Chapter 1

Introduction

Greater attention to processes unfolding in relation to school contexts will inform and improve the mental health and academic success of our children as well as the science and practice of changing systems and the course of development.

Masten (2003)

The past few decades have seen growth in our understanding of mental health disorders among children and the larger complex ecological and social contexts in which development occurs. The need to further clarify and intensify research efforts in these areas stems from the recognition that mental health disorders in children and adolescents generate a high burden in terms of morbidity, disability, family stress and costs incurred (Patel, Garrison, Mari, Minas, Prince and Saxena, 2008). Among children below the age of fifteen, 5-15 percent are afflicted by persistent socially handicapping mental disorders and a majority of this population lives in developing countries where mental health services are meagre or non-existent (Malhotra 1992).

The WHO document on Mental Health Programmes in Schools (1994) predicts that nearly one in five children and adolescents will have an emotional/behavioural disorder at some time during their youth regardless of their geographical and socio-economic contexts (Costello 1989; Baznenova 1992). In describing it as a ‘paradox’ of our times, Rutter and Smith (1995) observe that while indicators of social wealth and physical health amongst children worldwide have improved in the second half of the 20th century, mental health services in young people have been deteriorating.

Children may suffer from a wide range of psychiatric illnesses such as psychotic disorders, mood disorders, substance abuse and dependence, conduct disorders, eating disorders, attention deficit hyperactivity disorder (ADHD), adjustment disorders and anxiety disorders. Malhotra (2005) identifies enuresis, ADHD, learning disorders, conduct disorders and behavioural disorders as being among the
more commonly diagnosed child psychiatric conditions in India. Children with such difficulties exhibit a range of impairments which present across family, peer and school settings. They may experience poor academic grades, low academic motivation, have negative family interactions, poor social skills, be bullied or socially rejected and have a poor self-image.

The social stigma associated with seeking psychiatric help and the low levels of awareness amongst pediatricians, general physicians, teachers and parents in India about the occurrence of these conditions, translates into child mental health issues going undiagnosed and largely ignored. (Khandelwal, Jhingan, Ramesh, Gupta and Srivastava 2004). Untreated child mental health conditions create a set of cascading negative personal and social outcomes that persist into adulthood, escalating the risk and severity of adult psychiatric disorders.

1.1 Child Mental Health- India

Considering that children under 16 years of age constitute over 40 percent of India’s population, information about their mental health needs to be viewed as a national imperative (Srinath, Girimaji, Gururaj, Seshadri, Subbakrishna, Bhola and Kumar 2005). Kapur (2005) reports that there have been a fair number of clinics and community based epidemiological surveys in the urban and rural areas in the past two decades. In the 1970’s child referrals were mostly cases of intellectually challenged children who were typically seen as part of the adult population. From 1967 onwards, there have been 14 clinic-based studies, 7 population surveys in rural areas and 10 surveys in urban areas (Kapur 1995). Early Indian studies reported prevalence rates of psychiatric disorders among children ranging from 2.6 to 35.6 percent (Sethi, Gupta, Kumar R. and Kumar P. 1967, 1972; Verghese and Beig, 1974; Lal and Sethi, 1977). The reasons attributed for the wide disparity among the prevalence rates included the ‘varying modes of case ascertainment, sampling methods, instruments and the informants chosen across the studies.’ (Srinath et al. 2005).

However with the advent of exclusive child epidemiological surveys and the use of sophisticated statistical tools, a better though far from complete picture has emerged regarding the prevalence of childhood mental health. Current prevalence rates of mental health conditions among children in India using a common methodology found that amongst urban and rural children, between 4-16 years, in the community, there was an overall prevalence rate of 12 percent (Srinath et al. 2005). While the prevalence rates are lower than those established in epidemiological studies in Western countries (Shaffer, Fisher, Dulcan et al. 1996), the sheer number of children who require access to mental health services is
overwhelming. The history of child mental health services in India dates back to 1937 when the first Child Guidance Clinic (CGC) was established at the Tata Institute of Social Sciences, Mumbai.

A National Institute of Public Cooperation and Child Development (NIPCCD) study in 2003 indicated the presence of 164 such CGC’s in the last 67 years from 1937; suggesting that approximately two CGC’s a year were established in India and these were limited to major urban cities. Estimating the requirement of even a single clinic per one lakh child population, these figures clearly indicate that the growth of such clinics has been very sparse and is woefully short of the projected requirement of CGC’s across the country (Sharma 2005). Despite alarming statistics, it appears that successive governments have failed to recognize the magnitude of mental health problems in children. Murthy (1993) reflecting on the various government policy initiatives for children, expresses scepticism about issues of child mental health occupying centre stage in the near future given the limited number of mental health professionals engaged in areas of policy and decision making and the existing basic social and health development concerns of the public planners.

India currently does not have a separate child mental health policy. The mental health needs of children are indirectly alluded to in various long term and integrated national policy documents- Integrated Child Development Services (1972), National Policy for Children (1974), National Mental Health Programme for India (1982), National Policy on Education (1986), Integrated Education for Disabled (1988) and Integrated Child Development Scheme (1989). Common to these policy documents are useful recommendations that establish foundations for the overall health of the child with a view to reducing the incidence of mortality, morbidity, malnutrition and school drop outs. These documents and policies however, fall short of offering accurate data which would allow for establishing priorities and indicating directions in the area of ramping up and providing effective child mental health services.

In recognizing the impact of mental health disorders on the quality of life, WHO has accorded it the status of a priority disorder and has urged governments about the need for scaling up early detection and intervention for mental health disorders in ways that are culturally sensitive (WHO 2008). Child mental health research has clearly established the need for expanded mental health services. Innovative and community based approaches to child mental health has begun to emphasize schools as sites for intervention. Formal schooling or entering elementary school occurs when the child is usually 6 years of age in India. With over 1847 lakh pupils at the primary level, India now has the largest elementary student population in the world (MHRD 2006). Urban epidemiological studies conducted on school going children and adolescents in India; indicate prevalence rates of 10-30% for emotional and behavioural disorders (Kapur 2005). One such common childhood developmental disorder that is seen among the
elementary school going population that impacts on a child’s academic and social functioning is Attention Deficit Hyperactivity Disorder (ADHD).

1.2 Attention Deficit Hyperactivity Disorder

ADHD as defined by the American Psychiatric Association (2000) is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed or more severe than is typically observed in individuals at a comparable level of development. The World Health Organisation’s Classification of Diseases (WHO 1990) also recognizes this condition, referring to it as Hyperkinetic Disorders. Typically a triad of difficulties in the areas of attention, activity levels and impulsive behaviours form the core diagnostic features of ADHD. The behaviours associated with ADHD exist along a continuum from mild to severe. Two thirds of elementary school-age children with ADHD have at least one other diagnosable psychiatric disorder (Cantwell 1994; Arnold and Jensen 1995). Conduct disorders, oppositional defiance and mood disorders such as depression and anxiety, language and communication disorders and Specific Learning Disabilities are frequently diagnosed as co-morbid conditions (Cantwell 1996).

In its positional paper on ADHD, the National Association of School Psychologists (NASP), USA, recognizes that the core symptoms of ADHD, including both inattention and hyperactivity, are neurobiological in nature, and have the potential to adversely affect a child’s educational performance as well as social-emotional development (Barkley 2006). It suggests that attention problems may also be due to a variety of factors such as academic difficulties, anxiety, depression, and/or environmental factors (e.g., teaching practices, ineffective discipline, or stress; DuPaul and Stoner 2003).

International prevalence rates for ADHD vary between 3-6 percent of school aged children. Usually described as a western phenomenon, it has however been demonstrated to occur as a fairly stable psychiatric construct across social and cultural boundaries (Tannock 1998; Malhi and Singhi 2000; Ghanizadeh, Bahredar and Moeini 2006; Hong 2007; Karande, Satam, Kulkarni, Shalapurwala, Chitre and Shah 2007 and Einarsdottir 2008). While ADHD was earlier considered a childhood disorder, research indicates that 70-80 percent of individuals diagnosed with ADHD in childhood will continue to have associated symptoms as adolescents and adults and are at risk for developing relationship problems, employment difficulties, mood and substance abuse disorders as adults (Hinshaw 1994; Robin 1998).
Diagnostic Symptoms of ADHD

It is the dysfunction evident in school behaviour and performance that typically triggers a clinic referral for ADHD. Children with symptoms of hyperactivity and impulsivity are identified by teachers, because they often disrupt the classroom. Teachers are quick to notice distractibility and motor symptoms, such as fidgetiness as it makes demands on their ability to control the class.

In contrast, children who tend to be dreamy, lost in thought, do not participate in classroom discussions—have inattention related difficulties where hyperactive and impulsive symptoms are absent or minimal, may not come to the attention of teachers. These children may present with school underachievement (APA 2000).

