CHAPTER III
REVIEW OF LITERATURE

This chapter attempts to critically analyse global research and locate it within the larger discourse of childrearing and child mental health. This is followed by the key findings of both Western and Indian research. An attempt is made to explore crucial areas that have been studied with reference to factors that contribute to, or are detrimental to child well-being. This enabled the researcher to identify the challenges (the concluding section) in the field of mental health promotion, which further helped in detailing the scope of the study and identifying strategies that could confront and overcome these perceived challenges.

I INTRODUCTION

As indicated in chapter I, the increasing incidence and prevalence of mental health disorders worldwide, particularly in children is one of the biggest challenges facing humankind. Several Western studies (Harpham & Blue 1995; Miranda & Patel 2005) have highlighted the increasing incidence of psychiatric, emotional and behavioural disorders not only in the general population, but also in children. The next sub-section provides findings of some international studies that indicate the gravity of the situation.

Magnitude of the problem

Childhood neuropsychiatric disorders were projected to rise proportionately by more than 50% by the year 2020; to become one of the five most common causes of childhood morbidity, mortality and disability in the world (Nastasi et al. 2004). Of the 38% of children identified with a mental disorder, more than half showed moderate impairment of functioning and, alarmingly, 84% of these were emotional ('internalising') disorders (Kramer & Garralda 1998). Another serious concern that emerged from the literature review was that a sub-population of children and adolescents with more severe functional limitations, known as ‘serious emotional disturbance’ (SED), has been put at approximately 5 to 9 percent of children between the ages 9 to 17 (Mental Health: Report of the Surgeon General)\(^4\). Of further concern was Costello et al. (1999) study findings that revealed the associated high risk of functional impairment and severe pathology in adulthood that emerged from a childhood psychiatric disorder. This was endorsed by the WHO Report (2001) which claimed that 50% of all adult mental disorders have their onset in childhood. Studies (Rahim & Cederblad 1989) have also indicated the lack of gender

differences in the prevalence of mental disorders. Costello (1989) observed that there was a high rate of unrecognised and untreated child psychopathology in the community. This could have serious repercussions in terms of societal well-being as the accumulated burden and hazards of untreated mental disorders would not only overburden a currently inadequate mental health system but would also result in larger populations susceptible to mental ill-health. The projections for India are alarming as revealed in Murray and Lopez’s (2007) study that the most striking increases in the burden of neuropsychiatric disorders were projected for other Asia and islands, the middle eastern crescent, sub-Saharan Africa and India.

In the background of these alarming statistics regarding child mental health across the world, the literature review attempts to identify current lacunae in research, policy and practice that work as barriers in child mental health promotion. These were explored across three dimensions - the focus of mental health initiatives (pathological versus holistic approaches), urbanisation and family mental health and the role of families in child mental health promotion.

II KEY OBSERVATIONS ACROSS STUDIES ON CHILD MENTAL HEALTH

Focus of mental health initiatives (pathological versus holistic)

Conceptualisation of mental health
Research in the field of mental health has been extensive in the West in the last century. However, as the needs were largely identified from the psychopathology paradigm – clinical practices, hospitalisation and psychotherapy - huge gaps existed between perceived and actual needs. In addition, the major focus on the ‘dysfunctional minorities’ rather than the general population in terms of ‘functioning majorities’ also led to the practice of equating the number of psychiatrists and other mental health professional with well-being rather than get insights into the core factors that impeded or enhanced mental health. Symptomatic treatment not considering the root cause of disease was common. The focus of most studies was on mental disorders in terms of neuroses, depression and psycho-somatic complaints and their prevalence and incidence. In the West, although a shift came about in the sixties from hospitalisation to community mental health programmes, needs and resources as Kapur (2004) states were still mostly discussed in
terms of modern psychiatric practices developed within the realm of allopathic medicine. Based on this understanding, comparisons were drawn between the developed and developing nations and conclusions reached in both Indian and international studies indicated that resources both in manpower and facilities were extremely scarce and distributed unevenly in developing countries. Significantly, an important point brought up by Patel (as cited in Agarwal et al. 2004) is that in the West nations continued to face huge psycho-social and emotional problems even though there was a healthy population-psychiatrist ratio.

Apart from major studies that have attempted to establish indices for measuring health, an encouraging development was that Western research has evolved to looking at child mental health as a separate domain. Further, a strong movement was seen in Western research (Harari and others 2005), wherein there was a shift towards a more holistic and contextual approach taking into consideration the multiple influences in the child’s environment. These included family environments, parental personality and involvement, marital relationships, emotional development, media and technology, peer interactions, play and increasing pressures on the child due to changing value orientations of urban contexts. However, it is important to note that despite strong empirical research that provided direction regarding optimal guidelines to promote children’s emotional development, the recommendations have not been translated into concrete intervention strategies (Guest 2005).

