly immature nervous system as compared to her/his classmates. This may show up as poor coordination in walking or writing. Vulnerability may manifest itself as a temperamental inability to cope or compete with others, timidity, anxiety or fearfulness. During critical periods of development, particularly in adolescence, specific problems may arise.

Problems in the environment

Problems relating to the environment are those relating to the family, neighbourhood or school.

Family

- Parents who are quarrelsome and difficult;
- Parents who are very anxious and ambitious and expect too much from the child;
- Parents who are indifferent to the child;
- Parents who use excessive punishment;
- Sibling rivalry and jealousy; and
- Financial problems at home.

Neighbourhood

The child's family may not be like others in the neighbourhood and the child may not have suitable companions approved by her/his parents.

School

Teachers, like parents, may behave in a manner that distresses the child. They may punish children excessively, make criticisms and comparisons, expect too much from them or, even pick on one child constantly.

A child may get into trouble with other children. Teasing, bullying and fighting are common problems seen in classrooms. A child with physical handicaps or emotional problems, or one who is intellectually slow, or is suffering from epilepsy, stammering, etc., is often ridiculed by other children.

Usually there is a mixture of causes for a problem behaviour. A healthy child may not respond to adverse situations by showing disturbance. A particular factor may well produce different symptoms in different children; or a particular symptom may occur because of different causes in different children. Thus, it is essential to find out the causes of disturbed behaviour in a child, and then what to do about it. The child may then be referred to a specialist or managed at school.

Section 2: Disorders of emotion and conduct

Behaviour disorders can be broadly divided into disorders of conduct and disorders of emotion. A child may have a purely conduct-related or a purely emotional problem, or a mixture of the two. The causes have been explained in section 1.

What are the problems?

(*a*) Disorder of emotion are: Anxiety, excessive fear, phobia, extreme sensitivity, shyness, and timidity, difficulty in maintaining friends,

social withdrawal, moodiness, depression, daydreaming, nail-biting, thumb-sucking, compulsion, jealousy, school refusal, soiling, emotional factors and physical illness. These are generally very distressing to the child.

(*b*) Interplay of physical and psychological factors in the formation of illness. Examples are—headache, abdominal pain or asthma.

(*c*) Disorders of conduct are: lying, stealing, demanding, stubborn, temper tantrums, aggression, truancy, gang activities. These are generally distressing to those around the child.

Disorders of emotion

Anxiety

A child who is anxious is uncomfortable and frightened. The main symptoms of the child are palpitation, sweating (especially of the palms and feet), slight trembling, dry mouth, stammering and a look of fright and worry. Anxiety may be connected with something specific, like taking an exam or talking to a teacher. In some children anxiety may be a chronic condition.

Excessive fears

A child who is fearful is unable to accept or tolerate new situations, and is fearful about objects and situations which normally do not produce fear. When the child is afraid of these situations he expresses it, like refusing to go into a room alone because it is dark.

Phobia

Fear reaches an extent where the child acts in response to a situation or object, and restricts her/his activity—e.g., s/he refuses to go to school, lest s/he sees a dog on the street, the dog here being the object of the phobia.

Extreme sensitivity

It characterizes a child who reacts to criticism much in excess of what is expected, and who takes offence when none is meant.

Shyness and timidity

The child may not answer questions even when s/he knows the answers, and may not participate in classroom or extracurricular activities, withdrawing rather than making the effort to communicate. In this case the child is basically fearful but hides her/his fears behind withdrawn and timid behaviour.

Difficulty in maintaining friends

The child has trouble making and maintaining close contacts/friends. The child may also have difficulty in relating to her/his own siblings.

Social withdrawal

The child is not interested in being friendly or making friend, and avoids being with others.

Moodiness

The child, for no apparrent reason or for some trivial reason, suddenly becomes either sad, irritable or happy.

Depression

The child is not merely moody but depressed and persistently weepy, and avoids others. It is important always to attend to such children. Such children need very little to upset them and may even contemplate suicide.

Daydreaming

Daydreaming, to combat boredom, or during adolescence, is normal. If a child daydreams excessively throughout the day, it shows that s/he is distressed in her/his daily life.

Nail-biting, thumb-sucking and odd facial movements

These symptoms are generally indicative of nervousness and tension in the child, and are manifested when the child feels insecure.

Compulsion

This is characterized by repetitive acts (rituals) that the child performs, which follow a certain pattern. This behaviour is generally not noticed in the school setting, unless it is severe, as for example when a child repeatedly washes her/his hands.

Jealousy

A child may be upset about the teacher's partiality to some other child/children, or because the child may be jealous about what he/she lacks and some other child/children have. Similar factors at home can create jealousy in the child.

Interplay of physical and psychological factors in causing illness

Some disorders, like asthma, are greatly influenced by psychological factors. Though there is a physical basis for the problem, the illness is triggered by psychological or mental stress. For example, if a child is worried about examinations, an attack of migraine or asthma can start due to the tension. In such cases treatment is directed towards physical and psychological factors. There is another kind of disorder (e.g., headache or stomach pain) where a detailed physical examination reveals no physical basis for the pain, but the child still suffers. The pain is mainly due to a psychological problem, e.g., quarrels at home or inability to adjust in school. The treatment of the problem is mainly directed towards psychological factors.

Disorders of conduct

Lying and stealing

A child may resort to lying or cheating because of trouble with parents or at school.

Demanding and stubborn

The child insists on wanting something at any cost and will not rest until s/he gets it.

Temper tantrums

A child who does not get what s/he wants may cry, shout, beat others, throw and break articles, roll on the floor, stamp her/his feet on the ground and scream. The end result of this exercise is that the parent usually gives in to the child's demands. What s/he should do is to ignore the tantrum, and the child will quieten. Only if the child is in danger of getting hurt or hurting others should the child be restrained. The parent should not give in to the child's demands, as the child will then resort to a tantrum each time s/he wants something.

