CHAPTER I
THE CHILDERARING FUNCTION AND CHILD MENTAL HEALTH

This chapter introduces the core concepts of the doctoral study, *child mental health* and the *childrearing function*. This is followed by the statement of the problem that the study attempts to explore.

I BACKGROUND OF THE STUDY

Human development is a dynamic, continuous and multidimensional process that evolved as a result of the interface between the individual and his/her environment. Health, a critical factor in the development of individuals, families and societies, was a continuing pattern of change in all dimensions that occurred over the individual’s lifetime (Harpham and Blue 1995). The World Health Organisation Report defined health as “a state of complete physical, social, and mental well-being and not merely the absence of disease and infirmity” (World Health Organization 1978). This definition symbolised a significant paradigm shift in the global understanding of health as it moved beyond the traditional pathological parameters towards a more positive construct that incorporated the component of mental health in the conceptualisation of health. This can be seen in conjunction with the Indian worldview, where health is conceptualised as a holistic phenomenon with all its aspects (physical, psychological, spiritual, emotional and social) integrated and balanced. “Swasthya,” the Indian word for health which means ‘being oneself’, (rooted in oneself), was itself a positive concept (Pethe and Chokhani, NK).

Mental Health, an essential and inseparable component of health is a fundamental building block for human development (Pollard and Davidson 2001). It is tied to personal growth and the cultivation of one's full potential as mentally healthy individuals have a sense of autonomy, competence, self-acceptance, belongingness and purpose (Carruthers and Hood 2005). It is also an important determinant of a country's economic and social development (Krafft et al. 2003). Discourses on mental health (Alperstein and Raman 2003; Shastri 1996; Shaw and Nagin 2005) point to mental health indicators as being one of the principal predictors for some of the major social problems and underscore its significance in the overall development of societies. A further indication of its significance in societal well-being is indicated by the inclusion of the promotion of mental health as one of the eight components of primary health care at the International Conference on Primary
Health Care of Alma Ata, USSR (WHO 1978). In the Western context (Pollard and Davidson 2001, page 10), mental health was defined as a

“state of successful performance throughout the life course indicating physical, cognitive and socio-emotional functions that results in productive activities deemed significant by one’s cultural community, fulfilling social relationships, and the ability to transcend moderate psychosocial and environmental problems. Well-being also has a subjective dimension in the sense of satisfaction associated with fulfilling one potential.”

Despite the broadening of the notion of mental health as stated above, it is important to state that the contemporary Western mental health enterprise was rooted in a population-based public health model, where the main concern is the health of a population in its entirety within the physical and psycho-social parameters (The Surgeon’s General Report 2005). Therefore, focus of most mental health endeavours was predominantly on diagnosis, treatment, and etiology, the epidemiologic surveillance of the health of the population at large, disease prevention and access to and evaluation of services (Last and Wallace 1992 as cited in The Surgeon’s General Report 2005). Subsequently, extremely significant issues like emotional development, a sense of purpose and social connectivity associated with the spiritual dimension of mental health were largely disregarded in the process of health.

The next sub-section looks at the social circumstances and the changes that have occurred with a view to understanding the evolution of the current conceptualisation of mental health.

From an organismic to a mechanistic worldview
The philosophies and religions of most cultures linked mental health to the idealistic notion i.e. the realisation of man’s highest potentialities (Capra 1982, Murthy 2004; Paramahansa Yogananda 2006). The emphasis unlike the mechanistic model was to transcend the physical/psychological dimensions to the spiritual and non-material dimension (Carstairs 1969). Post-industrialisation, the Mechanistic worldview (guided by the Cartesian model which, posited that human beings being were nothing but machines) that emerged from the Scientific Revolution replaced the Organismic view of nature, disregarding nature-human interdependence (The Dalai Lama [Not mentioned]; Toffler 1980). The universal adoption of this worldview by political structures (Iwasaki 2005) saw a shift from the holistic and ecologically connected understanding of health to the uni-
dimensional bio-medical Western model which was limited, ambiguous and narrow in focus. Although several theories emerged based on the later contextual model, which posited that development can proceed along many different paths depending on the intricate interplay of internal and external influences, the Mechanistic model remained the pre-dominant worldview. Worldwide, the policies of governments (Thinley 2002) and the practices and lifestyles of populations clearly reflected this pattern (Dittmar 2001; Sharma 2007).