Extremely significant in western studies (Thinley 2002; Wallerstein 1983) was the emphasis on the relative negligence of governance structures to create policies that enhanced mental health of their populations despite evidence-based research providing alarming statistics of the increasing prevalence and severity of mental ill-health. An example of this is the statistics provided by the WHO Report (2001). Mental disorders represented four of the 10 leading causes of disability worldwide and the global burden of severe emotional disturbances in children has been put at an approximate 15%. Yet most nations spent less than 1% of the budget on mental health; more than 40% of the nations have no mental health policy and 30% have no mental health programme and most importantly, over 90% of nations have no child mental health policy.
In India, national policies mostly focus on the promotion of physical health (National workshop on CMH- TISS 1996:2). The latest Government legislation\(^5\) meant to promote mental health is the Mental Health Care Act draft (6\(^{th}\) December, 2010). The draft revealed the contemporary understanding of mental health in India, where the objective and definitions of every aspect of health including promotion and prevention were discussed with reference to mental ill-health. Despite reference to holistic approaches and children, the report’s focus was chiefly limited to basic needs of physical health, nutrition, literacy, medical issues, gender and children in difficult circumstances (disability, child labour, trafficking, street children, juvenile delinquency) clearly indicating a lack of interest over issues pertaining to the *normally functioning majorities.*

With reference to National plans and policies, India has been a signatory to all resolutions including the latest (1\(^{st}\) January 1996), which stated that every child will have equal opportunities, protection of rights and full participation (The Persons with Disabilities Act 1995). Notwithstanding the lofty intentions and the growth of initiatives in the last decade towards mental health promotion, the impact of policies and intervention programmes at the national level has been marginal. Further, documentation on the nature and outcomes of such interventions is limited and disorganised. One finds a lack of systematic frameworks that can address the growing needs in the field. The lack of understanding of the factors that contributed to mental health of populations and the will to make this a significant goal thus resulted in strategies that were more problem-oriented rather than solution-oriented.

In terms of research, although a shift in understanding mental health in the social context may have occurred in the last 30 years (Mane and Gandevia 1993) the studies were still in the developmental phase. This is indicated by the topics chosen for research which tended to focus on infrastructural factors (like poverty, toxic physical environments, malnutrition, etc) or group affiliation (rural/urban, schedule caste/non-schedule caste, tribal/non-tribal and children with special needs/normal children (Kaur, Menon and Konantambigi 2001). The review indicated an abysmal failure to recognise factors in the child’s distal and proximal environment that could have a role to play in developmental outcomes.

\(^5\) Ministry of Health & Family Welfare, Government of India
mohfw.nic.in accessed on January 18\(^{th}\) 2011
Lack of a contextual perspective

Post-urbanisation, the universal adoption of the western bio-medical model saw a similar preoccupation with clinical practices, hospitalisation and drug-based treatment models (Vishwanathan and Wetzel 1993) in non-western countries. Using his country’s (Japan) example, Iwasaki (2005) claimed that universal application of psychological theories and techniques in mental health services and rejecting one’s own uniqueness, led to other mental health issues that were not present earlier. The neglect of one’s own unique cultural systems not only hindered efficacious service delivery, but also led to increasing levels of discomfort and incompatibility in most non-western societies (including India) with the prevailing intervention systems. Caudill and Lin’s (as cited in Caudill et al. 1969, page 12) words summarised the essence of this:

*Mental Health research draws its theories and techniques mainly from modern psychiatry and social science, both alien to most cultures in Asia*.

As regards research, it is seen that despite emerging cross-cultural research, most research continued to be based upon white, middle class, mainstream populations of heterosexual men in the Western world and moving away from this norm was considered deviant (Kagitcibasi 1996; Nieuwenhuys 2009). Pollard and Davidson’s (2001) extensive work in mental health revealed that a majority of the research conducted on social and emotional well-being was done from a Western/Eurocentric perspective based on their individualistic and capitalistic ideologies, overlooking the multicultural nature of different groups. In the Indian context, over-dependence on the western biomedical model restricted the development of culturally relevant and promotive initiatives. Also, ground realities indicated the lack of a multidimensional measure of perceived wellness (Murthy 1993).

While studies (Dalal and Misra 2010; Kakar 1979, Saraswathi, 1999) have explored the Indian worldview, modern thought or research largely tended to ignore the rich and profound insights of indigenous literature. An outcome of the lack of acknowledgement of these factors in child well-being is that despite the abundant community-based resources of the traditional mould (Kapur 2004), these areas have rarely been a subject of investigation or use in the mainstream healing systems. Researchers have reiterated the need to undertake field-based studies so as to develop knowledge based on the real Indian child and for indigenisation of psychology (Sinha 1973 as cited in Vohra 2004) to make mental health interventions effective and culturally-relevant. An encouraging movement in this direction has been the emerging movement in Indian psychology (Dalal and Misra...
2006; Rao et al. 2008) that has placed tremendous emphasis on building a theoretical base that provides perspectives on Indian psychology. However, here again efforts are scattered and not a part of mainstream education, medical training, research or practice.