Aggression

The child resorts to violence in which s/he harms other's property, or even her/his own self, perhaps as a reaction to stress.

Truancy

The truant child says s/he is going to school but does not do so, and is found playing or roaming around with friends, and comes home at the time school is supposed to be over.

Gang activities

The child associates with a group of children whose activities are not desirable, and as part of that group the child may steal, drink, beat up others, and so on.

A child is influenced greatly by the environment s/he lives in. A teacher can follow some general guidelines in dealing with a child who has a problem:

- get friendly with the child;
- get the child to talk about family/friends;
- meet the parents and talk to them;
- if problems appear severe and of long standing, refer the family to a child guidance clinic.

Section 3: Problems of specific age groups

In addition to common problems faced by all children, special problems may present themselves at different stages of the child's development: Below 12 years (pre-school, primary and middle school); 12 years and above (High School).

Refusal to attend school

The child has to leave the security of his home and establish new relationships with strangers. The child may become fearful and/or weepy. The problem may also occur in an older child who feels unable to cope with some aspect of school life, her/his own expectations or those of parents and teachers. Older children may also suddenly become fearful of being separated from parents.

How do you find out?

1. A young child may cry, refuse to go to school and may complain of stomachache, headache or nausea. The child may wet the bed, and/or talk or behave in a babyish way.
2. An older child may become fearful and anxious, and may complain of headache, dizziness, poor memory and loss of concentration.

What do you do?

1. With a younger child a caring attitude helps a great deal. This may be shown by picking up the child when s/he is upset, playing with the child and so on.
2. After the child gains confidence and feels comfortable in the classroom, s/he may be helped to play with the other children.
3. With an older child ascertaining the reasons for anxiety may help in overcoming the problem. The child may be helped to return to school by tackling the problem in stages. At first, s/he may be accompanied by the mother and then when s/he feels comfortable, a friend. Finally the child may be able to go to school by herself/himself.

Speech problems

1. SPEECH DELAY Some children may start talking fluently before they are two, while others may do so only when they are around five. The latter may be faced with problems in the nursery class. The teacher must remember that the growth of language varies tremendously among children. In addition, delays in language development may occur due to any one of the following reasons: emotional problems, too many languages being spoken at home, the child being left alone most of the time, partial deafness. If problems in the child persist after s/he is 6 years old, efforts should be made to help the child.

How do you find out?

1. The child may have a lisp or difficulty in pronouncing some words (for example, would say 'labbit' for 'rabbit', 'seep' for 'sleep' and so on).
2. If the child is partially deaf, s/he may not respond to a call if spoken to softly; the child may appear inattentive and strain forward in order to hear what others say to her/him, or may talk in too loud or too soft a voice.

What do you do?

Spend some extra time in helping the child to pronounce the works clearly and slowly. It helps the child to imitate the way tongue and lip movements are made while pronouncing the word. If problems persist, refer to a speech therapist.

2. STUTTERING AND STAMMERING The child's speech is generally characterized by repetitions, excessive hesitation, inability to answer promptly and

read aloud in the class. The child may become tense and flushed, clench his fists, etc. Stammering or stuttering is often seen in children who are anxious. Making them less anxious with a friendly approach is often helpful. Note that a certain amount of stammering is normal up to the first year of schooling.

What do you do?

- Continue to ask the child questions as you do with other children.
- Look directly at the child when talking or listening to her/him.
- After asking a question give the child 10 to 20 seconds to answer. It may not be really long before s/he answers and a little patience goes a long way to help the child to relax.
- Do not prompt answers.
- Talk of matters that interest the child.
- See that others do not make fun of the child.
- Refer to a speech therapist if problem persists beyond 6 years. An older child with the problem can also be referred.

The restless child

Children of this age (10–15½ years) are sometimes overactive, and cannot pay attention in school. They may disturb other children in the class from getting on with their work. They will fidget in their seats at school and pay little attention to what the teacher says. They will often also do poorly in their studies. When such children become older they often bully others, and for this reason prefer to play with younger children.

Some children are restless only in special circumstances, or at school, or when visitors come to their homes. Restless children are often those who are bored.

How do you find out?

Restlessness will be obvious to you in the classroom. You will often notice that the child can be distracted easily by noises or other small disturbances in the classroom. Sometimes very intelligent children may also be restless because they are bored.

What do you do?

These children can be difficult to treat and may improve only slowly. It is therefore important to have the parents, teachers and the child talk together about the problem. Specifically the parents and teachers should:

- Make realistic demands on the restless child. Restless children cannot sit still for one or two hours at a stretch, and need to be given some freedom of movement.
- Encourage any possible talent. For example, s/he may be good at sport and should be praised for any success in that field.
- Help the restless child to have regular habits and few distractions. For e.g., encourage the parents to make the child do the same activities at the same time every day (such as collecting water, going to school, cleaning the house, etc.). This will give the child a sense of security and will calm her/him.
- Children who are restless often make unreasonable demands. Supervise the children well and do not give in to these demands. Advise the parents to do the same.
- If the symptoms do not change, and the impulsive and destructive child is at risk of being expelled from school for her/his behaviour, advise the parents to take the child to the child guidance clinic.

Wetting or soiling

For some time after school entry, a previously toilet-trained child may begin wetting or soiling herself/himself again. This may happen because the child is upset and anxious about a variety of problems on account of starting school.

What do you do?