The review of literature (Gil & Drewes 2005; Leavenworth et al. 1991) affirmed that essentially, across cultures, the desire for children was associated with happiness and success of individuals. Children and their well-being thus becomes a critical goal in the attainment of societal mental health. This is explored in the next sub-section.

**a) Child mental health**

Human development research (The WHO 56th World Health Assembly Report 2003 as cited in Madan 2004) had consistently underscored that children and adolescents were the basic fundamental resources for human, social and economic development. The importance of child well-being was further revealed in research findings that showed a positive correlation between the mental health level of the child and the global mental health level of the family, and consequently that of communities and societies. Considering their importance in societal well-being, children needed to be nurtured and protected. This function was assigned to the family unit (Naidu and Nakhate 1985) who were expected to provide a base of protection and support for its members, especially in the context of emotional development (Siegalman & Shaffer 1995). The next sub-section looks at the role of families in promoting child mental health.

**Role of families in the promotion of child mental health**

The social world was a complex and demanding place that required children to coordinate potentially competing goals, process complex social information and respond effectively to diverse situations. Attainment of these skills was considered vital to the well-being of the child and society as it helped regulate children’s behaviour and controlled antisocial impulses, promoted personal growth of the individual and perpetuated the social order (Shaffer 1994). Despite their inherent capabilities, families were instrumental in guiding children in the attainment of these skills. It has been established that most mental health
difficulties were centered around the lack of emotional competence (Denham 1998). According to Zahn-Waxler et al. (1990 as cited in Papero 2005) the inability to negotiate successfully, developmental milestones of emotional competence, puts children at risk for psychopathology, both at the present developmental stage and in adulthood. However, optimal family environments, particularly parents, by communicating feelings of safety and security, enhanced coping strategies and built emotion regulation capacities that helped children in ‘working out’ emotionally challenging situations (Gullone and Robinson 2005).

Empirical evidence (Bronfenbrenner, 1979; Harding, 2005) has strongly indicated that the circumstances in which human development occurred were shaped by the interplay of several factors in the larger environment. Thus it is reasonable to state that global phenomenon of industrialisation and urbanisation that brought in extensive change at all levels of human functioning would have a bearing on families and communities, consequently shaping mental health outcomes. This is discussed in the next sub-section.

The changing context

The Industrial Revolution in the nineteenth century, instrumental in the transition of an agricultural society to one based on industry (Encarta Reference Library, 2005) was accompanied by urbanisation, a fundamental and irreversible demographic process, which witnessed increasing populations migrate to urban centres. Urban studies (Pelican et al. 2005; World Youth Report 2005; State of the World Population Report 2007) indicated that the processes of urbanisation affected societies worldwide and influenced human development in diverse and profound ways. Along with advances in technology and mass media, Seymour (1998) affirmed that the forces of urbanisation, modernisation and liberalisation resulted in factors like market economy, increased socio-cultural heterogeneity, movement from ascribed to achieved roles and increased geographic and social mobility.

A revolutionary development of the urbanisation process was the collective perception that the Western model of economic development was the sole route to mental health (Paul-Pont 1969; Thinley 2002), leading to governments striving for economic prosperity (Wallerstein 1983). The newer value orientation of material prosperity being equated to mental health led to an undermining of the existing nature-human relationship.
Philosophers (both eastern and western) have asserted that maintaining a sense of harmony between the individual and the environment was fundamental to mental health, the absence of which could lead to maladjustment (Beaubrun 1969, page 67). The Indian worldview contended that mental development, a construct stronger than ordinary mental health, was a pre-requisite to optimal health. Consequently, the focus of health endeavours was preventive rather than curative and any deviation i.e., mental illness or disturbance in mental health was corrected through lifestyle change and not through short-term medical approaches (Swami Akhilananda 1952). The perceived lack of connection between science and spirituality was debated by several researchers and philosophers. Fritjof Capra (as cited in Kreisberger 2008), physicist and philosopher, and the Dalai Lama (2005) argued that there was no contradiction between science and spirituality (metaphysics) in our lives as each provided valuable insights into the other. Yet, there was a clear indication in urban studies (Bartlett 1998; Dutt et al. 2003; Toffler 1980) that the injudicious use of science and technology created anxiety and more fear. Capra (1982, page 28) indicating the lack of harmony between the ecological context and science in urban environments, stated that,