Notably, the perception that there was no Indian conception of childhood was widely prevalent. Kaur, Menon and Konantambigi (2001) incorrectly state that developmental stages have not been conceptualised in Indian research. There were many references to the Indian worldview regarding human development in philosophical, medical and anthropological studies as also in recent studies (Kakar 1979; Misra et al. 1999). However, due to the liberal borrowing of Western theories and psychological paradigms in policy, practice and research, the profound insights of Indian research has been mostly overlooked. Nieuwenhuys (2009) ascribes the mistaken notion of the lack of an Indian conception of childhood to the extreme dependence on western theories and lack of awareness of the rich cultural heritage that guided childrearing practices in India till the last two decades. As delineated in Chapter II, the Indian worldview conceptualised the childhood stage (upto the 12th year) separately from the other four stages of human development. This is so as the childhood stage was considered critical in laying the foundation for optimum development (Kakar 1979:28). Another notion according to Murthy (1993) that contributed to this situation was the popular assumption that the whole of Indian society needed Western guidance in understanding childhood. Nieuwenhuys (2009) attributed the academic construction of Indian childhood in contemporary research to two inter-related phenomena:

1. The British colonial heritage even post its departure sought justification of its cultural superiority not just in the field of science and technology, but also the innate rights of human beings. Issues of child marriage, infanticide, Sati, and other cultural practices were removed out of context to justify western domination over the native population in impelling the population towards the white man’s ideological understanding of progress. Indian ideas of childhood were therefore declared as bizarre, irrelevant and metaphysical making way for adoption of Western models of child development.

2. The domination of the Euro-American paradigms in global academic research (Kagitcibasi 1996; Vishwanathan and Wetzel 1993).
Urbanisation and family mental health

Western studies (Buckingham 2000; Ostrom and Moran 2005; Marsella 1995) have examined the extensive political, economic and social changes that have come about due to urbanisation and its implications on mental health. Yet the effect of socially dangerous environments on the mental health of families and communities and the environments in which families struggle or thrive has not been explored either in the Western or the Indian contexts. The emphasis of most definitions and conceptualisations of mental health chiefly remains on ill-health and material indices rather those that signify emotional well-being. Western research (Gibbs et al. 1989; Murali and Oyebode 2004; Shepherd et al. 2006) has identified certain health indices which when combined with disruptive demographic factors and poor external support generated stress that put families at risk by precipitating psychiatric disorders. Notwithstanding the shift towards a more comprehensive approach in the West, these findings have not been translated into comprehensive intervention strategies at the ground level accessible to all populations.

50% of the Indian population is projected to live in urban areas in the next two decades (WHO Report 2001), yet urban studies in India (Patel et al. 2008; Shastri 2009; Trivedi et al. 2008; WHO Report 2001) are mainly focused on infrastructural factors like poverty, unemployment, toxic physical environments or the lack of resources in terms of psychiatric professionals or financial support, ignoring various factors in the child’s environment that have a bearing on mental health outcomes. These could range from the family interactions, stressors in the external environment, challenging lifestyles in the post-urbanised context, childrearing practices, peer dynamics, support systems and educational systems. Also, a major portion of the resources goes to urban areas sidelining rural areas, most of it is directed to psychiatric hospitals and psychiatric departments of medical colleges.

While numerous Western studies have talked extensively about urban problems, there is a dearth of reliable and specific data in Indian literature especially considering the cultural diversity and the phenomenal pace of urbanisation in the Indian scenario. Within the context of increasing globalisation and cultural homogenisation, cultural variations in terms of families’ composition, childrearing practices, traditions, value systems across and within cultures also have not been adequately explored. Shaw (2007) stated that the

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6 Though a very important issue, not discussed as beyond the scope of the study.
urbanisation process along with economic liberalisation has resulted in newer and complex meanings, which in turn had created new and different spaces, identities and images. Yet, Indian research was largely focused on physical factors (poverty, unemployment, environmental concerns) tending to neglect the fundamentally significant social and mental health indices (functional and social competence, Social interest and emotional development) of human development. The increasing value of academic achievement in the Indian set-up and the ability of the child to balance school, studies, extracurricular activities, leisure time and family life in an increasingly stressed and demanding environment has rarely been the subject of study.

The recently released population report (State of the World Population Report 2007) states that by 2026, the urban centres of Delhi and Mumbai will be over 30 million each (State of the World Population Report 2007). Notwithstanding, the challenges in terms of provision of urban infrastructure and maintenance of urban environment, the costs (social and economic) in terms of mental health will be considerable. Yet the Report does not discuss mental health issues that large Indian populations will face. The report confidently states that better infrastructure and urban management will ensure optimum success. Further, the report states that the potential benefits of urbanisation far outweigh the disadvantages. The validity of this statement has to be questioned, as all aspects of the phenomenon of urbanisation have not been considered. Despite research findings available to planners, urban mental health initiatives continued to focus on the curative model, thus they have been rendered largely inefficient in responding to the changing urban communities’ mental health needs.

Families and child mental health

While the focus of most studies in child mental health has been on prevalence, incidence, clinical treatment and intervention, an expanding base of research in the West has looked at other factors that shaped developmental outcomes. Of these aspects, the current study has reviewed studies that were related to the childrearing function of the nuclear urban family (childrearing styles, behaviour outcomes, socialisation patterns, peer-interactions, parent-child relationship, linkages between urbanisation and family mental health). While empirical research on child mental health or childrearing styles was not been bound by any specific theory, some significant studies (Adler 1927; Baumrind 1966 -1991; Maccoby
and Martin 1983) have investigated the most optimal childrearing style in terms of children’s emotional development.