- Find out from the mother whether the child was previously toilet-trained. If not, advise her on toilet-training. If toilet-trained earlier, try to find out why the child is anxious about going to school. Reassure the child and give her/him some extra attention. Advise the parents to help make the child less anxious about school. The mother may accompany the child to school for some time.
- Make the child go to the toilet every two hours.
- Remember that a timid child may even be afraid to ask the teacher permission to go to the toilet.
- Try to make sure that other children do not ridicule the child in case of an accident, since this could worsen the problem by making the child even more anxious. Do not punish the child but have him/her cleaned, without drawing special attention to the child.

Specific problems of children between 12 and 16 years of age

1. Children in this age group may feel moody, weepy and insecure. They may contemplate suicide because of small or big problems. Always watch out for an adolescent who indicates that life is not worth living.
2. They may become aggressive if they perceive even a small injustice, because justice is an important issue for them. Many potentially explosive situations can be defused by attempting to answer the call for justice.
3. They may indulge in sleepwalking, talking in sleep, nail-biting. But these problems, which occur more often when the youngster is tense or anxious about something, do not warrant referral to a specialist, and generally disappear when the youngster grows up.
4. They may experiment with drugs, drinking and smoking, and this is quite normal. But, if the youngsters become addicted or dependent on drugs/alcohol it may lead to serious consequences. Youngsters who have emotional problems are the ones who become addicts and they should be referred to a psychiatrist. If the youngsters lack the desire (or motivation) to break the habit, very little help can be given to them. However, a teacher who is sympathetic and kind may be able to communicate with them and ensure that they do not discontinue the therapy.
5. They may display a variety of sexual interests.

Masturbation

This is a normal developmental phase, seen also in young children. Parents and teachers can make the child feel guilty by saying that the practice is harmful, and that it will lead to madness etc. Masturbation in excess, is similar to thumb-sucking in excess. It just shows that the youngster is lonely, insecure and needs help. Parents and teachers should take a very understanding and sympathetic view of this normal phenomenon. The youngster may be encouraged confide in the teacher or parents.

Homosexual activity

This may be less common than masturbation and may be present both in boys and girls, particularly among those who stay in hostels and boarding schools. This again is a developmental phase. Very few will continue to indulge in it when they grow up.

Normal heterosexual interests

Adolescents may suddenly lose interest in school and start showing an interest in the opposite sex. In Western countries this is acceptable, but in India it posses several problems at school and home. Developing an interest in the opposite sex is a normal phenomenon, brought about by physiological and psychological changes during puberty. But the social pressure against exhibiting such an interest causes distress to everyone concerned. Adolescents must be made aware that they need to conform to the norms of society.

Early adolescence is the most difficult time for parents and teachers. However, it must be remembered that it is an even more difficult time for youngsters. Because of tremendous psychological and hormonal changes the emotions of adolescents tend to be volatile. Although most children pass through the adolescent stage without much difficulty, and make a smooth transition to the next phase, the pressure on children, parents and teachers during the adolescent phase does remain high.

Section 4: Poor school performance

Poor school performance is a matter of concern not only to parents but also teachers. You can tackle the problem if you can ascertain why the child performs poorly at school.

You must find out when the problem occurred the first time. One or more of the following reasons may cause a child to consistently perform poorly:

- poor potential intelligence (moderate mental retardation);
- sensory or motor handicaps (poor vision, hearing, or motor coordination, etc.);
- environmental factors, such as ineffective teaching; a rigid educational system; unfamiliar medium of instruction; poor educational background at home;
- lack of physiological maturity (for example, a Class V student may be able to cope only with a Class III level of reading; and
- specific difficulties in reading or writing.

What do you do?

1. Have patience with a child who learns slowly, try and spend a little extra time with the child as and when possible. Praise the child when s/he learns well and encourage her/him to put in more effort. Do not beat or punish as this will make the child anxious and her/his learning will be affected adversely. Tuition or coaching after school hours will also help.

2. If visual or hearing defects are found to interfere with the classwork, the child should be referred for required corrective treatment.
3. If the parents are not literate, not very educated, or indifferent to the child's education, it may be helpful to get an interested adult to supervise the child's homework, and motivate the child.

If poor performance is of recent onset, find out why

1. A sudden setback in performance may be due to emotional problems caused by stress at home—for example, parental conflict and/or separation, and similar disturbing events.
2. Social or economic problems may cause school performance to suffer. For example, the father may have suddenly died, or become unemployed, so that the child is forced to go out to work to help the family. Social agencies may be helpful in resolving these problems; scholarships may be obtained or funds can be raised for such a child.
3. A sudden shift of interest from school life may occur when attention/interest gets focused onto someone or something else (particularly heterosexual relationships).
4. The fears, anxieties and worries of a growing child may affect her/his school performance.
5. There may be problems relating to teaching and learning methods. The problem may lie with the method of teaching in general in the school or a specific method adopted by a particular teacher. Students in the same class may respond differently to the same teaching method. The child may also have difficulty in organizing study material for classwork or a test. If the teacher understands the student's strengths and weaknesses, he/she will be able to help the youngster.

Section 5: Serious mental illness, fits and mental retardation

Serious mental illness

How do you find out?

1. Children who have developed normally, say up to the age of 3 or 4 years, may suddenly, or gradually, lose the skills they have learnt—like speech, toilet control, reading and writing. These children may not come to school at all.
2. Older children who have been normal in school may gradually or suddenly (*a*) become sad, depressed, weepy, unsociable; (*b*) laugh to oneself, talk with no connection to the question asked, neglect

personal hygiene, imagine that they see things or hear voices; (*c*) stop eating and start losing a lot of weight; (*d*) begin to express feelings of wanting to die; (*e*) have disturbed sleep.

What do you do?

1. For all the above problems, referral to a psychiatrist is essential.
2. When the child comes back to school after the illness, help her/him readjust, and be on the lookout for early signs of the illness if it recurs. Advise the child and the family on the need for regular medication and check-ups at the hospital.