“technology that is unhealthy and inhuman; a technology in which the natural organic habitat of complex human beings is replaced by a simplified, synthetic, and prefabricated environment.”

The links between urbanisation and mental health has been clearly established not only by early sociologists, but also by medical practitioners, social commentators, philosophers and political leaders (Harpham and Blue 1995; Marsella 1995; Simmel 1950; Swami Akhilananda 1952) argued that social deviancy and maladjustment could be traced to many of the social processes that accompanied urbanisation like competition, conflict, accommodation and assimilation. Factors that aggravated mental health were alienation and social isolation, poverty, changed social structures, stress, over-crowding, marginalisation, increasing wealth disparities, pollution, etc. (Sharma and Fischer 1998). From the socio-pathological dimension, the post-urbanisation period witnessed deterioration in interpersonal relationships and social connectedness attributed to weakening of social controls and norms (Dube and Singh 1988; Marsella 1995). Wilson & Blackhurst (1999) claimed that many mental health maladies like crime, mental disorders, family disorganisation, juvenile delinquency, substance abuse and certain pathological processes that were characteristic of most urban societies reflected the pathology of the culture rather than the individual itself. Durkheim ([1815-1917], as cited in Marsella
1995:21) who made a significant contribution to the sociology of family (Lamanna 2002) propounded ‘Anomie’, a treatise that meant an absence of norms and socio-cultural disintegration. He believed that it

“was in the urban context that the potent psychological and social determinants and consequences of societal influence (e.g. alienation, anomie, suicide) were found.”

It is therefore reasonable to conclude that it is in urban contexts that origins of emotional mal-adjustment and social pathology can be found.

Child development studies (Bronfenbrenner 1979; O’Leary and Covell 2002) postulated that the qualities of the setting in which the individual was raised were major determinants of psychological health and emotional well-being. The family, the child’s primary caregiving environment was a central component of the self-family-society relationship and is inherently tied to its social structure, values, and norms (Maccoby and Martin 1983). This means that changes at the macro-level will permeate into every aspect of human existence. Western studies (Department of International Development (DFID) 2000; Harpham and Blue 1995; UN-HABITAT’s State of the World’s Cities Report 2006) have highlighted the increasing association between urbanisation and mental health. Yet, its linkages to family mental health from the standpoint of the childrearing function of the family have largely been overlooked in research (Shenava 2008). The next sub-section looks at the linkages between the processes of urbanisation and family mental health to understand the shaping of childrearing function within the changing context.

**Urbanisation and family mental health**

Families, bound by the larger structural value of materialism witnessed pervasive change in structure, function and socialisation patterns. Keefe (1979) based on the works of Louis Wirth (1938); Robert Redfield (1941); Talcott-Pa rsons (1943, 1949) and Ralph Linton et al. (1949) asserted that urbanisation led to a decrease in the significance and durability of the larger kinship unit (family, neighbourhood and religious place of worship) and the emergence of the nuclear family. The immediate and extended family once considered the economic base was replaced by the urban occupational structure, where choices and decision-making was largely influenced by economic considerations and market forces (Thinley 2002).
Socio-religious sanctions and taboos also underwent changes due to occupational diversity, technology and better means of transport and communication. Education seen as a trajectory to better occupational prospects led to mass schooling which not only led to newer occupational arrangements but also a change in the established family hierarchies, an example being the decline of parental supervision in work (Woodhead et al. 1991). Notably, children due to their elevated educational status wielded a certain power within the family that also resulted in a new model of parenthood (Balan 2006; Seymour 1998), particularly in the emerging affluent middle-class population (Shenava 2008).