A formal diagnosis of ADHD takes into account information obtained from the child’s parents and teachers regarding frequency and intensity level of attention related difficulties and the degree of impairment it causes across a range of settings. The child may be administered standardized tests of ability and achievement, neuropsychological tests of attention and a physical examination. Clinicians usually refer to diagnostic criteria as listed in the DSM-IV to make a provisional diagnosis of ADHD. The DSM-IV criteria developed through several iterations by the American Psychiatric Association are based on clinical experience and active research. These criteria have more support in available research literature than other available diagnostic criteria (APA 2000). The DSM-IV criteria define 3 subtypes of ADHD:

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<tr>
<th>ADHD- Primarily Inattentive Type (ADHD/I, meeting at least 6 of 9 inattention behaviours)</th>
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<tr>
<td>ADHD- Primarily Hyperactive Impulsive Type (ADHD/HI, meeting at least 6 of 9 hyperactive–impulsive behaviours)</td>
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<td>ADHD- Combined Type (ADHD/C, meeting at least 6 of 9 behaviours in both the inattention and hyperactive–impulsive lists)</td>
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DSM-IV Diagnostic Criteria Table

A. Either 1 or 2

1) Six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

a. Often fails to give close attention to details or makes careless mistakes in schoolwork, or other activities
b. Often has difficulty sustaining attention in tasks or play activities
c. Often does not seem to listen when spoken to directly
d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behaviour or failure to understand instructions)
e. Often has difficulty organizing tasks and activities
f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
g. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books or tools)
h. Is often easily distracted by extraneous stimuli
i. Is often forgetful in daily activities

2) Six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

a. Often fidgets with hands or squirms in seat
b. Often leaves seat in classroom or in other situations in which remaining seated is expected
c. Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults may be limited to subjective feelings of restlessness)
d. Often has difficulty playing or engaging in leisure activities quietly
e. Is often ‘on the go’ or often acts as if ‘driven by a motor’
f. Often talks excessively
g. Often blurts out answers before questions have been completed
h. Often has difficulty awaiting turn
i. Often interrupts or intrudes on others (e.g. butts into conversations or games)
B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before 7 years of age.

C. Some impairment from the symptoms is present in 2 or more settings (e.g. at school/work/home)

D. There must be clear evidence of clinically significant impairment in social, academic or occupational functioning.

E. The symptoms do not occur exclusively during the course of a pervasive development disorder, schizophrenia, or other psychotic disorder and are not better accounted for by another mental disorder (e.g. mood disorder, anxiety disorder, dissociative disorder or personality disorder).

ADHD- The Rise of a Construct

Scientific documented origins of ADHD date back to 1798 when Alexander Crichton, a Scottish physician, described a range of attentional problems in otherwise healthy young people that he identified as ‘mental restlessness’. The first formal treatise on ADHD is however attributed to George F. Still (1902) who in a series of three lectures presented before the Royal College of Physicians of London, described a group of twenty children in his practice who, despite having no general intellectual impairments, had deficits in what he described as ‘inhibitory volition’ (Still, 1902, p. 1011). These children were reported to be defiant, resistant to discipline, exceeding emotional and passionate. They showed signs of serious issues with attention and were unable to learn in school. Still noted that these behaviours were symptomatic of a disorder possibly caused by physical disease, familial predisposition and/or injury to the nervous system (Barkley 1996; Stubbe 2000; Palmer and Finger 2001; Rafalovich 2001).

Neufeld and Foye (2006) in describing the historical rise of ADHD in North America opine that the encephalitis epidemic of 1917-1918 played an influential role in anchoring the roots of ADHD to a physiological etiology. Children who survived this sickness sometimes displayed excessive levels of motor activity and impulsivity. (Stubbe 2000). The concept of a brain-injured child syndrome (Strauss and Lehtinen 1947) arose from such cases where trauma and illnesses that caused brain damage resulted in altered behaviour patterns. The concept of the brain-injured child evolved into the notion of minimal brain damage and then minimal brain dysfunction.
The term MBD or Minimal Brain Dysfunction was coined in the 1940’s to describe children with symptoms of inattention, hyperactivity, brain damage and dyslexia (Barkley 1997). In the 1930’s, Charles Bradley, the director of a children’s residential hospital demonstrated the effectiveness of the stimulant Benzedrine in improving problematic behaviours in children with MBD (Bradley 1937).

In 1957, Maurice Lauffer, second director of this hospital, suggested a new name for MBD- Hyperkinetic Disorder, focusing on one aspect of this broad diagnosis that responded to medication. Lauffer claimed that ‘a favourable response to amphetamine is supportive evidence for a diagnosis of the hyperkinetic syndrome’ (Lauffer and Denhoff, 1957, p. 473). In the 1950’s children who showed signs of ADHD were diagnosed as having Hyperkinetic Impulse Disorder. This definition viewed hyperactivity as a brain damage syndrome.

Chess in 1960 classified ADHD as Hyperactive Child Syndrome, emphasising activity as an essential component of the condition and separated it from the concept of a brain damage syndrome. (Turner and Walls 1998). Hyperactivity continued to define the disorder until the American Psychiatric Association’s diagnostic classification of psychiatric disorders- the Diagnostic and Statistical Manual (DSM)-III (1980) coined a new term- Attention Deficit Disorder (ADD). This label shifted diagnostic emphasis from hyperactivity to attention as the core problem of disorder. A few years later, DSM-IIIR (1987) reflected this shift in thinking and ADD was changed to the present-day AD/HD—Attention Deficit Disorder with or without Hyperactivity.

Studying ADHD for over two decades, Russell Barkley (1997) a prominent researcher of ADHD has proposed that the current focus on attention as the core symptom of disorder is misguided. Instead, he refers to ADHD as a problem of regulation involving higher order neuropsychological processes. Observers of the search for a clinical definition of ADHD speculate that Barkley’s theories may influence yet another shift in diagnostic nomenclature (Goldstein 1998). Over the past six decades the label has changed in response to what mental health professionals understood of attention processes in children. Many of the key markers and assumptions regarding the disorder continue to generate heated debates and rather polarized perspectives of ADHD, its symptoms, etiology and treatment.
1.3 The Etiology of ADHD- Perspectives

Parallel to the changes in nomenclature and acknowledging what symptoms constituted the disorder was literature that began to surface in the 1960’s that challenged the validity and existence of ADHD as a behavioural and psychiatric condition. The absence of definitive biological markers and the inherent subjectivity involved in differentiating behaviours that are perceived as difficult but within the gambit of normal child development as compared to behaviours that are considered pathological and deviant, has fuelled the ‘anti- ADHD’ debate (Conrad 1975; Shrag and Divoky 1975).

The biomedical oriented studies understand the etiology of ADHD as primarily biological. Tannock (1998) in a comprehensive review of research on causes of ADHD identified cognitive, neuroimaging and genetic areas as the broad areas of causal research in ADHD. In absolute contrast to the biomedical oriented studies are the anti-psychiatry perspective studies that range from viewing ADHD as fraudulent (Breggin 1998; Baughman 2000) to a condition that has been socially constructed to promote modern day capitalist ideologies (Kindlon and Thompson 1998). The high sales and widespread use of stimulant medication for the treatment of ADHD especially in the United States as compared to the rest of the world (Diller 1998; United Nations Report 1999) has also lead to the perception of it being a condition constructed to suit the vested interests of the pharmacological industry (Breggin 1998).

The polarity of these two perspectives has lead to research that has failed to consider the ‘potential of the unique intersection of the two’ (Lee and Stacy 2008). In an attempt to shift from the simplistic ‘nature-versus-nurture’ conceptualizations of ADHD, Frith (1992) argues that biological causes and behavioural outcomes are mediated by experiential and environmental factors. ADHD is a complex phenomenon and needs to be understood in a more holistic, Biopsychosocial framework (British Psychological Society-BPS, 2000). This conceptualization draws into focus the role and importance of developmental contextual factors and the social environment in determining levels of coping and dysfunction.

Biomedical Perspective

Maurice Lauffer in 1957 coined the term ‘hyperkinetic disorder of childhood’ for the cluster of ADHD-like behaviours in children. Emphasizing the organic components of the disorder, he observed that a positive response to amphetamine provided supportive evidence for a diagnosis of the condition and hence recommended its use in treatment. The new term hyperkinetic disorder of childhood effectively narrowed the condition in terms of symptoms and treatment prescribed (Lauffer and Denhoff 1957).
There appeared to be a renewed interest in biological psychiatry following Lauffer’s research. Psychiatrists were urged to actively consider organic factors when diagnosing children’s behaviour rather than being exclusively focused on psychogenic factors (Knobel 1959). Research attention was drawn to the possibility that multiple factors of organic causation could explain child psychiatric conditions and that clinical and research efforts should attend to these rather than interpersonal and stress related factors (Clements and Peters 1962). From the early 70’s onwards, the use of methylphenidate came to be the mainstay in the treatment of ADHD (Singh 2007). The origins of ADHD are thus seen to arise from a medical model. Tannock’s (1998) review on ADHD research identifies 3 areas of theoretical exploration of this subject that are shaped by this perspective:

1. **Cognitive research** - This research focuses on impulsiveness as the central feature of ADHD. Individuals with ADHD appear to have a core difficulty in inhibiting or delaying a behavioural response. The nature of dysfunction in this system is described as a failure of the inhibitory control system to become activated or as an extreme delay in the activation of the system. The dysfunctional response inhibition system is located in the pre-frontal cortical region of the brain. Barkley(1997) drawing on this proposes that these problems in response inhibition lead to problems in 4 major executive functions of cognition-working memory, internalized speech, motivational appraisal and reconstitution or behavioural synthesis. These difficulties create challenges for children in school where an emphasis is on sedentary behaviour, passive listening, self-regulation and recall.

2. **Neuro-imaging research** - Most medical conceptualizations of ADHD presume an underlying neurobiological basis for cognitive dysfunctions. Research using modern neuro-imaging techniques has so far shown the presence of a range of abnormalities in the development of certain brain regions in individuals with ADHD. However studies do not show a direct link between neurobiological abnormalities and ADHD (Hinshaw 1994; BPS 1996).

3. **Genetic research** - ADHD is more common among biological relatives of children with ADHD than it is among biological relatives of children who do not have it. Twin and adoption studies have repeatedly shown a much greater incidence of ADHD among monozygotic than among dizygotic twins (Tannock 1998; Levy and Hay 2001). There is evidence from molecular genetic research that points to genetic abnormalities in the dopamine system (Levy and Hay 2000) which plays a key role in the regulation of movement and selective attention (Thompson 1993).
Mental health professionals who subscribe to biomedical models of ADHD opine that much of the social debate that ADHD generates in the popular media fails to integrate an understanding of the clinical realities of children’s behaviour problems and the important difference that psychotropic drug treatments can make for children and families (Barkley, 1997).