Epilepsy

How do you find out?

Epilepsy (fits or convulsions) is a common condition among both children and adults. The child may suddenly jerk, fall down, lose consciousness and froth in the mouth very briefly and may 'wake up' confused. You may be frightened when you witness a fit and wonder what to do about it. The following are some of the do's and don'ts when you see a child (or an adult) having a fit.

What do you do?

1. For all problems listed in the paragraph above referral to a neurologist is essential.
2. Start first aid measures.

Dos

1. Clear some space around the child and remove hard objects or furniture so that s/he does not get hurt by them.
2. Make the child lie on her/his side so that the child does not choke on saliva.
3. Loosen any tight garments around the neck.
4. Try and time the attack and watch the child carefully as the description of the fit is very important to the doctor.

Don'ts

1. Do not put anything between the child's teeth. You may accidently break them or damage the gums.
2. Do not give anything to drink. You may choke the child by forcing a drink.

3. It is unnecessary to put an iron object in the child's hand (this is just a superstition). The fit will stop whether you do this or not.

What causes fits?

Fits are caused by electrical discharges in the brain, which may arise out of fever, tumour, head injury, etc., and they are not contagious. A fit usually lasts for a few minutes and then stops. If it continues for longer than 15 minutes then a doctor should see the child immediately. Whatever the reason for the fit, the child must be referred to a neurologist as soon as possible. Each fit causes some degree of brain damage. Untreated fits can lead to poor memory, personality problems, poor intelligence and, in extreme cases, even severe mental illness. Most fits can be completely controlled with adequate medication over a long period of time. The neurologist makes the decision as to how long the child should be on treatment (generally for 3–5 years). Regular medication (even a single missed dose can result in a fit) and long-term follow-up is absolutely necessary. Taking extra medication after or just before a fit is absolutely useless.

A child who is on regular medication and follow-up, can attend school regularly and play all games if the fits are controlled. Always see that other teachers and children have a sympathetic attitude towards the child. The child should not be made to feel unwanted and an invalid. Treat her/him like a normal child.

Mental retardation

A child may be born with a defect on account of which his intellectual development is below that of other children of the same age (i.e., a 10-year-old child may have the intelligence of a 3-year-old). Or, a normal child may develop a fever (e.g., brain fever), and become retarded in intellectual growth.

There are degrees of retardation. A child able to attend school, probably suffers a moderate degree of retardation. If retardation is severe and profound, the child will not have much speech, no social or self-help skills, and hence will rarely attend school.

All degrees of retardation must be referred to a specialist as there are special schools for the retarded and parents can be given effective guidelines to train their children to acquire new skills. A point to be remembered is that in all degrees of retardation, training the child in the right way will always bring about an improvement.

Section 6: Where to refer in Bangalore

1. CHILD GUIDANCE CLINIC
   National Institute of Mental Health and Neuro Sciences,.
   (NIMHANS), Hosur Road, Bangalore – 560 029.
   The clinic works on Mondays, Wednesdays and Fridays.
   Registration of cases is between 9.00 A.M. and 12.00 noon.
2. EPILEPSY OR FITS OR OTHER NEUROLOGICAL PROBLEMS
   Neurology/Outpatient department
   National Institute of Mental Health and Neuro Sciences,.
   (NIMHANS), Hosur Road, Bangalore – 560 029.
3. SPEECH PROBLEMS
   - Speech therapy department of NIMHANS.
     (The child must be registered in one of the above clinics first.)
   - Institute of Speech and Hearing,
     Hennur Bagalur Road,
     Kariana Palya,
     Bangalore.

Acknowledgements

Valuable ideas were obtained from discussion with schoolteacher participants in various programmes, as well as from *A Manual on Child Health and Psychological Development. Part V—for Schoolteachers*, WHO Regional Office for South East Asia, New Delhi – 110 002, India, 1982.

Appendix III

Process of counselling*

Section I: Counsellor characteristics

1. A counsellor should care about the client.
2. S/he should be honest in her/his dealings with clients and informants.
3. S/he should try to consider everybody's viewpoints equally and impartially, and should not be biased.
4. A certain formality in relationships should be maintained. For example, going to the cinema or to a restaurant with the client should be discouraged.
5. The counsellor should be a trustworthy person, who can keep confidential information to herself/himself. For example, s/he cannot reveal the information that a child has stolen something from the school to the principal, without the child permission. But you (counsellor) can persuade the child to own up her/his wrong doing and help the child resolve the situation. Confidentiality can be broken only under extremely serious situations, where there is danger of homicide or suicide or some similarly serious action.

Section II: Interviewing techniques and establishing a working relationship

Interviewing technique

Section II highlights the importance of cultivating a good interviewing technique. The assessment form below gives certain guidelines for conducting an interview.

* The process has been jointly formulated by Illana Cariapa and Malavika Kapur of the National Institute of Mental Health and Neuro Sciences, Bangalore.

Assessment of interview

The following record form may be filled up immediately after the interview session.

Technique of interviewing

(1) Introduction and explaining the purpose of the interview was carried out. Yes (1) No (0)

(2) Facilitation of blocks in communication was required. Yes (1) No (0)

If yes, was it carried out? What was the nature of blocking Yes (2) No (0)

If so, how?

.....

.....

.....

(3) Avoiding rambling talk during the interviews was necessary. Yes (1) No (0)

If yes, was it carried out? Yes (2) No (0)

If so, how?

.....

.....

.....

(4) Clarification of problems (or complaints) was necessary. Yes (1) No (0)

If yes, was it done? Yes (2) No (0)

If so, how?

.....

.....

.....