Within the context of the economic development model, the nuclear urban family became a unit of consumption. Cross-cultural research (Roopnarine et al. 1994; Kagitcibasi 1996; Saraswathi 1999) presented overwhelming evidence of the strong influence of Westernisation and internationalisation on the various life-domains of collectivist cultures like India which saw a shift to a more consumeristic and individualistic lifestyle (Dittmar 2001; Jayadev et al. 2007; Seiter 1995). Aspirations for better standards of living led to the involvement of women, including mothers in wage-labour, changing gender relations. With regard to changing family structure and function due to dual-career families, emerging studies in India (Sharma 1999; Daftuar and Anjali [1997, 1998], as cited in Vohra 2004) asserted that indicators affecting mental health in modern urban contexts were occupational stress, organisational commitment, job involvement and satisfaction and self-actualisation. Moreover, the immense pressure on individuals to conform to contemporary social values and norms that happened due to the process of ‘enculturation’ (adoption of values of the dominant culture by the individual and society) resulted in a conflict between traditional interdependent cultural values and emerging Western values of independence (Iwasaki 2005).

Universally, the rise of the nuclear urban family and the associated consumeristic lifestyle raised concerns over the changed status of the family in terms of its trend towards ‘selfish individualism’ (Wright and Jagger 1999:1). The new ideologies that emerged from the changing value orientation were reflected in the childrearing style and this was seen predominantly across the primary life domains of lifestyle, education and sexuality (Abraham and Kumar 1999; Sharma 2007). Optimal lifestyles that balanced work and recreation to attain one’s full potential were considered a critical goal for family mental health (Csikszentmihalyi 2000). However, the increasing focus on material goals and
pleasure-centred lifestyles led to demanding schedules that left little time for leisure, social, emotional and affiliation needs of the family (Landreth 2005). Unhealthy parental lifestyles, a product of the entertainment culture that emerged from changing socialisation patterns inculcated habits and practices that were detrimental not only to the child’s emotional and physical health but also damaging to the child’s development of self and personality. Transient lifestyles focused on increased consumption patterns saw the emergence of newer lifestyle diseases like obesity and weight related problems (e.g. Type 2 diabetes, high blood pressure, high blood cholesterol, asthma, arthritis), compulsive behaviours [for e.g. compulsive shopping, addictions (gambling, internet, substance abuse)] (Chaufan 2004). Reduced play, increased mass-media usage and decreased physical activity exacerbated the situation further (Shenava 2008).

Although patterns of urbanisation have been universal, the Indian context, considering its diversity, needs to be considered separately. Some significant aspects are discussed in the next sub-section.

The Indian urban family

India presented a unique case in terms of the sheer size of its population and its heterogeneity in respect to its physical, economic, social and cultural conditions. India’s population of about 1.2 billion people makes it the second most populated country in the world. India has the largest child population which increased by 192 percent in the last decade (Shastri 1996). Children and adolescents constitute approximately 40-44% of the total population (WHO Report 2001). This is a sizable population especially when one considers the associated populations that would be affected if children were vulnerable to mental ill-health.

Urban India has been in transition for centuries, yet the last decade (1991-2001) of the twentieth century saw large-scale transformations due to urbanisation and the accompanying modernisation, economic liberalisation and associated structural reform (Shaw 2007). India has seen the emergence of a consumer culture arising out of growing disposable incomes moving from a socialist pattern to a capitalist one, where the top 10-15 percent of the population led lifestyles comparable to some European societies (Sharma 2007). Singh (2007) quoting from government figures affirmed that the new urban India in actuality was referring to less than 300 million people out of a population of over 1
billion. Sharma (2007) claimed that the new economic order gave rise to an affluent middle-class in urban societies in India. Sociologist Manas Roy (as cited in Dutta 2007) opined that the post-globalisation generations had moved from ‘Gandhian frugality’ and belonged to a modern India symbolised by consumerism and pleasure-oriented lifestyles. In addition, the predominant urban culture led to the dilution of certain prevalent traditional practices, irrespective of the religious or cultural background. The desire to live a materially rich life in contrast to traditional simple living, characteristic of the Indian way of life, brought in tremendous inter-generational and interpersonal conflict (Swami Akhilananda 1952; Nagpaul 1996; Yogananda Paramahamsa 2006).