Social Perspective

The central aim of this research is a critical analysis of social and cultural factors in the drug treatment of ADHD (Singh 2007). A strong critique of this model of ADHD emerges out of 1970’s anti-psychiatry movement and is based on the work of Thomas Szasz (1974). Szasz suggested that in the absence of clear biological pathology as an etiological factor, mental illness amounted to a metaphor for culturally disapproved thoughts, feelings and behaviours. Following Szasz’s work, Shrag and Divoky (1975) describe the ADHD ‘myth’ and its links with mechanisms of social control that operate through institutions such as schools and hospitals, allowing for regulation and control of individual behaviours (Conrad and Schneider 1980,1992).

At the extreme end of such critique, is the perspective that rejects the existence of ADHD as a disorder. Breggin (1998) argues that ADHD does not exist, and that Ritalin is a way to deflect focus from schools and parents that do not want to take accountability for children’s’ behavioural difficulties and inappropriate behaviours. The disorder according to Breggin is orchestrated to generate power and wealth for medical institutions and pharmaceutical companies.

DeGrandpre (1999), echoing Breggin’s critique of ADHD, reflects that our social landscapes are competitive, fast, high sensory cultures. In such settings psycho stimulants provide children with the speed they require to function effectively. In a harshly competitive world where achievement is equated with survival, the possibility that medication can chemically enhance performance is alluring yet fraught with ethical concerns (Diller 1998). Research in the last decade that addresses issues of ADHD diagnosis in relation to social needs and expectations highlights the issue of gender bias in ADHD diagnoses. The approximate ratio of four boys: one girl suggests that ADHD is probably medicalising ‘normal’ boys who fail to attain high achievement in a competitive social and academic world. An ADHD diagnosis and medication enables a boy to then develop typical male behaviours that are associated with societal expectations of achievement and success (Pollack 1998; Kindlon and Thompson 1999).
A major criticism with research that subscribes to these views is the lack of empirical data to support assertions. While this work challenges the validity of the ADHD diagnosis and its positivistic assumptions and is important as cultural and critical commentary, it doesn’t address attention related difficulties that children and their families experience from a practitioner’s point of view, which as Singh (2002) observes tends toward a more holistic picture owing to their pragmatic orientations.

**Biopsychosocial Perspective**

Rutter (2001) posits that the development of ADHD cannot be predicted on the basis of genes or neurology alone. Neurological development is the product of the dynamic interaction between biological, social/physical environmental factors. These individual factors are nested within a further set of influences which are of a structural and cultural nature. In the case of ADHD a purely medical perspective may emphasize only the neurological aspects of etiology and medication therapy as the most effective intervention. A purely social or educational perspective on ADHD is more likely to emphasize the contribution that different social or family factors or teaching strategies and patterns of educational organization and management make to the child’s educational performance. A combined approach may look at ways in which these two approaches may complement one another.

Frith (1992) in her model suggests that biological causes and behavioural outcomes are mediated by experiential and environmental factors. The individual’s learning and experience may give the individual required coping or compensatory skills to address deficits or provide varying levels of motivation which will in turn affect the individual’s ability to cope. Patterns of influence would seem to be bi-directional and recursive. Biological propensities may create initial difficulties for the child, in terms of attentional and activity problems, these are interpreted and responded to in cultural, social, school and family contexts. This conceptualization of ADHD makes the social environment consisting of the family and school a critical feature in considering effective intervention.

**Developmental Contextual Perspective**

Similar to the Biopsychosocial perspective of ADHD in its core understanding that biological expression of behaviour is realized and shaped in specific environments is the Developmental Contextual perspective. Developmental contextualism has its roots in biology and ethology (Hinde 1980; Gottlieb 1983), and has more recently been applied to understanding children and adolescents in family and school
contexts by Lerner (1978, 1984 and 1989). Developmental contextualism posits a ‘transactional, not unidirectional, relation between individual organisms and their environments’ (Pelligrini and Horvat 1995). Biologically oriented models tend to be unidirectional in that relations are characterized by an individual affecting its environment. In contrast, a transactional model considers that children and their environments influence each other. It expands on the Biopsychosocial model by emphasizing the timing of these transactions. Lerner (1989) explains timing as specific behaviours that have different meaning depending upon the specific phases of development in which they occur in specific contexts. For example a 2 year old child displaying temper tantrums can be considered to be displaying age related behaviour, the same expression of behaviours in a 12 year old is considered problematic and suggestive of other psychological difficulties.

The likelihood of a specific outcome, such as ADHD, depends upon a child exhibiting a specific set of behaviours in a certain place at a certain time. Behaviour is then not viewed as predetermined by biological or environmental conditions; rather it is shaped by the transaction between multiple systems. A dichotomized perspective of biological versus environmental effects on a complex condition such as ADHD is simplistic and does not take into account the realities of how organisms interact with their environments.

The educational implications of this perspective suggest that children's functioning in school is the result of within-individual factors being embedded within specific school systems. ADHD diagnoses have been noted to increase dramatically as children move from preschool and kindergarten into primary school suggests developmental issues at play as children begin to experience increasing academic demands as they transition from play oriented to formal school settings and more stringent demands on their behaviour. In keeping with this idea, the educational goals should be developmentally specific. As Lerner (1984) notes, the consequence of this theory is recognition of developmental plasticity, where childhood functioning is facilitated or inhibited by the placement of specific children in specific environments at specific times.
1.4 ADHD- Impact on the school going child

Disobedient, troublesome, obstinate, bothersome, irritating are some of the typical behaviour descriptors used by teachers in referring to a child with ADHD type behaviours. As Cooper (2001) explains, the behaviour of children with ADHD is often misconstrued by parents and teachers as willful misconduct. Behaviours are viewed as stemming from problems with volition and motivation rather than as reactions to conflicts between the child’s abilities and the demands of the environment. Schools are often rigid and inflexible when it comes to displaying a tolerance to behaviours that threaten their notions of classroom order, teacher control and student compliance. Hence students with ADHD are frequently subject to negative teacher and peer interactions and expectations. ADHD has proximal detrimental effects on classroom functioning, academic achievement and peer interaction; it also raises the risk for distal negative outcomes (Barkley, Fischer, Smallish, & Fletcher, 2004).

Students with ADHD typically exhibit a variety of difficulties with school functioning. Hyperactive-impulsive behaviours that may comprise ADHD often lead to disruptive behaviours in the classroom including walking around the classroom when staying seated is expected, talking out of turn, bothering other students, intrusive verbalizations, not following through on instructions and interrupting teacher instruction. Children with this disorder also have difficulties in sustaining attention and exhibit significantly higher rates of off-task behaviour when passive classroom activities (e.g. listening to teacher instruction and reading silently) are required relative to their non-ADHD classmates (Abikoff et al. 2002; DuPaul, Jitendra, Volpe and Cleary, 2006). Students with ADHD who evidenced oppositional/aggressive behaviour or severe social impairment were rated by general education elementary teachers as significantly more stressful to teach than students with ADHD who did not evidence these associated difficulties (Reinke et al. 2011).

The combination of ADHD and disruptive behaviour can interfere with learning and classroom activities for students with ADHD and these behaviours are frequently associated with deficits in academic skills and performance. Difficulties in academic functioning in response to the complexities of academic demands become more pronounced as the child transitions from elementary to middle school. Often the academic slide in grades that begins in middle school continues into high school (Fischer et al., 1990). Approximately 20–30% of students with ADHD also meet diagnostic criteria for a Specific Learning Disability in reading, math, or writing (Semrud-Clikeman et al.1992; DuPaul and Stoner 2003). ADHD symptoms are also linked to performance difficulties on achievement tests (Barkley, Du-Paul and McMurray 1990; Fischer, Barkley, Fletcher and Smallish 1990; Brock and Knapp 1996).
Rapport and colleagues (1999) proposed a Dual Pathway model to explain the relationship between ADHD symptoms and academic achievement difficulties. They suggested that certain components of both cognitive and behavioural pathways served to mediate the effects of ADHD on achievement. The cognitive pathway is hypothesized to mediate the effects of ADHD on achievement through vigilance and memory deficits, whereas the behavioural pathway mediates the effects of ADHD on achievement via disruptive classroom behaviour. Findings from two recent studies exploring connections between ADHD and achievement problems in mathematics and reading have indicated that prior achievement and classroom behaviours, specifically motivation, study skills, and academic engagement acted as mediators of the effects of ADHD (DuPaul et al., 2004; Jitendra et al., 2007; Volpe et al., 2006). Thus, the relations between ADHD and achievement are complex.

Goodman and Stevenson's (1989) examination of 570 twins suggests that ADHD is associated with one or more specific cognitive deficits rather than a general intellectual limitation. Children and adolescents with ADHD often have difficulties developing and maintaining positive relationships with peers, teachers, and other school personnel (DuPaul and Stoner 2003; Barkley 2006). Difficulties with inattention and impulsivity inhibit the development of appropriate social relationships in several ways. Children with ADHD may have trouble following the implicit rules of reciprocal conversation and hence are likely to interrupt during conversation, not listen closely to what others are saying, and respond in an irrelevant manner (i.e., talk about something that is not specific to the conversation topic).

Students with ADHD may disrupt ongoing peer activities by entering in an abrupt, impulsive manner, e.g., joining a game when it is in progress and expecting to be given a key role (DuPaul and Stoner, 2003). Fallout of such behaviours may result in peers choosing to exclude the child with ADHD from activities. Children with this disorder are more likely than their non-ADHD classmates to behave in a verbally or physically aggressive manner, presumably because of their problems with impulse control (Barkley 2006). Studies have indicated that children with ADHD are less well liked, more often rejected, and have fewer friends than their non-ADHD peers (Hoza et al. 2005).