(5) Were there cues (clues/hints) to be picked up? Yes (1) No (0)

If yes, was it done? Describe the cues. Yes (2) No (0)

.....

.....

.....

(6) Cross-checking of information necessary because of certain inconsistencies in the information gathered. Yes (1) No (0)

If yes, was it done? and how?

.....

.....

.....

(7) Asked if there is anything else or if there were any doubts.

If there were doubts what were they?

.....

.....

.....

Introduction and explaining the purpose of the interview

It is necessary to explain to the client why s/he is being interviewed and how the counsellor is trying to help her/him. To start the interview abruptly leaves the client confused and embarassed. It is also absolutely essential to reassure the client that all information given by her/him will be kept confidential and will not be divulged to anyone without her/his permission. The counsellor should be honest about the purpose of the interview. For example, s/he must not say, 'I can help you if you have any problems . . .' or, 'I am just being friendly . . . I am trying to help you in your studies . . .'. It is better to say 'I have noticed that you look inattentive in class', or 'your father said you are not studying well'. A direct approach to the problem is the best one. If the counsellor is frank, the client in turn will respond in the same manner.

Facilitation of removal of blocks

Some clients are shy or reserved and may not talk freely. With such clients the counsellor has to make an extra effort by showing that s/he is interested in them and cares about them. With older children one talks with genuine interest about hobbies, favourite films, books, music or games. Younger children can be given some plain sheets paper, colour pencils or crayons and asked to draw whatever they wish; this often elicits excellent cooperation. In addition such drawings often give useful clues about their inner states of mind. It is important that children should not be bullied or pressurized into giving information. An atmosphere where they will volunteer information has to be created.

Always make it a point to talk about little things. The child may be a good singer, for example, and if you know of it, you could praise the child's talent. But there should be honest appreciation, no flattery.

Counsellors tend to become very anxious if the client becomes tongue-tied or tense. It is important that the counsellor relaxes and copes with the silence. S/he should ask a question and wait as long as it is necessary to get an answer.

Avoidance of rambling talk

Some clients tend to talk too much, without giving the counsellor a chance to conduct the interview. It may be necessary to first listen for about half an hour, without interrupting. After that, attempts should be made to make the client answer questions to the point. Often adolescents use this technique to get away from the interview situation. For example, if the client goes on talking about a film he has seen, in great detail, you may interrupt to say '. . . but I was asking you about how well you performed in your exams last month'. This approach will force the client to stop rambling about irrelevant issues. With some clients it may be necessary to use this technique often. As soon as the client realizes that you are aware what s/he is doing, s/he will stop using this technique to avoid crucial issues.

Clarification of problems

Sometimes the original version of the history (story) given by the client or those with her/him (informants) may not be very clear. One needs to clarify the situation. For example, a mother may say that the reason for the problem is that she does not keep well and that the boy's father comes home drunk every night. The counsellor has to ascertain what the actual problem is and how it relates to the given situation. The problem may be that the boy does not come home till late, or that he does not attend his

classes regularly. If the mother expects the boy to give the drunken father his dinner and put him to bed, as she is too ill to cope with the task, it is not surprising that the boy stays out late. But if the boy misses school for the same reason, the problem is more serious. It is necessary to clearly state the problem for the sake of the informant, client and counsellor. Vague information does not help in resolving problems.

Picking up cues

We tend to forget that we reveal a lot more about ourselves in our actions than by words. A counsellor should be observant about picking up such clues and hints given by the client. For example, the client may go on tapping the table or pressing her/his forehead or squinting her/his eyes, as if in pain; sit on the edge of the chair, as if ready to run away; may be dressed neatly in clean though old clothes or in dirty though expensive clothes. All these observations can reveal a great deal about the client.

Cross-checking information

Quite often, information given by client and other informants may need rechecking. For example, at the beginning of the interview the client (child) may have said that s/he had changed school six months earlier, while at the end s/he may say that s/he had been staying home for a year before rejoining school. One should look for an accurate account of events. Inaccuracies may be due to forgetfulness or a deliberate attempt at deception. Thus, it is important to look for inconsistencies in the information given by different people. When versions vary, this gives important clues regarding the motives of people providing the information.

Asking if there are any doubts

As a last step, ask the client if there is anything s/he would like to discuss or if s/he has any doubts, as a client may have some reservations regarding the interview, or some issues may not have been be discussed openly.

Application of the interview for therapy

• The interview was conducted in order to collect information	Yes (1)	No (0)
• The client appeared comfortable with the interviewer	Yes (1)	No (0)
• The interviewer appeared comfortable with the client	Yes (1)	No (0)

- As the interview progressed, the emotional interaction (rapport) appeared to get better — Yes (1) — No (0)
- The interviewer advised changes in the distress-causing situation — Yes (1) — No (0)

Section II: Interviewing

Most initial interviews are carried out to collect information about the client. But it is important to remember that unless the client feels at ease with the counsellor, the information gathered may be minimal. All of us tend to reveal our inner most thoughts and feelings only to a person we can trust.

At the same time the counsellor should also feel comfortable with the client. If the counsellor gets irritated or annoyed with the client, the relationship between the two is bound to deteriorate into one of confrontation and annoyance. In an effective counselling situation a warm, caring relationship is one of the most important aspects.

In addition to establishing trust, useful advice can be given at times. With some problems advice can be given straight away, while others may require further interviews and clarifications. For example, a client worried about masturbation may be reassured that it is not injurious to physical or mental health. However, if the problems are complex (e.g., marital disharmony between parents), additional interviews are required before any advice can be given.

Section III: Case presentation

Preparation of a case material

The course devised by the authors is essentially meant to help you (the counsellor) in understanding practical aspects of counselling. The authors have attempted to break up the counselling process into components to help you to understand what is involved in terms of actual work that is to be carried out.