Although, children had the essential core competencies for optimal socialisation, these were nurtured and developed by the care-giving environment (Cichetti et al. 1991). Further, the child’s sense of self and connectedness were associated with a particular set of skills, competencies and activities. Parents played a vital role in imparting these competencies (Pollard & Davidson 2001) through the function of childrearing. This is discussed in the next section.

b) Significance of the childrearing function in child mental health

The universal goal of childrearing was to raise a spiritual, respectful, knowledgeable and competent child who would be equipped with necessary skills to survive in that particular cultural context (Yearwood 2001). Ogbu (1981) defined child rearing as "a process by which parents and other agents transmit and by which the child acquires the prior existing competencies required by the culture to assume valued future adult tasks" (p. 418). Robert LeVine (cited in Shaffer 1994, p. 238) who examined childrearing practices in diverse cultures concluded that families in all societies had three basic childrearing goals (Box 1.01).

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Box 1.01: The three universal childrearing goals

1) **The Survival goal** – to promote the physical survival and health of the child, to ensure that he or she will live long enough to have children too.

2) **The Economic goal** – to foster the skills and behavioural capacities that the child needed for economic self-maintenance as an adult.

3) **The Self-actualisation goal** – to foster behavioural capacities for maximising other cultural values (for example, morality, religion, achievement, prestige and a sense of personal satisfaction).

A significant understanding was that over time, families changed their child-rearing practices in response to historical factors, level of acculturation, adaptation and survival forces (Bronfenbrenner 1958). The childrearing style would thus be shaped by significant adults in a process that was historically bound, mediated by culture and focused on meeting current environmental needs. In the current context, this means that the macro-processes of urbanisation and modernisation would have a bearing on the childrearing style of the contemporary urban family, with ripple-like effects on child mental health.

Considering the significance of the childrearing function in child mental health, research (Baumrind 1991; Lambert 2004; Beidel & Turner 2005) has consistently advocated a healthy parent-child relationship which buffered the ‘vulnerable child’ against negative conditions in the external environment. The next sub-section discusses the significance of the parent-child relationship in the promotion of child mental health.

**The parent-child relationship**

Regardless of the child’s biological disposition, healthy family relationships particularly the parent-child relationship had been validated in research as being the strongest support system in developing emotional competence (Maccoby and Martin 1983; Pollard & Davidson 2001). Further, it has been established that *healthy parent-child interactions were bi-directional, as they not only enhanced children’s development but also had a positive effect on parental attitudes and behaviours* (Denham 1998). Empirical evidence showed that adults who were emotionally stable themselves were more likely to provide a secure base for their children (Mikulincer et al. 2002, as cited in Akistera & Reibstein 2004) contributing to the well-being of the entire family. Zaslow et al. (2006) identified two parenting constructs that were crucial to the formation of healthy and strong parent-child relationships.
1. Parental affective responses to the child
   a. *Positive responses* included support, responsiveness or positive social interactions
   b. *Negative responses* were characterised by hostility or intrusive control

2. Provisions of interactions, activities and environments that stimulated the child cognitively and promoted learning.

Urbanisation and the associated changes in families have led to a decline in the significance of childhood as a unique phase in itself (Woodhead, Light & Carr 1991). The next sub-section explains the importance of the developmental stage of childhood in human development and significant changes that have occurred post-urbanisation in the status of children.

*The value of the developmental stage of childhood in mental health*

The French philosopher Rousseau in the 1700s was among the first to comprehend and acknowledge the intrinsic value of childhood (Lebo 1982 as cited in Gitlin-Weiner 2000) in human development. However, economic liberalisation and changing value-orientations have seen a shift in these notions. Industrial societies viewed childhood not as a distinct phase with its unique developmental requirements, but as a preparatory phase to equip children with skills and competence that would facilitate industrial discipline in adulthood. Also, social and occupational mobility and economic compulsions tended to create smaller family units, which though suited to the needs of the workplace and adult world, was incompatible with family needs as it led to a decrease in social connectedness.