Cripps (2009) article review of various studies done with reference to families and child mental health was significant to the current study, not only in terms of the diversity of areas covered but also the emphasis on examining aspects that were connected with positive developmental outcomes for the child and the family. Some significant findings of studies reviewed are stated below:

a) Positive linkages between perceived parental involvement and children’s psychological well-being, especially in the areas of self-esteem and self-evaluation and peer relationships.

b) The significance of parent education in ensuring positive development of children through competent parenting.

c) Emphasis on cohesive family processes that can lead to greater individual member functionality, appropriate parent-child communication, significant marital agreement and applicable behavioral outcomes.

d) Affection established early in the parent-child relationship remained a psychological benefit even after children reached adulthood.

e) The degree of attachment possessed independently in both father-child and mother-child relationships were positively related to the grown children’s psychological well-being.

f) Children and adolescents who were found to have a more fulfilling relationship with parents had healthier peer relationships, were more knowledgeable about their children’s activities and veered away from the use of love withdrawal as a method of discipline.

Notably, these significant issues related to child mental health have been ignored in Indian research and consequently policy and practice also become largely insular and ineffective.

The study of resilience as a construct and framework to create intervention for a positive state of well-being, through developmental, preventive, and wellness enhancing approaches and the focus of western research on developmental aspects of child mental health not only indicated a clear shift from pathology to holistic health but also
highlighted a strength-based orientation. Although resilience research (Rutter 1987, 1990, 1999; Garmezy 1999; Walsh 2003; Werner & Smith 1992) has not provided specific theories on the childrearing function or parenting styles, it viewed the family as an important context for intervention in child well-being. Of great significance to the current study is the notion of family resilience which changed the deficit-based approach of viewing families in difficulty as damaged and beyond repair (Walsh 2002). Most significantly, it can be said that intervention was seen from the preventive standpoint as due to the empowerment of the family, its ability to meet future challenges was enhanced. However, even in the West, whether the research recommendations have been converted into accessible and affordable intervention strategies for larger populations has been questioned (Guest 2005).

In the Indian context, despite evidence (Pillai et al. 2008) that strong family support was a critical factor associated with low prevalence of mental disorders, families and their role in the promotion of child mental health was largely ignored both in research and policy. Consequently, their place in practice is peripheral. A clear indication of this is seen in the Mental Health Care Act draft (6th December, 2010) where stakeholders identified included the psychiatrist, clinical psychologist and medical nurse excluding families and communities completely. Studies (Anandalakshmy 1979; Caster 1984; Patni 1988; Sharma et al. 1989; Misra, 1977 as cited in Roopnarine et al. 1994) related to family variables and their linkages to developmental outcomes mostly do not view the family as a unit and therefore tend to neglect intra-familial interactions.

While mother-child interactions have been cursorily studied, attempts at studying parent-child relationships or the role of involved and nurturant parenting in the promotion of the child’s emotional development were scarce. Indian studies (Mathur 2001) have explored some aspects of child mental health like parenting and personality characteristics, however, considering the importance of this area and its role in societal well-being, the effort has been rather insignificant and lacking in depth. There is no effort whatsoever to understand the changes that have occurred in the Indian family post-urbanisation, nor is there any concerted attempt to examine child mental health from the standpoint of the family’s childrearing function.
Studies on the influence of macro-level changes on family structure and function are rare and issues of well being and family mental health, especially in terms of their resources and vulnerabilities in a rapidly urbanising environment are not given serious consideration. While professionals are significant in healthcare, the essentiality of working with families and caregivers in terms of collaborative approaches has not been sufficiently stressed. This also revealed a lack of understanding into the significance of the childrearing function in the promotion of emotional and overall development of the child, either in research, planning or clinical practice. The language used itself is indicative of the standpoint from which the whole process works. Words like ‘burden-sharing’ used with respect to families indicated a pathological rather than a pro-active approach that did not look at families as partners in the process of health. Though strong family support was seen as a critical factor associated with low prevalence of mental disorders, this aspect has not been explored in detail. Studies on parenting style or parent-child relationship or child’s emotional development are largely restricted to newspaper articles, blogs or newly evolved parenting workshops where access is only to the affordable minority. Empirical studies mostly were centered on issues of nutrition, feeding practices, immunisations and Government schemes. While it is established that urban contexts have inherent mental risks for families, urban studies, especially in India, tend to ignore this area.

Further research continues to look at problem issues rather than promotive or protective factors that can bring about positive developmental outcomes. An area of great significance is that of sexual development, yet most research is focused on reproductive health and risky sexual behaviour, for e.g. sexually transmitted diseases, reproductive rights, pregnancy-related care, contraception, infant mortality. Although, some studies (Abraham and Kumar 1999; Shekhar, Ghosh and Panda 2007) have looked at changing sexual behaviour of urban youth, very little focus is on the changes in sexual behaviour among children and youth in the normal population that is occurring due to changes brought in by urbanisation.