Teachers commonly report feeling stressed working with children with disruptive and acting out behaviour, attention problems and hyperactivity (Reinke et al. 2011). It is the dysfunction evident in school behaviour and performance that typically triggers a clinic referral and leads to a diagnosis of ADHD. In response to supporting children with ADHD in the classroom, teachers feel they need additional training in the areas of working with externalizing problems, effective classroom management skills, specific behavioural interventions, and communicating effectively with families (Reinke et al. 2011).
Research indicates that classroom contexts are a challenge for children with ADHD and their teachers. A key aspect of improving the behaviour of children and young people in schools involves the classroom practice of individual teachers (Hart 2010) and engaging actively with issues of school mental health.

1.5 Schools and Mental Health

Children spend a significant part of their childhood in schools, interacting with the curriculum, teachers and peers. The Public Report on Basic Education in India (1999), states that the average urban child today spends between 5-7 hours in school. It would be logical to assume then that schools play important roles in the psychosocial development of the child as they come to form frames where developmental domains such as intellectual, social and physical, engage and transform (Noam and Hermann 2002) and are also arenas where childhood behavioural and emotional disorders will be played out.

Masten (2003) locates the emphasis that current mental health research places on the emergence of schools as sites for prevention and intervention to growth in the area of developmental psychopathology over the past two decades. Developmental psychopathology allows for a more integrated conceptual understanding of how behavioural and emotional problems in children arise and the processes by which they are sustained. In synthesizing the research, Masten (2003) highlights 3 fundamental tenets of developmental psychopathology with relevance to school based practices and research:

**Developmental Psychopathology- Relevance to Schools**

a. Children are living systems whose lives reflect complex interactions with other systems including schools which in turn are embedded in larger systems

b. Understanding positive adaptation and development is important for preventing and treating problems particularly among children at risk for psychopathology

c. More complex approaches are required in order for interventions or research to accommodate the embedded multi system realities of children’s lives and these approaches require collaborations at a much earlier and deeper level
Bronfenbrenner’s (Bronfenbrenner 1979, 1995; Bronfenbrenner and Crouter, 1983) model of embedded systems and their interactions has had a tremendous influence on models of etiology and intervention in developmental psychopathology. The ecological model posits that the developing organism is strongly influenced by context. It describes four nested levels of interdependent structures for classifying context beginning with those ecologies in which the child directly interacts and proceeding to increasingly distant levels of the social world that affect child development.

The first level, the microsystem, is composed of ecologies with which the child directly interacts such as the family, school, peer group, and neighbourhood. The microsystem is the ‘pattern of activities, roles, and interpersonal relations experienced by the developing person...with particular physical, social, and symbolic features that invite, permit, or inhibit, engagement in sustained, progressively more complex interaction with, and activity in, the immediate environment’ (Bronfenbrenner 1993). Most of the research on behaviour problems has focused on the microsystem (Stacks 2005). The classroom and the teacher are part of the child’s microsystem. When children experience predominantly negative interaction patterns with teachers they tend to construct mental representations of negative teacher–child relationships that they carry forward to new relationships (Howes and Smith 1995).

The mesosystem encompasses the relationships between the various microsystems (e.g., the family-school connection or between the parents and the child’s peer group and peers’ families). The absence of mesosystem links may also be an important risk factor in development. The exosystem consists of those contexts and actions that indirectly impact the child’s development. The exosystem is made of linkages between at least two settings, one of which the developing person is not a part of. The events in the setting that do not contain the developing person, however indirectly influence the process in that person’s immediate environment (Bronfenbrenner 1993).

Finally, the macrosystem represents the widest level of systems influence, consisting of the broad ideological and institutional patterns and events that define a culture or subculture. To this basic Ecological Model, Bronfenbrenner added the concept of proximal processes. He clarified that ‘Throughout the life course, human development takes place through processes of progressively more complex reciprocal interaction between an active, evolving biopsychological human organism and the persons, objects and symbols in its immediate environment. To be effective, the interaction must occur on a fairly regular basis over extended periods of time. Such enduring forms of interaction in the immediate environment are referred to as proximal processes.’

Bronfenbrenner described learning new skills, acquiring new knowledge, problem solving, parent child, teacher-child and child-child activities as some examples of these processes.
Underlying the Bioecological model is a cardinal theoretical principal that genetic material does not produce finished traits but rather interacts with environmental experience in determining developmental outcomes (Bronfenbrenner 1993). Viewed in context of Bronfenbrenner’s Bioecological Model, schools as microsystems provide excellent settings for targeting children’s mental health, their academic performance, and the important connection between them (Greenwood, Kratochwill and Clements 2008). Effective teacher student interactions communicate warmth and respect, positive and clear expectations and provide frameworks for engaging in rich opportunities for learning (Hamre and Pianta 2010). These interactions are critical to academic and social emotional development particularly among children experiencing emotional or behavioural difficulties (Hamre and Pianta 2005; Mashburn et al. 2008).

In addition to the logistical accessibility, children with mental health needs identified in school are more likely to enter and receive treatment when mental health services are offered in school rather than when they are offered in the community (Ringeisen, Henderson and Hoagwood 2003). According to WHO (1994), schools are currently the best place to provide a comprehensive mental health programme for children because:

- Almost all children attend school at some time during their lives
- Schools are often the strongest social and educational institution available for intervention
- Schools have a profound influence on children, their families and the community
- Young peoples’ ability and motivation to stay in school, to learn and to 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 psychosocial 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, mental well being and in treating mental disorders
- When teachers are actively involved in mental health programmes, the interventions can reach generations of children
- Teachers have often received some training in developmental principles. This makes them potentially well qualified to identify and remedy mental health difficulties in school aged children
Kapur (1995) opines that while the entire area of education and intervention seems to be a new pasture for the mental health professionals to reach out to - the limited experience gathered in India, suggests that it’s likely to be a ‘very promising endeavour.’ The National Mental Health Policy document (1984) states under section 7 - Education Sector’s Role in Mental Health Care - that; ‘Social, behavioural and learning problems are manifesting themselves in schools. Addition of mental health inputs in school health programmes is likely to play a major role in their amelioration.’ Recognizing the rapid economic, social and technological changes that are impacting children and families in complex ways, WHO in its document on Mental Health Programmes in Schools (1994), acknowledges schools as being central to the lives of children and their well being.

Figure 1.1- WHO model for school mental health programmes (1994)
As illustrated in Figure 1.1, the WHO (1994) document on School Mental Health orders psychosocial issues faced by children in schools in a four tiered structure. Issues of well being and social competence affect the entire school community. Improving coping skills, decreasing stress and increasing support for a healthy school community strengthen the mental well being by building in early prevention mechanisms of effective coping. Specific knowledge about mental health conditions, addressing issues of stigma, acceptance and inclusion help in the early identification of difficulties and choosing appropriate interventions if required. A significant number of students experience a range of psychosocial problems ranging from adjustment related difficulties such as bullying with peers to experimenting with alcohol. This group benefits from specific interventions, children who continue to experience stressors in this group are at risk for developing other serious mental disorders. A smaller percentage of children exhibit psychological difficulties that require intensive early intervention and supportive school-family networks.

Reinke et al. (2011) observe that in response to the growing need for mental health services for children, research on the use of universal (i.e., targeting all students) and selective (i.e., targeting students at risk) school based interventions for mental, emotional, and behaviour problems has grown considerably over the past decade (Weissberg, Kumpfer and Seligman 2003; Hoagwood et al., 2007; Stormont, Reinke and Herman 2010).

There is a critical need for child mental health professionals to move beyond the development and testing of clinic based treatments and engage more actively with creating and researching interventions relevant to the contextual needs of a dynamic education system. The disconnect between efficacious practices (practices that have been determined to be effective in research trials), and effective practices (practices that are adopted and used in the desired contexts), needs to be addressed (Walker, 2004; Schaughency and Ervin 2006). Capella (2011) rightly highlights that interventions are most promising when they fit their implementation context and are delivered well with existing resources. Within schools, teachers through the use of evidence-based practices can significantly influence mental health outcomes in children by implementing universal interventions for school based mental health and by creating referral pathways for selective or indicated interventions (Greenberg et al. 1999).

Kapur (1997) in describing teacher training programmes conducted by the National Institute of Mental Health and Neurosciences, Bangalore, since 1975 in the early detection and management of mental health problems amongst children, contends that while such programmes offer a wide range of feasible strategies to deal with mental health and educational problems of children in the urban community, the experience in the field has ‘not always been easy or encouraging’.
The difficulties in implementing an effective programme in schools are attributed to denial of problems, low teacher interest, inflexibility about timings and perceptions by teachers about increased work load. Adelman and Taylor (1999) wryly remark that ‘Schools are not in the mental health business. Their mandate is to educate.’ Hence most schools view with apprehension any activity not directly related to instruction as taking resources away from their core objective of teaching. Mental health interventions will not be successful if they are perceived as being extraneous to academics or as additional burdens to the system. The successful implementation of school based mental health programmes and their sustainability depends on factoring school specific contextual factors at multiple design and implementation levels (Ringeisen 2003). Often these contextual factors are ignored as mental health professionals deliver programmes in a top down manner not taking into consideration perspectives of school professionals.

Fantuzzo and Atkins (1992) reflect that teachers may appear resistant or uncooperative to a mental health programme when in reality such responses might be a reaction to interventions that are perceived as far removed from their traditional educational practices or too complex given their current levels of training. Effective mental health interventions in schools will require mental health professionals to enter into collaborative relationships with teachers, instead of viewing themselves as experts dispensing advice, they would need to take into account teachers’ knowledge, strengths and perspectives (Stratton, Reinke, Herman and Newcomer 2011), the multiple systems of individual, school and state or governance factors that they shape and are shaped by. This would be critical in closing the gap between mental health research and school mental health practice. Intervention in schools is shaped not just by content and its delivery but its implementation in care contexts.