Further, demanding lifestyles of parents emerging from excessive focus on economic prosperity resulted in the modern conception of child competence, what Elkind (1988) referred to as the *Superkid*\(^2\) phenomenon. He claimed that this phenomenon was a social invention that was convenient for all the levels of society as it satisfied different functions in contemporary urban society. For parents it helped alleviate anxiety and guilt for their reduced involvement in childrearing duties. For business, it signified economic opportunities (Seiter 1995) because of the ‘*compensation culture*’ practiced by parents to compensate materially for the reduction of emotional and physical availability.

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\(^2\) A child pressured by parents and society in general to do too much too soon. This was seen in the increased *overscheduling* of children’s activities that have them engage in organised sports and other activities that may not only be age-inappropriate, but uninteresting to the child.
Additionally, with increased exposure and usage of media, especially in terms of violent and sexual content, the stages of adulthood and childhood were becoming increasingly merged (Meyrowitz\(^3\), as cited in Buckingham 2000). Moreover, media perpetuated the blurring of markers between children and adults by simplifying access to information and exposure to experiences that can be considered unsuitable to children and adolescents. Due to the all-pervasive media culture, societal emphasis on beauty and superficial concepts of wellness (Dittmar 2001) endorsed materialistic values that have led to dramatic changes in children’s clothing, toys and accessories due to which they look and behave like miniature adults (Postman 1982; Aronson 2005). These have a definite effect on the emotional development of children and adolescents as, apart from having to deal with early pseudo-maturity, they also have to grapple with the conflicting values and messages that they receive from the adult world. The lack of conceptualisation of childhood separate from adulthood and the changing status of childhood in modern urban contexts have been explained by some researchers (Erikson 1950; Postman 1982; Elkind 1988; Buckingham 2000) as symbolic of a continuous effort on the part of adults to gain control over childhood, often at the expense of children themselves. In this scenario, it is reasonable to conclude that children could be deprived of the normal experiences that constituted the developmental stage of childhood, an extremely significant phase in human development.

Mental health discourses have consistently pointed out that social contexts influence symptoms of distress (Lambert 2004). According to Forman & Davies (2005), the two significant assumptions that endanger the child’s emotional security are adverse family experiences that weaken the family as a source of security, and children's vulnerability to psychological difficulties. Recent research in the West (Quart 2006) reported that the urban families, undergoing the challenging processes of urbanisation over which they have no control, experienced increasing levels of stress, frustration and pressures in meeting life-goals making them extremely ‘vulnerable’. The next section presents a brief understanding into problems that the current study explored, namely the shaping of the childrearing function of the family within a context of increased vulnerability of the family and its repercussions on child mental health.

\(^3\) Joshua Meyrowitz – Author of “No Sense of Place”
II STATEMENT OF THE PROBLEM

Vulnerable families and vulnerable children

There is consensus that the family is critical in the promotion and in the maintenance of both mental and physical health. It is also the greatest natural resource for the wide range of stresses associated with modern lifestyles (Gullone and Robinson 2005). Most mental health difficulties have been sourced to deficits or unusual patterns of emotional behaviours; indicating that positive emotional development buffered individuals against future maladaptive health outcomes (Cichetti et al. 1991). Prominent theories investigating causes of child mental health problems in urban environments showed that several factors in the child's distal and more proximal care-giving environment were associated with pathways that led to chronic externalising trajectories (Coard et al. 2004). Amongst these, childrearing was considered one of the leading predictors for some of the most complex social issues afflicting modern urban contexts (Gadeyne et al. 2004).

Due to pressures of careers, maintaining a reasonably comfortable standard of living, lack of support systems and increasing interpersonal discord, childrearing in urban contexts was progressively more associated with uncertainty, doubt and tremendous strain. Increased nuclearisation of the family unit, reduced community linkages and a consequent increase in care-giving (of older family members and children) responsibilities has further added to the ever-increasing pressures faced by urban families (Dutta 2007). In such challenging circumstances, it was reasonable to assume that caregivers were increasing challenged in providing a stable environment to foster the child’s emotional development.