In the Indian context, there is neither an understanding into the real issues shaping child mental health outcomes, with an almost insular focus on medicalising issues and a staunch pursuit of contextually inappropriate models in health. This is indicated in the kind of research and practice procedures where contemporary issues are scarcely taken up. Examples of this are the links of urbanisation and family mental health, parent-child
relationships, play and other psycho-social factors in mental health (emotional development, interpersonal relationships, issues related to self, childrearing function, toxic and dangerous social environment, influence of the media, etc.).

The next sub-section highlights the key findings of some significant Indian studies (Table 3.01).
### III KEY FINDINGS OF INDIAN RESEARCH

#### Table 3.01: Key findings of Indian research studies

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<th>Sr. No.</th>
<th>Author</th>
<th>Title</th>
<th>Conclusions/Key Findings</th>
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<tr>
<td>3.</td>
<td>Srinath S, Girimaji, S, Gururaj, G, Seshadri, S Subbakrishna, D, Bhola, P and Kumar, N (2005).</td>
<td>Epidemiological study</td>
<td>Middle-class urban areas had highest and urban slum areas had lowest prevalence rates.</td>
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<td>5.</td>
<td>Kamkhedkar et al., (2007). Changing Concepts in Referral Patterns in a School Mental Health Clinic of a Tertiary Municipal Hospital in India across 25 years.</td>
<td>Annual reports of three nodal years (1979, 1994, 2005) were studied across 25 years.</td>
<td>Furthermore, onset and severity of mental disorders (notably depression) are earlier and increasing in severity.</td>
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Rates of increase in mental health are forecast to increase by 100% in developed countries between 2001 and 2040, but by more than 300% in India, China, and their South Asian and Western Pacific neighbours. |
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<td>11. Wasan, A. Neufeld, K and Jayaram, G. (2009). Prescribing practices in Delhi, India and Baltimore, USA. <em>Social Psychiatry and Psychiatric Epidemiology</em>, 44:2, 109–119</td>
<td>2-stage study using ethnographic methods</td>
<td>Although the quality of care did not differ greatly, the lack of trained psychiatrists in India greatly increases the volume of patients seen, lack of time for psychotherapy in busy hospital settings, and burden sharing with family members</td>
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Higher prevalence of psychological disorders in females both in PHC settings and the general population
Low recognition of emotional disorders by primary care physicians |

The key observations across the three dimensions that emerged out of the review of Indian studies has been summarised in Box 3.01.
Box 3.01 Observations regarding Indian studies

**Focus of intervention (pathological versus holistic health)**

- No mention of mental health in the goal: ‘health for all by 2000 AD’.
- Key elements of child mental health low priority in research, policy and practice
- Curative models take precedence over promotion and prevention
- Mental health planning restricted to urban areas (hospital and psychiatric settings)
- Psychiatric problems (most common depression and anxiety neuroses), psycho-somatic complaints with no identifiable organic cause, psychosocial problems and pain syndromes on the rise in primary health and general population settings.
- Intervention in India seen mostly in terms of manpower and facilities with comparisons made with the developed countries, lacking focus on the real issues plaguing child mental health.

**Urbanisation and family mental health**

- 50% of the Indian population projected to live in urban areas in the next two decades, Yet, mental health initiatives unable to respond to the changing needs of the urban communities.
- Studies investigating linkages between poor mental health outcomes and urbanisation scarce.
- Newer issues that shape developmental outcomes in urban contexts not explored, these include early and multiple learning systems, increased media usage and exposure, reducing context of engagement, issues of sexuality (early initiation into sexuality and hastening of children’s development).
- Research tended to neglect the general functioning population. Longitudinal (prospective), multi-axial, co-morbid, family functioning and quality of life studies were rare.

**Families and child mental health**

- Children and adolescents constitute 40-44% of the total Indian population, Yet, no child or family mental health policy.
- Strong family support was a critical factor associated with low prevalence of mental disorders, yet collaborative approaches with families’ non-existent.
- Low recognition of emotional disorders by primary care physicians
- Issues of well being and emotional development were not given serious consideration.
- 10-12% of those less than 18 years suffer from disorders of behaviour, learning and development yet few studies have investigated issues related to changing academic [early and multiple learning systems] cultures and family situations and their consequent effects on child mental health.
- Higher prevalence of psychological disorders in women (the primary caregivers) both in primary and the general health care settings
- Multi-focal, evidence-based, context-specific and integrated initiatives that strengthen protective factors within families and communities not explored.
- Efforts and advocacy is largely geared towards increasing mental healthcare workers rather than investing in families and communities.
- Traditional Indian literature includes grandparents, siblings, peers and significant others in the family, unlike Western studies where despite the large number of diverse studies on families,
family meant the nuclear family unit.