A small group will be formed which will consist of people who are interested in helping children with their emotional problems. Each week one trainee will present a case in detail and everyone in the group will discuss the case. In addition, everyone will make an assessment on the assessment proforma provided. The assessments are not meant to criticize a person but to help her/him to do better the next time. Counselling is a very complex process and all of us are bound to make mistakes at one time or the other. Free discussion between the members will be encouraged. It is very difficult to make all the decisions about a case all by oneself, and

the group can help the person in making such decisions. However, the group shall not discuss the personal aspects of the trainee. They will only discuss the client's case and aspects of the relationship between the trainee and the client.

Assessment of recorded case material

1. Historical information (when you assess this, the emphasis is on whether you consider the information complete, to your satisfaction) (justify your rating in the space given below)
   .....Inadequate 0
   .....Adequate 1
   .....Good 2
   .....Excellent 3
2. Observational capacity (the emphasis is on the degree of clarity and accuracy with which the interviewer has observed the client) (justify your rating in the space given below)
   .....Inadequate 0
   .....Adequate 1
   .....Good 2
   .....Excellent 3
3. Formulation and conclusions (when you assess this item, the emphasis is on whether a logical and complete interpretation of the material collected has been made) (justify your rating in the space given below)
   .....Inadequate 0
   .....Adequate 1
   .....Good 2
   .....Excellent 3
4. Lines of management (in assessing this item the emphasis is on whether the method of management suggested is practicable) (justify your rating in the space given below)
   .....Inadequate 0
   .....Adequate 1
   .....Good 2
   .....Excellent 3

Historical information

When you present a case, you have to narrate it in detail, as if you are telling a story. For example, you may collect the following information.

- name
- age

- sex
- class

What are the complaints • according to the child? • according to the parents? • according to the teachers? • according to other children? • according to yourself?

(Whenever you have been unable to obtain information from any of the above sources, please indicate as to why you were unable to do so.)
Always give a descriptive account of disturbed as well as normal behaviour of the child (client).

- How long has the client been having the above problem?
- Were there any changes, events at home, school or in the neighbourhood at about the time the client started showing disturbed behaviour (for example, change of school, birth of a brother or sister, failure in school, illness of parents, new or unreasonable teacher, and so on)?

However, you may find that some children have always had problems. In such cases you may have to make enquiries on adjustment problems at home and school. If the child is restless, distracted and aggressive, the following questions should be asked:

- Sleep pattern : As a baby, was s/he a good sleeper?
- Feeding pattern : As a baby, was s/he a fussy eater?
  As a baby, did s/he have difficulty in drinking milk?
  Was s/he a lonely child?
  Did s/he play by herself/himself?
- Patterns of play : Did s/he cling to the mother?
  Played with younger children?
  Had one or two friends?
  Mixed freely with others?
  Dominated the group?
- Punishment pattern : Has the child been punished at home or school and how? (e.g., scolded, beaten, locked up.)

Capacity for observation

- When the child approached you for the first time how did s/he behave? For example, was the child shy, fearful, anxious, angry, friendly talkative, restless, fidgety? Did the child take time to warm up or did s/he not talk at all? It is important that the child's behaviour and talk are described in detail. One need not use any technical words while doing so.
- How does the child behave with her/his parents?
- How does the child behave with her/his teachers?
- How does the child behave with other children?
- Is the child's behaviour in any way unusual (twitches the face, drums the table, etc.)?

The idea is to enable the members of the group to get a kind of mental picture of the child, even when the child is not present.

Formulation

After you have described the sequence of events leading to the problem, and the actual behaviour (symptoms), you have to attempt to build links or connections between the history and the symptoms: e.g., the child is very aggressive in the class, because he is being ill-treated at home by his parents who beat him for no reason at all; the child cannot cope with school work because of a change in the medium of instruction; and so on.

It is true that you cannot always have a complete answer. So you have to choose one or two alternative explanations as the possible causes of disturbance.

Lines of management

There are two possible ways of writing up a case. One is *what you have actually done* to resolve the problem, the other is what *you propose to do in future*, to solve the problem. An example of the former is that if you discover that a child sitting in the back row is inattentive in class because he is partially blind or deaf, you may move him to the front row and see if this helps the child to concentrate better. (This is what you actually do). Then you may propose to take or refer the child to an ENT surgeon or eye specialist. (This is a proposed management.)

Quite often problems may not be as simple as the ones mentioned above. In a complex situation you may want to discuss the various possibilities before carrying out any action. For example, if an unmarried pregnant girl seeks help, the following courses of action may be suggested by the teachers.

- call the parents.
- meet the boy who was her partner.
- arrange the marriage.
- take her to a clinic for abortion.

In such a situation, discussion with the group members can be very helpful to determine the pros and cons of each of the above courses of action.

For all the four preceding sections, the assessment proforma provides certain categories of scoring. At the end of the case presentation, all the members of the group may assess the performance on the assessment proforma. However, when they give a score of 0 (indicating that it was an inadequate presentation) or 3 (indicating an excellent presentation), they have to justify their score. For example, when a score of 0 is given one may have to point out that certain important information has been left out. To illustrate the point further, the trainee may neglect to describe the home environment in the historical information section, or fail to describe the child's behaviour adequately in the observation section, or fail to propose a formulation or suggest an adequate course of management.

The information on their performance in each session will be given to the trainees subsequently. This will enable them to modify their future performance accordingly.

Section IV: Group interaction

The fourth section of the interview schedule consists of assessment of group participation. Here the contribution by each of the members of the group is assessed by all members. If a member does not say anything or merely repeats what others have said, s/he may be given a score of 0. If s/he adds a minor point or highlights a point already mentioned, but not emphasized, he gets a score of 1. If s/he adds a new point requiring to be probed or suggests a new formulation or a line of management, a score of 2 may be given. The purpose of this assessment is to get all the members involved in the group process to evolve effective management strategies for the case in question.