However, few studies have assessed teachers’ perspectives of mental health needs in schools or their preparedness. Teachers according to Singhal (2005) are the main agents of change, yet they are marginalized in processes that involve change. The need to understand teacher perspectives in relation to children whose range of classroom difficulties challenge teachers skills and time, takes on a critical yet often ignored dimension (Fantuzzo and Atkins 1992).
1.6 Teacher Perspectives

Attention to the beliefs of teachers and teacher candidates can inform educational practice in ways that prevailing research agendas have not and cannot. Pajares (1992)

The beliefs an individual subscribes to lie at the core of decision making processes and behaviours. Beliefs teachers hold affect their perceptions and judgments, which, in turn, influence their behaviour in the classroom. Prior to 1975, the dominant research paradigm in the area of teacher research and effectiveness was the process-product approach which dealt with considering patterns that were essentially co-relational in nature between teachers’ classroom behaviour, students’ classroom behaviour and student achievement. A paradigmatic approach to research on teaching emerged when research began to include tacit or implicit frameworks and perspectives that defined teacher thinking and action in the classroom (Buchmann 1984; Munby 1982, 1984; Tabachnick and Zeichner 1984; Ashton and Webb 1986; Clark and Peterson 1986; Dinham and Stritter 1986; Feiman-Nemser and Floden 1986; Fenstermacher 1979, 1986; Nespor 1987; Goodman 1988; Ashton 1990; Brookhart and Freeman, 1992; Pajares 1992). Clark and Peterson’s (1984) model of teacher thought and action is offered as a heuristic device (Figure 1.2) of understanding how teacher thought processes are linked with teacher behaviours. Figure 1.2: Model of teacher thought and action, Clark and Peterson (1984).

Figure 1.2: A model of teacher thought and action
The model describes three major categories of teachers’ thought processes: a. Teacher planning- pre active and post active thoughts (before and after classroom interactions) b. Teachers’ interactive thoughts and decisions and c. Teachers’ theories and beliefs. These refer to the planning processes that teachers engage in, their theories and beliefs that affect their planning and decisions. The action component of the model occurs in the class. Teachers’ and students respond and interact in ways that suggest reciprocal directionality. Causation is depicted as circular or cyclical in both the domains and is nested in a frame of constraints and opportunities- explained as the degree of responsibility and participation that teachers are given or perceived to have in decision making processes.

The concept of teacher frames (Minsky 1975; Schon 1983; Wyer and Srull 1984) can be used to consider the ways in which teachers perceive and execute their professional tasks. According to Barnes (1993) the term frame is used to refer to the ‘clustered set of standard expectations through which all adults organize, not only their knowledge of the world but their behaviour in it’. Extant literature in the area refers to teacher frames and belief constructs using a variety of terms- knowledge, dispositions, values, judgments, perceptions, conceptions, internal mental processes, personal theories, ideology, perspectives etc. The term teacher perspective has been used in the present study as it offered a comprehensive understanding of the construct.

Kaufman- (2006) in their study on teachers’ beliefs identified seven elements that constituted their definition of beliefs. Teachers’ beliefs:

(a) Are based on judgment, evaluation, and values and do not require evidence to back them up,

(b) Guide their thinking, meaning-making, decision-making, and behaviour in the classroom,

(c) May be unconscious such that the holder of beliefs is unaware of the ways in which they inform behaviour,

(d) Cross between their personal and professional lives, reflecting both personal and cultural sources of knowledge,

(e) Become more personalized and richer as classroom experience grows,

(f) May impede efforts to change classroom practice, and

(g) Are value laden and can guide thinking and action (Nespor 1987; Kagan 1992; Pajares 1992; Evans 1996; Richardson 1996; Romanowski 1998; Borg 2001; Lortie 2002).
Tabachnick and Zeichner (1984) in their research with teachers chose to use the term teacher perspectives, a term earlier used by Janesick (1977) and defined as ‘a reflective, socially defined interpretation of experience that serves as a basis for subsequent action ... a combination of beliefs, intentions, interpretations, and behaviour that interact continually’ (Clark and Peterson 1986). They considered the construct of beliefs and teaching ideology to be nothing more than opinions, abstract and lacking in action and preferred the more situation-specific and action-oriented perspective. Perspectives, they postulated, include both the beliefs teachers have about their work (goals, purposes, conceptions of children, curriculum) and ‘the ways in which they [give] meaning to these beliefs by their behaviour in the classroom’ (Tabachnick and Zeichner 1984).

Goodman (1988) in understanding the term teacher perspectives opined that it was not so much the orientation to action but the interpretation of the belief that guides behaviour. Beliefs according to Rokeach (1968) have to be inferred and this would need to take into account the ways that individuals give evidence of belief: belief statements, intentionality to behave in a predisposed manner, and behaviour related to the belief in question.

Clark and Peterson (1986) drew attention to the psychological context of the theories, beliefs and values with which a teacher works. Based on their findings in a case study, Clandinin and Connelly (1986) suggested that teachers acquire practical knowledge through an interaction between their own personal narratives and particular situations.

Knowles (1992) offered a Biographical Transformation Model (Figure 1.3) which suggests that early childhood experiences, early teacher role models and previous teaching experiences are most important in the formation of an image of self as teacher. These experiences in turn are dynamically linked with teacher behaviours. Elbaz (1981) notes that teachers use intuition to fit themselves into their image of good teaching. The impact of teacher thinking research on teacher training models suggests that the formal, linear theories of learning and education presented in teacher-education programs are interpreted and executed through the lens of teachers’ personal constructs (Schoonmaker and Ryan 1996).
According to the Knowles Model, an individual’s formative experiences of school and family are interpreted and analysed through the lenses of other prior experiences and reference points, particularly the values that each person comes to accept. These formative experiences have both immediate inherent and reflective assigned meanings. The particular interpretation assigned to an experience is transformed into a schema. The schema acts as a cognitive filter in understanding or resolving present and future contexts and providing a basis for future teacher centered classroom practices. Schemas determine the manner in which future encounters with teachers or learning environments are interpreted and acted upon and are transformed into a frame work for action. An individual’s personal goals and teaching practice behaviours are embedded in this framework for action.
Recognizing the importance of accommodating teacher biographies in shaping future teaching behaviours of students in training, Gupta (2006) observes that ignoring its role will create teachers who ‘teach in the manner in which they were taught and who will be limited in the ways in which they can professionally develop.’ Olson’s (1981) research substantiates this by demonstrating that teachers tend to modify curriculum in ways that are more compatible with their implicit beliefs creating tensions between teachers’ implicit beliefs and curriculum developers’ beliefs. Teachers’ thinking as Richardson (1994) notes is defined by context and experience, yet this is seldom recognized in teacher training programmes.

While teacher practices are a product of a complex set of personal experiences and modifications of prior experiences, they are moulded and embedded in cultural contexts. Through socialization processes and lived experiences a teacher comes to receive, use and sustain culturally defined models of pedagogy. Clarke's (1995) review of teacher thinking literature identifies variation between teachers located in different parts of the world. She observed that cultural differences in pedagogy accounted for variations that exist in the way teachers formulate goals, relate to their students, and negotiate curriculum delivery and understanding in the classroom. Clarke (1995) draws attention to the paucity in teacher thinking research which rarely includes detailed analyses of the impact of culture constructs on teachers' thought and action and the implications of this for reform in instruction.

Teacher thinking research is primarily located in the Anglo-European world and seldom deals with teachers from different cultures, especially developing countries, and the culture specific constructs that underlie their teaching practice. Based on her anthropological and psychological research, Clark (2001) identified, four cultural constructs representing the broader meaning system that underlie pedagogical practices in Indian classrooms. The first construct is a shared holistic worldview that supports the acceptance of regulation (Shweder 1991; Marriott 1990). Individuals are linked together in interdependent systems and are driven by social relationships. There is hence a sense of feeling at ‘ease in regulating and being regulated’ (Shweder 1991). The second construct is the conception of instruction as duty. Shweder (1991) elaborates that among duty based cultures there is an ‘objective obligation… an imperative that tells us what we must do or must not do regardless of what we feel like doing.’

In the Indian context according to Clark (2001) this is interpreted in the context of Karma, which is a moral order. The third cultural construct is a social framework that is defined by structural and qualitative hierarchy (Roland 1988). This applies to the role of teacher authority in the classroom, the ways in which classrooms are organized and the nature of teacher student relationships. The teacher is viewed as being responsible, nurturing and more knowledgeable than the student and is accorded respect and unquestioning acceptance. Clark’s fourth cultural construct is knowledge as collectively accumulated,
attested and transferred (Kakar 1978; Kurtz 1992 and Derne 1995). Choices made by the community are seen as being more influential in determining an individual's decisions and choices and less significance is attached to autonomic or individual processes of knowledge construction.

In addition to locating teachers' pedagogical beliefs in cultural contexts, of specific interest to this study are perceptions teachers hold about children. Tomkins (1987) refers to two orthogonal dimensions - normative and humanism to describe personal ideologies an individual maintains toward belief and value-based components. Normative socialization is oriented toward teaching and directing the child along predetermined pathways. Conforming to external standards is considered more important than deriving pleasure from individual feelings (Stone and Schaffner 1988). In contrast, the humanistic orientation regards the child’s feelings and desires as central. The child’s feelings and sensitivities are acknowledged as important to further growth (Stone and Schaffner 1988). Hargreaves (1977) identifies three models to account for the process of how teachers type children:


He argued that teachers have an image of the ideal student against which students are matched as either good or bad. Good pupils therefore conform closely to the ideal in displaying ability and successful learning, in conforming to classroom rules and regulations. The characteristics model refers to students and teachers typifying one another in terms of sets of characteristics. Drawing from Kelly’s Personal Repertory Grid, this model reveals that primary teachers value academic achievement in students as a dominant construct (Nash 1973; Taylor 1976). The dynamic interactionist model takes into account changes in perception and typification over time and endeavours to reflect situational or contextual variations. Hargreaves used this model in studying ‘Deviant students’ and found that teachers through analytical phases come to develop a highly complex and stable typification for a student, which then becomes resistant to change.