Considering the expanding base of research in the West and the diversity of topics undertaken, the literature review also helped to identify areas that would help in the promotion of child well being in the Indian context. Table 3.02 presents the key findings of western research on child mental health.
### IV KEY FINDINGS OF WESTERN RESEARCH

Table 3.02: Studies on mental health at the International level

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<tr>
<th>Sr. No.</th>
<th>Bibliography</th>
<th>Methodology</th>
<th>Conclusions/Key Findings</th>
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<tr>
<td>1</td>
<td>Nastasi, B. Moore, R. &amp; Varjasm, K. (2004). <em>School-Based Mental Health Services: Creating Comprehensive and Culturally Specific Programs</em>. Washington, D.C.: American Psychological Association.</td>
<td>Epidemiological study</td>
<td>Childhood neuropsychiatric disorders will rise proportionately by more than 50% internationally by the year 2020 to become one of the five most common causes of childhood morbidity, mortality, and disability in the world.</td>
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- Most nations spend less than 1% of the budget on mental health  
- More than 40% of the nations have no mental health policy  
- 30% have no mental health programme  
- Over 90% of nations have no child mental health policy |
<p>| 4       | Health care reform for Americans with severe mental illnesses: Report of the National Advisory Mental Health Council. 1993. <em>Am Journal of Psychiatry</em>; 150:1447-1465 |  | Annually, treatment costs are an estimated $27 billion a year, which is 4% of total U.S. direct health care costs. Totally, inclusive of social costs the financial toll is $74 billion. |
| 5       | Mathers, C. Lopez, A and Murray, C. 1993. <em>The Burden of Disease and Mortality by Condition: Data, Methods, and Results for 2001</em>. (The Global Burden of Disease (GBD) study sponsored by World Bank, WHO and the Harvard School of Public Health) | (The Global Burden of Disease (GBD) study Estimates drawn from more than 8,500 data sources, including epidemiological studies, disease registers, and notification systems. | Introduced a new metric, the disability-adjusted life year (DALY- summary measure of population health that combines years of life lost from premature death and years of life lived in less than full health), to quantify the burden of disease. |
| 6       | Murray, C &amp; Lopez, A. 2007. Alternative Projections of Mortality and Disability by | | The most striking increases in the burden of neuropsychiatric disorders were projected for other Asia and |</p>
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<td>11.</td>
<td><em>Mental Health: Report of the Surgeon General</em> - <a href="http://www.surgeongeneral.gov/library/mentalhealth/chapter2/sec2_1.html">http://www.surgeongeneral.gov/library/mentalhealth/chapter2/sec2_1.html</a></td>
<td>Epidemiological studies</td>
<td>A sub-population of children and adolescents with more severe functional limitations, known as “serious emotional disturbance” (SED) has been put at approximately 5 to 9 percent of children (ages 9 to 17).</td>
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<td></td>
<td>Authors</td>
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<td>12.</td>
<td>Rahim, S. I and Cederblad, M.</td>
<td>1989</td>
<td>Quantitative study</td>
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<td>13.</td>
<td>Weeramanthri, T &amp; Keaney, F.</td>
<td>2000</td>
<td>Surveyed 25 general practitioners (GPs)</td>
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<td>14.</td>
<td>Kramer, T. and Garralda, M.E.</td>
<td>1998</td>
<td>Quantitative study using questionnaires and research interviews.</td>
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<tr>
<td>15.</td>
<td>Hooper, L.</td>
<td>2009</td>
<td>Literature Review of clinical and research literature on individual and family resilience.</td>
</tr>
<tr>
<td>16.</td>
<td>Rao, N. McHale, J.P. &amp; Pearson, E.</td>
<td>2003</td>
<td>Quantitative study of mothers of 4–5-year-old children from two schools each in Beijing, China and Bangalore, India.</td>
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<td>17.</td>
<td>Cripps, Kayla</td>
<td>2009</td>
<td>Article review</td>
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The findings of the various studies in Cripps (2009) article review have been summarised as per the 3 dimensions. These are given below: 

|   | (Amato, 1994; Amato & Ochiltree, 1986; Buri et al., 1987; Dekovic & Meeus, 1997; Dmitrieva) adolescents’ perceptions of parental involvement | Adolescents determine personal self-worth, self-efficacy, and self-esteem based on perceptions gained from |

| 19. (Baumrind, 1966, 2005; Mussen, 1983; Santrock, 1990, 2004; Steinberg 2001; Buri et al. 1987; Doyle & Markiewicz 2005; Gecas, Ginsburg & Bronstein 1993). | (b) Parenting style related to higher levels of psychological well-being. (c) Impact of assorted parenting styles on adolescent psychological well-being. | The authoritative/democratic parenting style is associated with greater psychological well-being especially during and after adolescence related to the positive developmental outcomes. Parents need to be educated about findings related to normal adolescent development and competent parenting during adolescence along with familial changes that are occurring during this time period. |
| 20. (ASCA, 2005; Jennings, Pearson, & Harris, 2000; Taylor & Adelman, 2002) | Implications for middle school systems, middle school counselors, families, parents, and community members. | Middle schools should focus on parent education in-services to share the impact of parenting styles and perceived parental involvement on student personal, social, and academic achievement. |
| 21. Farrell and Barnes (1993) | A sample of 699 families located in a large northeastern city was analyzed. | A cohesive family possesses greater individual member functionality, appropriate parent-child communication, significant marital agreement and applicable adolescent children behavioral outcomes. |
| 23. Amato (1994) | National study of 471 young adult participants. | The degree of attachment possessed independently in both father-child and mother-child relationships were positively related to the grown children’s psychological well-being. |
| 24. Dekovic and Meus’s (1997) study explored adolescent-parent and adolescent-peer relationships. | Cross-sectional study of 508 families, composed of adolescents aged 12 to 18. | Adolescents who were found to have a more fulfilling relationship with parents had healthier relationships with peers, were more knowledgeable about their adolescents’ activities and veered away from the use of love withdrawal as a method of discipline. |
As indicated in table 3.02 the review clearly indicates that despite the focus on pharmacological approaches, a growing base of research is looking at families, holistic approaches and parental involvement in child mental health. A summary of the observations of the literature review is presented in Box 3.02.