Section V: Follow-up

It is very important to conduct interviews, gather historical information, observe the client and prepare a formulation, propose lines of management and establish therapeutic (helpful) relationships. However, it is more important to remember that casework does not end with the description of a case. One has to stay with or *follow up* the case as long as the client needs help. Sometimes the client may need a counsellor's help only for a few weeks; for example, during the time of examination, the client may become fearful and panicky. Another client may however, need the counsellor's support for two or three years.

The number of sessions (lasting 30–45 minutes) may vary, depending on the needs of the client. In general, one session a week may be sufficient for long-term management, while initially more sessions may be required. A client's well-being over the weeks, months, or years is the final test of good counselling effort.

Appendix IV

Developmental Psychopathology Check List for children

(A) Developmental history

		Absent	*Present*
1.	Did the mother, before, during, or just after child-birth, suffer from any problem like illness or difficult labour?	0	1
2.	Did the child have any serious illness soon after birth? (If yes, specify.)	0	1
3.	Has the child had epilepsy, head injury, infections or any other serious illness? (If yes, specify.)	0	1
4.	Has the child any problems in seeing? (If yes, describe.)	0	1
5.	Has the child any problems in hearing? (If yes, describe.)	0	1
6.	Between the ages of 1 and 3, could the child walk, climb, throw a ball? (If not, mark as present.)	0	1
7.	Could the child by the age of 3 cut paper, thread beads? (If not, mark as present.)	0	1
8.	Between the ages of 1 and 3, could the child speak in small sentences? (If not, mark as present.)	0	1
9.	Could the child between the age of 1 and 3 years show appropriate emotional expression in relation to parents and others and did he/she enjoy playing with other children? (If not, mark as present.)	0	1
10.	Could the child between the age 3 and 5 years, feed, wash and dress him/herself? (If not, mark as present.)	0	1

(B) Developmental problems

Currently or in the past, has there been a problem:

11.	of dropping things, falling or tripping frequently?	0	1
12.	for brief periods when the child cried continously to the extent of holding breath, become stiff?	0	1
13.	of making odd or funny, repeated movements of the face, body, arms and legs?	0	1
14.	in pronouncing words clearly (for example, 'labbit' for 'rabbit')?	0	1
15.	of stammering or stuttering?	0	1

Currently, does the child have the problems of:

16.	not talking at all and remaining mute, despite knowing how to speak, in some situations and to some people?	0	1
17.	repeating the words spoken by others exactly in the manner it was heard, without appearing to understand the meaning?	0	1
18.	appearing to understand what is being said but seemingly not being able to answer?	0	1
19.	not able to understand what is being spoken?	0	1
20.	appearing to understand and knowing how to speak, but speaking in a manner which other people find difficult to understand, and refusing to use gestures to convey his/her needs?	0	1
21.	not being able to relate to people?	0	1
22.	not being able to play with other children?	0	1
23.	feeding, such as overeating, undereating, food fads or fussy eating habits, and eating non-edible things such as mud (if present, specify)?	0	1
24.	wetting clothes or bed from a very early age?	0	1
25.	resuming wetting of the clothes or bed, after being dry earlier on?	0	1
26.	soiling of the clothes or constipation (if present, specify)?	0	1
27.	sleeping, such as sleepwalking, sleep-talking, teeth grinding, nightmares, etc. (If present, specify)?	0	1
28.	masturbating or any other sexual problems (which is indulged in public)?	0	1

(C) Psychopathology

(The items below are marked as being present only when they occur often or most of the time but not when they occur sometimes.)
Does the child have problems of:

29.	poor attention?	0	1
30.	distractibility—(if the child is doing a task and someone enters the room, or he hears a sound does he easily get distracted by this)?	0	1

31.	inability to sit in a place, and always moving around?	0	1
32.	acting without thinking, like while crossing the road not looking out for the traffic?	0	1
33.	stubbornness?	0	1
34.	disobedience?	0	1
35.	often interrupting others' games, talk, being disruptive while playing, or breaking/throwing things frequently?	0	1
36.	quarrelsomeness and fighting?	0	1
37.	aggression as seen by hitting, biting and pinching others (with/without provocation)?	0	1
38.	getting very angry, crying a lot, rolling on the ground and continuing to be so for a long time, when his/her demands are not met?	0	1
39.	going to school and coming back on time, but actually does not attend the school?	0	1
40.	indulging in lying and cheating?	0	1
41.	refusing to go to school and staying back home for a duration of weeks or months?	0	1
42.	poor school performance?	0	1
43.	reading difficulty?	0	1
44.	difficulty in writing?	0	1
45.	difficulty in arithmetic?	0	1
46.	forgetfulness or poor memory?	0	1
47.	daydreaming?	0	1
48.	being very quiet and reserved (withdrawn)?	0	1
49.	talking very little even with family members?	0	1
50.	worrying?	0	1
51.	anxiousness and nervousness?	0	1
52.	shyness and timidity?	0	1
53.	is fearful of animals/people/situations?	0	1
54.	clinging?	0	1
55.	crying easily?	0	1
56.	doing a particular thing over and over again, such as washing hands, or repeatedly saying certain numbers, or expressing certain thoughts that come to his/her mind repeatedly to the extent that it interferes with his/her daily activities?	0	1
57.	complaining of dizziness or giddiness?	0	1
58.	complaining of aches and pains?	0	1
59.	complaining of/or appearing to be always tired?	0	1
60.	complaining of stomachache?	0	1
61.	fainting spells?	0	1
62.	attacks of jerky movements and unconsciousness (fits or convulsions to be differentiated from epilepsy by a clinician)?	0	1
63.	complaining of pulling sensation of the limbs?	0	1
64.	chronic physical illness (specify, if present)?	0	1