With specific reference to how children, childhood and teachers are viewed in an Indian context, Joshi (2009) reflects that children are viewed as a gift from God and any illness or disability is interpreted as a result of bad karma or ill wishes of people outside the family (Kakar 1978; Anandalakshmy 1998). Children below age three enjoy considerable freedom, are believed to be innocent, and they are nurtured rather than treated with strict discipline (Kakar 1978; Kaur 1997). Shame, punishment and learning from the consequences of their inappropriate behaviour are considered to be effective disciplinary methods. Children tend not to be given lavish praise and rewards as these are seen as unhealthy, resulting in spoiling of children (Anandalakshmy 1998).
Indian society, considers education to be the primary tool to advance one’s socio-economic status (Desai 1972) therefore, education is taken very seriously right from the early years of the child. Early training in the ‘3Rs’ (reading, writing and arithmetic) is considered imperative and necessary (Anandalakshmy 1998) and the emphasis is on engaging in formal scholastic rather than play based learning experiences. Gupta (2003), in her study of teachers found that the role of a teacher in India is culturally preserved. She opines that the role of a teacher is contextualized in ‘culture-bound parameters’ and is resistant to change. These parameters are rooted in the philosophical and cultural understandings and images of who a teacher is, as opposed to more modern Western and technical notions of teachers as reflective practitioners and action researchers.

The image of teacher is equated to the image of mother hence she is given the social authority to discipline and nurture her students. Reprimanding is perceived as a way of helping a child to be and do his best, not as a way of punishing. The teacher respondents in Gupta’s study stated that apart from educating children they shared responsibility with parents in moulding children’s character, correcting their behaviours and imparting values. Given the ‘incomplete and sometimes incomprehensible picture’ we have of teaching and learning in India (Clarke 2001), it is crucial to initiate efforts in this area through initially exploring teacher perspectives.

1.7 Teaching- Historical Context

The development of education and the concept of the teacher in India can be understood by tracing its origins in the history of this ancient land. The term for education Vidya comes from the root Vid, meaning to know. Knowledge was considered sacred and powerful; it promoted material and more importantly spiritual welfare. It provided mukti or emancipation, freedom from the shackles of illusion and ignorance. According to Bourai(1993), the root Vid provides at least 5 distinct meanings indicating knowledge, reality, attainment, discrimination and sublime emotion. The initiation into formal education began in childhood and marked a significant milestone in a child’s life. In modern day Kerala, a state recognized for the highest literacy rates in the country, regardless of parent religious denomination, the ancient ceremony of Vidyaarambham or formal initiation into learning in early childhood which consists of tracing initial letters in a plate of rice is still conducted with reverence, a testament to the importance that is ascribed to education by the community.
A recorded history of formal and informal education in India dates back to between 3,000 and 4,000 years. Rooted in religion, education in ancient India was based directly on Vedic philosophical verses and scriptures compiled in an archaic form of Sanskrit as early as 2000B.C. (Gupta 2003). The Guru or teacher was regarded as endowed with powers to disperse darkness caused by the lack of awareness. The importance ascribed to the Guru is perhaps best summed up in a couplet by Kabir the renowned philosopher-poet:

_Guru and God both appear before me_  
_To whom should I prostrate?_  
_I bow before Guru who introduced God to me_  

_**Kabir- Selected Couplets from the Sakhi in Transversion (2001)**_

Revered more than a parent, the Guru became the most influential adult in the life of a child and in the community of the Gurukula. Situated in forests, away from the ebb and flow of city life, gurukulas, equipped with only the bare necessities were centers of learning and student community life. Student life was marked by rigour and routine and in addition to their daily lessons, students were required to tend to the gurukula and perform daily domestic chores. Qualities sought after in a student were sincerity, humility, curiosity and self control (Altekar 1965). There was a high stress on maintaining celibacy and practicing self denial. The student was to hold the teacher in deep reverence and demonstrate unquestioning obedience. The story of Ekalavya in the Mahabharatha who is said to have severed his thumb on Guru Dronacharya’s command provides a glimpse into the absoluteness of the guru’s command.

Vedic knowledge was imparted in the gurukula, this was believed to be revealed- hence valued and respected. Instruction relied on the oral tradition, repetition and consigning large pieces of text to memory was required. Debates, use of fables, dialogic methods were also used. Students would also be asked to observe new facts and compare them with established ones but the basic methods of learning were those of Shrvana-to listen, Manana-to reflect and Nidhi- dhyasna-meditation (Bourai 1993).
During the Vedic period and shortly after, teachers came to be differentiated in a hierarchical manner on the basis of their knowledge and consequently their roles. Bourai (1993) identifies four kinds of teachers: Guru—considered to be wise and powerful, great in learning and moral conduct; he had the authority to deliver instructions in the Vedas. The Acharya initiated a pupil and could teach him certain parts of the Vedas. Gurus and Acharyas were considered to be teachers who were advanced in their fields of knowledge and also wrote scholarly manuscripts and texts. The Upadhyya taught only a very limited portion of the Vedas in consideration of fees and the Adhyapka was a regular paid teacher who delivered a functional curriculum.

Teachers presented an ideal of great learning, discipline, spirituality simplicity and humility and were honoured more particularly because of this (Bourai 1993). The relationship between teacher and pupils was regarded as filial in character. The teacher was the student’s parent in all matters of instruction. Teachers did not receive fixed monies but depended on their priest duties and the patronage of the communities in which they existed to sustain their living. At the end of the formal period of study a student would make an offering in gratitude to his teacher.

The general aims of education in ancient India according to Altekar (1965) were an infusion of a spirit of piety, character formation, personality development, inculcation of civic and social duties, promotion of social efficiency and preservation of the national culture. The Buddhist system that followed the Brahmanic created formal monasteries and universities where the role of the teacher grew to be more defined and the number of students who could avail of education increased. It sought to bring in a spirit of inclusiveness by offering education to students irrespective of caste and delivered instruction in the medium of Pali—the common language of the day. The relationship between teacher and student however continued to reflect brahmanical traditions of reverence and respect (Thomas 1970).

The Muslim invasions during the 11\textsuperscript{th} century impacted on the patronage schools were receiving and a general decline was observed. The new rulers established Madrasas and Maktabs which were schools of learning attached to mosques. Ustads, or teachers who had achieved high levels of mastery with their specific subject areas were honoured. The learned teacher would not take payment; it was an obligation on the part of the community to support him (Chakrabarti 1958). Education initiatives became increasingly centralized around this period. Reports of education in Medieval India indicate evidence of indigenous education being provided by local village schools or pathshalas. The origins of this date back to the 12\textsuperscript{th} century and were established by local communities, either wealthy individuals or through subscription from community members to provide practical instruction to students.
Teachers continued to relate to their students authoritatively and students related to their teacher with reverence. The teacher’s freedom to punish children physically was understood as an aspect of his authority (Kumar 1991). A 16th century description of such a school provides insights into the nature of the highly ritualized relationships that characterized teacher-student interactions: ‘When the Guru or teacher enters the school, he is always received with the utmost reverence and respect. His pupils must throw themselves down at full length before him; place their right hand on their mouth and not venture to speak a single word until he gives them express permission. Those who talk and prate contrary to the prohibition of their master are expelled from the school.’ (Fra Paolino-1796, quoted in Clarke, 2001).

The subsequent Portuguese, French and Dutch invasions and the powerful growth of the East India Company ushered in western education models. Early Christian missionaries were at the helm of providing education and health services. The focus from this point shifted to the institution rather than the individual teacher (Thomas 1970). Textbooks which dealt with secular subjects such as math and geography began to be introduced in printed format. This according to Kumar (2004) marked a huge shift in authority being vested in the teacher. Knowledge was now located in a printed text and not in the person of the teacher. It symbolized, he reflects, the teacher’s ‘subservient status’ in the changing educational culture. The juggernaut of centralized initiatives further ‘eroded the teacher’s autonomy by denying him any initiative in matters pertaining to the curriculum’ (Kumar 2004).

By the mid 17th century, the British became the main providers of education and in 1854, Wood’s Despatch signalled the beginning of formal teacher training measures. Referred to as the Magna Carter of Indian education, it established the foundation of the present system of education in India (Thomas 1970). It visualized a more logical and systematic extension of the monitorial system and recommended payment of stipends to pupil teachers who after completion of their training were to be given certificates and employed as school masters on a salary basis (Garg 1991). By the close of the 19th century some essential features in teacher training had been established, pedagogical courses had replaced general education and examination and certification had been introduced with an emphasis on practical aspects in teaching.

The Hartog Committee (1929) paid special attention to primary school teachers training. It suggested curricular reforms and measures to raise standard of training of primary teachers by making it of a longer duration, frequent refresher courses and conferences, adequate staffing of the training institutions and improving the service conditions of the primary teachers. The period up to 1947 was considered as a period of institutionalization in the area of teacher education. It saw the setting up of departments of education in some universities and the building up of infrastructure in teacher training institutions.
1.8 Systemic Factors

The historical context has served to define the changing role ascribed to the teacher in India. The teacher operates within a school setting that can be best described as multidimensional in terms of factors acting upon it and the responses it generates. Schools and teachers consequently engage with these multidimensional factors in ways that do not conform to logical and linear organizational analysis (Lortie 2002). Through complex transactions with systemic factors such as policy initiatives for teachers, pre-service and in-service education models, ownership of schools and the curriculum, schools come to develop their distinctive cultures. The diagram in Figure 1.4 indicates the areas of focus in discussing systemic factors related to schools that impact on teachers. The bi-directional arrows indicate that teacher thought and practice is shaped by and in turn shapes these systems.