**Box 3.02: Observations of Western research studies**

- Vast research base in epidemiological studies that indicated incidence and severity of mental disorders in both the general as well as child population.
- Expanding base of literature on issues related to family investment, parent-child relationship, parenting style and children’s emotional development.
- Family studies mostly focused on the nuclear family unit with little consideration of significant others in the child’s environment.
- Childhood neuropsychiatric disorders projected to rise proportionately by more than 50% internationally by the year 2020 to become one of the five most common causes of childhood morbidity, mortality, and disability in the world. Yet
  - Most nations spend less than 1% of the budget on mental health.
  - More than 40% of the nations have no mental health policy and 30% have no mental health programme.
  - Over 90% of nations have no child mental health policy.
- 50% of all adult mental disorders have their onset in childhood. Functional impairment played an important role in the adolescent consequences of childhood psychiatric disorder, **yet**
  - Primary prevention and promotion not indicated in practice settings with emphasis more on therapy and drug-based medical approaches.
  - Psychiatric and curative modalities of treatment preferred over investment in communities and collaboration with professionals.
- 84% of all psychiatric disorder were emotional ('internalising') disorders, yet
  - Psycho-social factors in mental health (emotional development, interpersonal relationships, self-esteem, functional competence, sense of purpose and meaning) not addressed in practice.
- A high rate of unrecognized and untreated child psychopathology in the community, which could lead to the development of recurring mental illnesses, thereby adding to the accumulated burden and hazards of untreated mental disorders.
- World's mental healthcare needs are largely unmet, not only in less-developed nations but also in the high-income countries indicating that current intervention systems may be ineffective in meeting the mental health needs of populations.
- There was no sex difference in the prevalence, indicating that prevalence was across gender.
- Resilience-based intervention approaches have been recommended for a positive state of well-being, yet promotive and holistic approaches recommended in research not translated into intervention for the general population.
- High levels of perceived parental involvement linked to children’s psychological well-being and healthier peer relationships.
- The *authoritative/democratic* parenting style was associated with positive developmental outcomes.
- Parental training and education regarding optimal child development and competent parenting endorsed.
- A cohesive family possessed greater individual member functionality, appropriate parent-child communication, significant marital agreement and positive behavioral outcomes.
- Affection established early in the parent-child relationship remained a psychological benefit even in adulthood.

The next section presents the challenges in the field of mental health based on the literature review of Indian and Western research studies.

### V CHALLENGES IN CHILD MENTAL HEALTH PROMOTION

1) Despite alarming statistics not only regarding onset, severity, prevalence and non-treatment of childhood disorders, treatment modalities, focused on clinical, curative and drug-based approaches, form the major bulk of intervention in child mental health.

2) Despite alarming statistics of chronicity of mental disorders and associated functional impairment, treatment procedures do not look at holistic and developmental initiatives interventions that focus on lifestyle management, personal growth and social development. Further early intervention as recommended in research is not applied in general practice.

3) Very little emphasis in practice settings on reducing risk and enhancing resilience, as advocated in traditional Indian health systems

4) In the West, despite extensive research, a healthy professional-patient ratio and adequate resources, studies indicated that mental healthcare needs are largely unmet; not only in less-developed nations but also in the high-income countries. The understanding here is that policy and practice need to look beyond contemporary treatment approaches.

5) Families and significant others (communities) were extremely significant in the promotion of child mental health, yet their involvement is largely peripheral. Further, the significance of the childrearing function of the family and the value of the developmental stage of childhood in human development is not acknowledged,
especially in the Indian context that traditionally placed great emphasis on optimum childrearing practices in child well-being.

6) Evidence-based research that addressed issues that compromised individual parents' abilities to provide safe and caring environments for their children largely neglected. Further, family-based health initiatives that encompassed a holistic, comprehensive understanding of how children develop within the contexts of their families were largely ignored in practice.

7) Despite striking increases globally in emotional, psycho-somatic and psychiatric disorders in children, investigation into the origin and maintenance of emotional disorders was rare, especially in the Indian health system.

8) Although, there is an awareness and acknowledgement of the sorry state of mental health care in India and the mental health issues plaguing children, efforts and advocacy was largely geared towards increasing mental healthcare workers rather than investing in families and communities.