Maccoby (1992) states that although the goal of childrearing has essentially remained the same, i.e. to enable children to become competent, caring adults; it is seen that contemporary urban caregivers universally experienced pressures and challenges not faced by previous generations (Goleman 1995). This does not mean that parenting was any easier in the earlier generations but indicated the presence of added stressors, chiefly modernisation, affluence, dual-career families, reduced support systems, materialistic lifestyles and powerful media influences, that activated embedded mental health risks.

From the standpoint of mental health, that children were in crisis was indicated by both the incidence and prevalence of mental health issues that affected the normal functioning
majorities of the population (Agarwal 2004). Mental health problems that affected children ranged from social problems like fragmented families, child abuse, violence, substance abuse to emotional problems of lack of affiliation, lack of ‘Social interest’ (Adler 1927), insecurity and instability. The burden of suffering experienced by children and their families were indicated by the growing numbers of children whose emotional, behavioural and developmental needs were not met by society and its institutions, created explicitly to take care of them. The statistics that emerged from the literature review validated this. Nastasi et al. (2004) reported that worldwide, childhood neuropsychiatric disorders were projected to rise by 50% proportionately by the year 2020 to become one of the five most common causes of childhood mortality, morbidity and disability. The WHO report (2001) further claimed that the global burden of severe emotional disturbances in children was an approximate 15%. Despite lofty policy-making and agendas at health forums, that child mental health and its promotion was not a global agenda was revealed by the fact that over 90% of nations had no child mental health policy.

Growing mental health disorders among urban children indicated the ‘vulnerability’ that children faced (Gitlin-Weiner et al. 2000). Further, increasing mental ill-health had placed additional demands on an existing inadequate health system. The magnitude of the problem is best summarised in the World Health Report 2001 (as cited in Agarwal et. al. 2004) that stated,

“Contrary to popular belief, mental and behavioural disorders are common during childhood and adolescence. Inadequate attention is paid to this area of mental health.”

Due to the lack of a viable alternative, the family continued to be the primary system in which different generations in society cohabited (Gfoerer et al. 2004) as also the mediator between the child and the external environment. Therefore, the vulnerability of the family unit due to challenging environments has been viewed with unease due to its repercussions on child mental health (Gitlin-Weiner 2000). Anaokar (2007) maintains that western research has stressed on the need to strengthen families not only to meet the challenges of raising children in a rapidly changing world, but also to promote their mental health. Yet in reality, this strategy is constrained both in policy and practice by the lack of emphasis on encouraging growth within the individual for attainment of individual potential and identification of concepts that go beyond pathology towards positive mental health. Further, the inability of planners and health professionals in viewing families as ‘partners’ in the process of mental health promotion has resulted in very little progress in the field.
In the final analysis, it can be stated that challenging urban contexts with reduced support systems affected family functioning which in turn affected its stability and cohesiveness that was reflected in the quality of parenting, interpersonal relationships and interactions with the community and society as a whole (Douglas 1999). The repercussions in terms of the all important parent-child relationship and family’s emotional health were also profound. ‘Vulnerable families’ thus lacked the skills, capacities, support and resources to provide for optimum emotional development of their members, particularly children, rendering them ‘vulnerable’ to mental ill-health. It is therefore reasonable to conclude that urban childrearing environments had inherent mental health risks for children.

In the light of the magnitude of mental health problems faced by urban families, mental ill-health clearly becomes a matter of concern as it impeded the well-being of families, the primary care-giving system for the child. In this backdrop, the current doctoral study attempted to gain an in-depth understanding into the factors, both risk and protective, within childrearing environments that shaped the children’s developmental outcomes.

India’s cultural diversity necessitates the need to move beyond simple and generalised descriptions of children’s life situations in the attempt to understand their lives. Chapter II presents the Indian worldview with reference to the developmental stage of childhood and the childrearing function with a view to understand the contextual background of the Indian child. This would assist the Indian researcher to get a more holistic understanding of the Indian child in a globalised context.