![Diagram of Systemic Factors](image-url)
Policy Initiatives in Teacher Education

After independence, India’s education policy has been largely based on the structure provided in 1944 by Sir John Sergeant, educational advisor to the British government. In 1949 the University Education Commission responding to Nehru’s vision of a national system of education, recognized the need for quality teacher education. However it was the Kothari Commission Report (1964-1966) that succeeded in making recommendations that have remained the basic framework on which important decisions on teacher education were taken by successive governments (Rao 2010). The report famously declared that ‘the destiny of the nation is being shaped in our classrooms’ and recommended programmes of education for teachers that would ensure a qualitative improvement in the professional, academic and social aspects of teaching.

The Chattopadhyay Committee (1983-1985) laid stress on making in-service teacher education more effective. It recommended that needs of teachers be identified at institutional and other levels and training programmes be customized to meet those requirements. It envisioned new roles for the teacher in being able to communicate to students the ‘importance of and the feeling for national integrity and unity, the need for a scientific attitude, a commitment to excellence in standards of work and action and a concern for society.’ Kumar (2008) rues that the findings of this committee ‘has been erased from policy memory- perhaps because its stress on treating school teaching as a professional responsibility finds no resonance in our policy and social ethos.’

The Acharya Ramamurty Committee (1990) felt there was need to revamp existing teacher education programmes. It strongly recommended the need for an internship teaching period spread over a long duration to strengthen the development of required teaching skills. The Yashpal Committee Report (1993) titled Learning without Burden noted that teacher preparation programmes should be restructured to ensure its relevance to the changing needs of school education. The emphasis in these programmes should be on ‘enabling the trainees to acquire the ability of self-learning and independent thinking’.

Sarva Shiksha Abhiyan (2001), was launched as the flagship elementary education programme of the government of India, its major aim was to achieve the goal of UEE. Among its core goals was the provision of education of satisfactory quality for all by 2010. To realize the objectives of the SSA, 104 programmes were designed to address issues ranging from in service training to providing inclusive education for children with special needs. The National Curriculum Framework (2005)-attempted to frame its recommendations using a constructivist approach to learning. It described the teacher as being a ‘facilitator who encourages learners to reflect, analyse and interpret in the process of knowledge construction.’
It emphasised the primacy of the active learner and stated that knowledge had to be connected to life outside school and that the curriculum could be enriched by making it less textbook centered. The Focus Group report on Teacher Education for Curriculum Renewal- NCERT (2005) stressed on the need for creating reflective teacher practitioners who could in turn revitalize school education. The National Policy on Education-1986 and the Programme of Action (1992) envisaged a National Council for Teacher Education with statutory status. This came into existence in 1995 with its major objectives being to achieve planned and coordinated development of teacher education and the regulation and proper maintenance of norms and standards. But as Rao (2010) observes it appears to have confined itself to a licensing role and has hence been unable to fulfill the objectives for which it was created.

Common to these reports were their recommendations of the urgent need for overhauling teacher training programmes, increasing the rigour in training programmes, making teaching relevant to the needs of the community, the need to embrace the use of technology and to contextualize learning in the classroom moving it away from traditional text book centered learning. While the various education policy initiatives reflect the changes occurring in a rapidly changing technological, social and economic scenario, the effect of these initiatives has yet to percolate to any serious change level in teacher training programmes. There appears to be a significant disconnect between well articulated, urbane, prescriptive education policy and actual classroom practice as we understand it today.

The policies do not appear to engage in factoring the cultural contexts and the lived personal histories of teaching experiences in India which are critical to teacher thinking landscapes. These create frameworks that direct how policy will be interpreted in classroom contexts. The government’s need to universalize elementary education, the thrust on inclusive education and the complex roles it expects teachers to play in classrooms does create demands in terms of their academic preparation at pre- service and in-service levels.

**Teacher Education**

Teacher training in India according to Kochhar (1989) ‘suffers from arrested development.’ He adds that most teacher training institutions with a few exceptions are much the same today as they were in 1949. Current understanding in the area of education research recognizes that efforts to improve the quality of schooling do not exist separately of efforts to improve the quality of teachers and the training they receive. Teachers find themselves today dealing with complex changes in the classroom orchestrated by changes in the larger social and ecological systems of which they are an intrinsic part.
Access to non-formal education sources such as technology and mass media, a consumerist oriented middle class and competitive aspirations of parents for their children, are placing fresh challenges in the classroom. The training that teachers receive at pre-service and in-service levels are not adequate to help them meet these challenges effectively (Govinda 2002).

Pre- Service Training

Rao (2010) observes that problems in the area of pre-service teacher education have been in existence since the beginning of formal teacher education and lists out five specific problems:

a. Mushrooiming growth of sub-standard institutions
b. Malpractices and irregularities in many private institutions
c. Serious mismatch of demand and supply of trained teachers in some states
d. Large backlogs of untrained /unqualified serving teachers in most states
e. Existence of a large number of trained unemployed teachers in several states

The table 1.1 lists the total number of types of schools and the number of untrained teachers at the Primary- (5.22 lakh) and Upper primary levels- (2.60 lakh).

<table>
<thead>
<tr>
<th>Stage</th>
<th>Types of Schools</th>
<th>Total</th>
<th>No: untrained</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Govt.</td>
<td>Local body</td>
<td>Pvt. aided</td>
</tr>
<tr>
<td>Primary</td>
<td>8.65</td>
<td>5.63</td>
<td>1.18</td>
</tr>
<tr>
<td>Upper Primary</td>
<td>5.94</td>
<td>3.63</td>
<td>1.52</td>
</tr>
</tbody>
</table>

Source: 7th All India School Education Survey (NCERT). All figures in lakhs

The figures reflect the logistical difficulties facing teacher training, the other equally significant issue is the quality of teaching of teachers who have received the standard teacher education programme. The B.Ed. or Bachelor’s in Education is the standard training for secondary school teachers. Offered by a few government institutions and a number of private colleges, it is a university based, post graduate degree of one year duration. These programmes are regulated by norms prescribed by the National Council for Teacher Education. Kumar (2008) opines that the B.Ed. in India represents a ‘mechanistic model’ of
teacher training. There is a perception that it has a nominal role in providing a degree that allows for job eligibility but that it carries a severely limited actual value in terms of skills learned. The B.Ed. is meant for preparing teachers for secondary stage of education, however most private schools also prefer teachers with B.Ed. for primary classes, implying that the same programme is considered equally relevant and useful for different stages of school education (Arora and Panda 2000).

During the 19th century when primary teaching preparation programme was started, the entry qualification was just ‘primary pass’, subsequently it was raised to matriculation level. Currently for primary schools in Karnataka (site of present study) the Teacher Higher Certificate- TCH diploma programme (after 10+2) is offered by private institutions, Teacher Training Institutes, private as well as government, and District Institutes of Education and Training (DIETs). The syllabus for the TCH programme is uniform throughout the State and is monitored by the Directorate of School Education, Research and Training (DSERT) (Govinda 2002).

There is the unwritten and completely unsubstantiated assumption that elementary school teachers have to transact a curriculum which is simpler because it deals with younger children, hence require a suitably watered down training programme. Delhi University has introduced the B.Ed. Elementary four year integrated programme. It hopes to professionalise the training that teachers receive in primary school, combating the weaknesses of the traditional one year programme with the possibility of now combining the study of content and methodology.

Additional concerns that have been raised concerning pre-service training are that Teacher training Institutes appear to be isolated from Universities of higher learning and from the school system itself. The training methods are dominated by theory and have remained stagnant. The faculty in these colleges that offer elementary education have typically completed their B.Ed. and M.Ed. courses pertaining to secondary education with no experience of having taught in elementary schools.

In Service Training

In 1948 the University Education Commission observed that ‘We must realize that experience needs to be supplemented by experiment, before reaching its fullness and that a teacher to keep alive and fresh should become a learner from time to time.’ The various education commissions since have stressed the need for in service training. There has however been no systematic identification of teacher’s needs and
consequently the content and quality of programmes offered was poor. State Institutes of Education were set up in different states and Union territories to improve the quality of education; these are mostly not autonomous and are yet to make a substantial difference in the areas of training and curriculum development. For primary education, the District Institutes of Education and Training (DIETs) are expected to carry out regular in-service training programmes. In the District Primary Education Programme districts, curricular and pedagogic ideas and changes are communicated to teachers in the form of various training modules, via the structure of Block Resource Centers and Cluster Resource Centers.

While there are some states that offer evidence of conducting in-service education programmes for teachers in government schools through these initiatives and institutions, in many states this is not a priority at all. In-service training in private schools is entirely dependent on the management and philosophy of the school. Since this is not mandated it does pose a challenge in terms of tracking schools for accountability. The Eleventh Plan envisages a national system of teacher education which will bring the various programmes in the context of school education under one umbrella. It focuses on upgrading content and pedagogical knowledge of teachers, strengthening in-service training programmes, providing incentives for effective teachers, raising pay scales and setting standards for teacher performance.

**Role of Private Sector**

The sample schools chosen for the study were private schools. Hence a brief perusal about the role of these schools is in order here. Private schools in India may be established under articles 19, 28(1), 28(2) and 30 of the constitution. A pluralistic framework of education and a variety of delivery mechanisms within this have been in place for a long time (National Institute of Educational Planning and Administration, NIEPA 2000). Increased parental demand for education on the one hand and declining quality of government schools on the other appears to have fuelled the need for private schools. There is however a paucity of research on the private sector in school education as a whole and the issues it grapples with. India has nearly 2.44 lakh private elementary schools constituting 20 percent of all elementary schools in the country. Private schools can be Aided- these schools are funded by government but management is private. They can also be Unaided- these schools depend on fees and donations for their functioning.