9) Despite increasing linkages between the urbanisation process and mental ill-health, mental health initiatives largely operated from the psychiatric paradigm within the realm of allopathic medicine. Though, traditional healing systems were prevalent in the Indian system, these have not become a part of mainstream practice. Integration of the various systems to create holistic systems of health care was largely overlooked.

The literature review helped in detailing the scope of the study by providing a reasonable understanding into the current conceptualisations of mental health, indicators of child well-being and the direction of intervention in the field of child mental health in India. The primary issue that came out was the need to address child mental health issues. Further, an acknowledgement of the interplay of various factors in the environment in shaping developmental outcomes was seen. The critical role of parents and the childrearing function of the family was emphasised in Western research yet not applied to intervention strategies largely still confined to the pathological paradigm. The review revealed that child mental health from the standpoint of the childrearing function and the all-important parent-child relationship has been mostly overlooked in the Indian context. The researcher therefore attempted to examine these areas to gain an understanding that could provide a starting point to intervention research from a holistic and contextually-relevant standpoint. Moreover, the recommendations presented in Western and indigenous research would be
used to build a solid knowledge base on the ‘Indian child’ in an increasingly globalised context and ensuring that this knowledge is translated into concrete intervention strategies at the ground level.

While the field of mental health in India presented several challenges, the current study focused on a few factors that were perceived as critical to child mental health promotion, these emerged as the rationale for the current study.

The rationale or the purpose statement is a major guiding element of the study as it indicates “why you want to do the study and what you intend to accomplish” (Locke, Spiduso and Silverman 2000 as cited in Creswell 2002, page 87). The following section details the rationale that emerged from the literature review.

VI RATIONALE OF THE STUDY

‘A nation’s children are its supremely important asset and the nation’s future lies in their proper development. An investment in children is indeed an investment in nations’ future. A healthy and educated child of today is the active and intelligent citizen of tomorrow.’

...Rabindranath Tagore (as cited in Kumar 1988).

Tagore’s profound statement endorses the primary reason for the doctoral study, which is that children are significant from the standpoint of societal well-being. Research findings clearly indicated that children in urban contexts are vulnerable to mental ill-health. This could be attributed to the following reasons.

1. *The pre-dominant focus of research, policy and practice on the dysfunctional minorities rather than the functional majorities.* Although a large body of literature has explored issues in child development, predominant focus is on psychopathology, clinical practices and the curative dimension rather than primary-prevention and promotive mental health strategies. In addition, policymaking and practice in child mental health was geared to physical and larger structural issues like poverty, unemployment, etc. based on the understanding that economic development would lead to better mental health. Recognising that a majority of children are healthy and socially competent, the study attempted to highlight the vulnerabilities that this majority is exposed to. Additionally, a better understanding into the dimensions of mental health could contribute to initiatives that addressed issues of prevention and
promotion. Finally, the study will add to intervention research by providing insights from existing literature on making a shift from the current predominant problem-oriented and deficit-based approach to a promotive and strength-based one.

2. **Role of families in child mental health from the standpoint of the childrearing function largely neglected:** In the light of the linkages between family adversity and psychopathology, the risk factors that were embedded in childrearing contexts, predominantly the family context become a matter of concern. The childrearing function was a clear predictor of child mental health outcomes (Yearwood 2001). Yet, the role of families and the significance of the childrearing function were not accorded the importance that they deserved. In this context, it becomes mandatory to discuss child development with reference to family achievement that included parental childrearing practices, children’s socio-emotional adjustment and maladjustment, academic conditions, play, peer interactions, using a socio-ecological approach. The study attempted to study factors that compromised the family’s ability to provide safe and caring environments for their children. Further, factors that addressed family needs based on existing resources of the family, supported social networks that empowered parents to improve their life circumstances, promoted personal responsibility, provided information and emotional support and built parental skills were explored.

3. **Deficits in childrearing behaviours are chronic, lasting well beyond adolescence and into young adulthood.** Deficits in parenting behaviours were chronic, lasting well beyond adolescence and into young adulthood. Further, considering the bi-directionality of healthy parent-child relationships the study proposed to make a case for interventions that addressed emotional competence and social development with emphasis on the parent as well as the child’s emotional health, rather than those that focused on communication skills or child development alone.

4. **Childrearing styles not based on the child’s developmental requirements and parental needs.** Conceptualising childhood as distinct from adulthood and recognising its developmental significance in child well-being has been validated in research. The study attempted to explore childrearing practices that were optimally based on the child’s developmental requirements and parental needs that would strengthen the families’ mental health and contributed greatly to building the child’s emotional competence.

5. **Lack of consideration of the contextual dimension.** Anthropological, historical and philosophical studies have established that the Indian texts and practices are rich sources of psychological knowledge (Kakar & Kakar 2007). Yet, the increased focus on
pathological and curative models constrained the development of indigenous frameworks that were not only contextually relevant but provided a multidimensional measure of well-being. The study attempted to explore child development through a socio-ecological approach, with reference to the family that included traditional childrearing practices, children’s socio-emotional adjustment and maladjustment, interpersonal relationships, changing value orientations, educational conditions and play.

Chapter IV presents the methodology of the doctoral study.