65.	physical handicaps (specify, if present)?	0	1

(The items 66 to 78 are to be marked as present even if it has occurred more than once in the past or present)
Currently or in the past, has there been a problem of:

66.	hearing voices and seeing things when no one was around?	0	1
67.	maintaining postures, being stiff, over long periods (if present, describe)?	0	1
68.	saying that he/she was a great person, or a bad person, or that he/she was being harmed by other people without real basis for such beliefs?	0	1
69.	talking and laughing to self?	0	1
70.	very poor appetite, sometimes leading to loss of weight?	0	1
71.	poor sleep/disturbed sleep?	0	1
72.	wetting and soiling during illness and being unware of it?	0	1
73.	loss of interest in play and daily activities?	0	1
74.	moving and responding unusually slowly?	0	1
75.	being depressed, sad and dull?	0	1
76.	talking much more or faster than he/she normally used to?	0	1
77.	being irritable?	0	1
78.	being unusually cheerful and happy?	0	1
	(others, if any)	0	1

(D) Psychosocial factors

(The items to be marked as present, whether in the past or in the present)
Family history of:

79.	anyone having mental illness?	0	1
80.	anyone taking alcohol excessively?	0	1
81.	anyone having epilepsy.	0	1
82.	anyone having problems in reading, writing or arithmetic?	0	1
83.	anyone with a problems of bed-wetting?	0	1
84.	anyone having speech problems.	0	1
85.	anyone being very dull or mentally retarded.	0	1
86.	have there been any precipitating events at the time of onset of the problems (specify, if present)?	0	1

Interaction in the family

Is there any evidence of:

87.	problems with parents (if present, describe)?	0	1
88.	sibling rivalry (jealousy of brothers and sisters)?	0	1
89.	marital disharmony (parents fight a lot)?	0	1
90.	punitiveness (parents frequently resort to hitting, beating or punishing the child)?	0	1

91.	over-expectation (the parents expect from the child beyond his abilities, especially in school performance)?	0	1
92.	over-involvement (the parents are involved with all the child's activities to the extent that he/she does not do anything on his/her own)?	0	1
93.	over-indulgence (the parents meet all the demands of the child, whether reasonable or not)?	0	1
94.	indifference (the parents are not bothered about the child's physical or psychological needs)?	0	1
95.	inconsistent disciplining (the parents do not agree about the way to discipline the child)?	0	1
96.	multiple care taking (the child is brought up by a number of adults in the family)?	0	1
97.	single parent (the child has been cared for by a single parent)?	0	1
98.	any change of school, medium or specific subjects or teachers?	0	1
99.	the child complaining of problems with teachers?	0	1
100.	the child having problems in playing, mixing or socializing with other children?	0	1
101.	the child having problems such as poverty and other stressors, not covered in the above section (if present, specify)?	0	1

(E) Temperamental profile

Descriptions of some aspects of the child's nature or temperament are given, and for each description there are three options to choose from. Encircle the options which fit the child best. If the description is not applicable, it may be mentioned, especially for younger children.

(a) Psychosocial

102.	Easy to manage	mostly 0	somewhat 1	not at all 1	N.A.
103.	Independent (can manage himself/ herself)	mostly 0	somewhat 1	not at all 1	N.A.
104.	Dependable	mostly 0	somewhat 1	not at all 1	N.A.
105.	Sensitive (to other people needs, emotions)	mostly 0	somewhat 1	not at all 1	N.A.
106.	Sensitive (only about oneself)	mostly 0	somewhat 1	not at all 1	N.A.
107.	Trusting	mostly 0	somewhat 1	not at all 1	N.A.
108.	Trustworthy	mostly 0	somewhat 1	not at all 1	N.A.
109.	Moral (discriminates between good and bad knows it's bad to hit others, steal, etc.)	mostly 0	somewhat 1	not at all 1	N.A.

(b) Biosocial

110.	Sleep pattern	moderate 0	too little 1	too much 1	N.A.
111.	Appetite	moderate 0	too little 1	too much 1	N.A.
112.	Activity	moderate 0	too little 1	too much 1	N.A.
113.	Emotionality	cheerful 0 (stable)	angry/tense 1 (intense and variable)	dull 1 (nonreactive)	N.A.
114.	Persistence	good 0	variable 1	too little 1	N.A.
115.	Sociability with family members	mostly 0	variable 1	not at all 1	N.A.
116.	Sociability with non-family members	mostly 0	variable 1	not at all 1	N.A.
117.	Aggressive (verbal)	not at all 0	mostly 1	somewhat 1	N.A.
118.	Aggressive (physical)	not at all 0	mostly 1	somewhat 1	N.A.

(F) Helpful factors for management

119.	Does the child have any helpful person at home/outside: Somebody with whom the child is attached to who helps the child, takes him/her out, buys the child gifts? (If yes, describe.)	0	1
120.	Does the child have friends in the neighbourhood or school? (If yes, describe.)	0	1
121.	Does the child have interest in drawing, painting, games, music, etc.? (If yes, describe.)	0	1
122.	Does the child have any special talents? (If yes, describe.)	0	1
123.	Is the child good at sports? (If present, describe.)	0	1
124.	Is the child creative, can put together commonplace objects in a new fashion, or make objects with hands? (If present, describe.)	0	1
	Other observations, if any:		

Summary

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Note: The details of scoring and standardization, and the translated versions in Kannada, Tamil, Telugu, Malayalam, Marathi and Gujarati are available with the author.

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