The Post independence era has seen tremendous growth in the number of private, aided, unaided and unrecognized schools. Private schools have shown an annual growth of 25 percent while government
schools have recorded only 7 percent during the past decade. According to Assessment Survey Evaluation Research (ASER) reports, the number of children in the 6-14 age group attending private schools increased from 16.4 percent in 2005 to 22.4 percent in 2008. The increase was particularly striking in the states of Karnataka, Uttar Pradesh and Rajasthan (Rao 2010).

The recruitment of teachers is done locally with some schools adhering to government recruitment policies and requirements for teacher training. Teachers’ salaries constitute the single largest expenditure incurred by the managements- around 95 percent. Consequently smaller unaided schools are paid far less than government teachers. For parents who are increasingly opting for their children’s admission into private schools, it offers the promise of a better quality of education. Often however in the absence of regular controls, private schools operate out of dingy premises, are overcrowded and have teachers who are not adequately trained.

**School Curriculum**

The curriculum in Indian early childhood schools may be another factor influential to classroom pedagogy. The word curriculum from its early Latin origin means literally to run a course. Oliva (1997) has analysed curriculum as:

*That which is taught in schools*

*A set of subjects*

*Content*

*A programme of studies*

*A set of materials*

*A sequence of courses*

*A set of performance objectives*

*Is everything that goes on within the school, including extra-class activities, guidance,*

*and interpersonal relationships*

*Everything that is planned by school personnel*

*A series of experiences undergone by learners in a school*

*That which an individual learner experiences as a result of schooling*

While the term curriculum is commonly interpreted to mean the text book, as is evident it refers to matters beyond bound textual information.
As described earlier, in the context of the Indian culture, early educational experiences are viewed as laying a foundation for future education, and therefore, training in the ‘3Rs’ is considered valuable (Anandlaksmy 1998). The underlying implication suggests that classroom activities are more structured and children are limited in the choices they make and the opportunities they have for decision-making. In discussing the class dynamics that she found in her study of early childhood classrooms in India, Gupta (2004) observed that the teachers by designing creative and interesting activities negotiated the intensive academic curriculum which lead to high degrees of cognitive stimulation and energy for the children. Teachers and parents in her study seemed to be in agreement about the expectations they had from the children leading to consistency in teaching of the content and high academic standards expected for the children (Gupta 2004).

Curriculum delivery in India is text book driven and as Joshi, Rogers and Akerson (2011) point out, the system has a strong focus on assessment due to a rigid examination system. Government organizations such as the National Council for Educational Research and Training (NCERT) promote a national curriculum that translates into a prescribed syllabus and a set of corresponding textbooks for each grade level nationwide. The table 1.2 indicates the primary school curriculum framework that will be followed in a majority of Indian classrooms as provided by the NCERT for language and math:

**Table 1.2**

Primary School Curriculum- Language and Math

<table>
<thead>
<tr>
<th>Std</th>
<th>Language</th>
<th>Mathematics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Std 1&amp;2</td>
<td>Basic skills of listening, speaking, reading</td>
<td>Form basic pre-number concepts related to size, length, mass etc.</td>
</tr>
<tr>
<td></td>
<td>Writing and thinking</td>
<td>Sharpen skills in grouping, classification and sequential thinking</td>
</tr>
<tr>
<td></td>
<td>Standardization of pronunciation</td>
<td>Sound foundation for learning numbers and developing competency of addition and subtraction</td>
</tr>
<tr>
<td></td>
<td>Good handwriting, correct spelling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Silent reading with comprehension</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Creative self expression</td>
<td></td>
</tr>
<tr>
<td>Std 3-5</td>
<td>More aural and oral skills of language are to be emphasized at the primary stage</td>
<td>Introduced to numbers and fractions as a concept. Four fundamental operations-addition, subtraction, multiplication, division and computational skills related to them need to be mastered on numbers and fractions. The concepts of length, mass, capacity, money, time, area and volume to be developed along with the units</td>
</tr>
<tr>
<td></td>
<td>All the skills i.e. listening, speaking, reading and writing and thinking are to be aimed at in a balanced manner by the end of the upper primary stage</td>
<td></td>
</tr>
</tbody>
</table>
Slightly more attention is to be paid to the skills of reading and writing at the secondary stage. The most crucial and ultimate task of language education at all these levels remains to prepare the learners to use the languages effectively in either mode (spoken/written) whenever and wherever required in their day to day life situations of all sorts.

Gain familiarity with geometrical forms and figures and be able to appreciate patterns and symmetry in the environment. Simple applications of arithmetical processes should find an important place.

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Source: NCERT Curriculum Framework, 2005

Since education in India is covered under both state and central governments, students can opt to complete basic schooling up to grade 12 by appearing for examinations offered either by the central government or the state government. Often to bypass the rigidity of rules prescribed by the states, several private schools opt to get affiliated to the national boards. Schools that seek affiliation have to conform to the rules and regulations set forth by the body that gives the affiliation. There are 33 different educational boards in the country, including the two major national level boards - Central Board of Secondary Education (CBSE), Council for the Indian School Certificate Examinations (CISCE) and the various State Boards.

Central Board of Secondary Education is an eminent board of school education in India. CBSE requires its affiliated schools to follow syllabi of NCERT for the students from Lower Kindergarten (L.K.G.) to Class VIII. It conducts two board examinations: the All India Secondary School Examination for Class X and the All India Senior School Certificate Examination for Class XII, which is a school-leaving examination. There are many private schools across India and other countries which have CBSE affiliation. The medium for education prescribed by CBSE is either English or Hindi. Recently the Board has been involved in addressing reforms in examinations based on student centered paradigms of learning.

The Council for the Indian School Certificate Examinations (CISCE) was established in 1956 in India as a private and non-governmental body of school education in order to act as the governing body of Indian Council to administer the education syllabus, adhering to the education standard of the University of Cambridge in India. It conducts two types of examinations, namely the Indian Certificate of Secondary Education (ICSE)-Grade 10 examination and the Indian School Certificate (ISC)-Grade 12 examination. The Boards that these schools are affiliated to, determine the curriculum and consequently the information that is transacted daily by teachers in their classrooms.
The nature of assessments, their frequency and in-service training that teachers receive are shaped largely by the curriculum they subscribe to.

In the preceding pages there has been an attempt to understand the constellation of factors that teachers’ perspectives are nested in. While certainly not complete or exhaustive in its coverage, these have included historical contexts, policy initiatives, teacher education, types of school and curriculum linked factors. Inagaki (1993) reflects that even though the fundamental foundations of education remain the same, there is a shifting trend in the roles and responsibilities of teachers and their changing social conditions. Teachers are being urged to move beyond teaching to the text to incorporating pastoral concerns such as engaging more actively with issues of children’s positive mental health, fostering a sense of resilience and being able to demonstrate sensitivity in negotiating interactions with the curriculum and children.

However teachers report not having adequate information or skills in effectively managing the kind of behavioural difficulties they are increasingly called upon to deal with in classrooms. Collaborating with teachers, designing and implementing effective class room intervention programmes for a range of challenging behavioural conditions such as ADHD, involves change and as Ahuja (2002) aptly describes it, ‘change for teachers does not always happen in the ways ‘experts’ describe it because the realities of teaching are different from idealized versions.’ Kumar (2008) reminds us that the change that needs to happen in the Indian education system can only begin when ‘we look at teaching from the teacher’s viewpoint, standing with her in a real average school.’

1.9 Present Study

The present study aims to understand perspectives of teachers in elementary school towards ADHD type behaviours exhibited in the classroom. Teachers in elementary school are the first adults to see children in formal group settings that have very different expectations from their play schools and homes. They are well placed to identify developmentally inappropriate behaviours in the classroom context and can hence initiate early intervention pathways. The need for early intervention can be ascertained from Kapur’s (1995) description of ADHD as ‘one of the most annoying problems faced by parents, teachers and clinicians’. The term ‘annoying’ perhaps does not adequately convey the negative parent and teacher interactions that a child with ADHD is exposed to on a daily basis. It also assumes that the difficulties are located solely in the child. ADHD type behaviours do place demands on a teacher’s energy and instructional time. Often children displaying these behaviours are seen as being obstinate, difficult and
challenge the teacher’s perceptions of classroom control and discipline. These early negative perceptions tend to persist into adolescence and adulthood.

Anecdotal incidents of children displaying ADHD behaviours being beaten and/or ridiculed by teachers are fairly common. Research on ADHD in India is in its nascent stage and initial epidemiological studies indicate that prevalence rates for ADHD vary from 5-10 percent of the general population (Malhi and Singhi 2000). Chawla (1981) reports that the incidence is higher in boys than girls in the ratio of 7:4. Studies conducted on ADHD have been entirely located in clinic settings and are mostly epidemiological in nature. Karande et al. (2007) reported that the delay between ADHD and Learning Disability symptoms first being noticed and the child being diagnosed was nearly six years on an average. Studies on ADHD in India reveal that problems in school performance as opposed to specific symptoms of ADHD are common reasons for referral to child development centres and clinics (Karande et al. 2007; Wilcox, Washburn and Patel 2007). The only qualitative study on ADHD in India by Wilcox et al. (2007) indicated that while parents did perceive their child as having a difficulty, they were unlikely to adopt the biomedical model and were most likely to pursue educational and religious treatments. Educational interventions were perceived as more helpful than other interventions, suggesting the important role that schools in India and teachers specifically play in identifying and providing appropriate intervention for ADHD.

ADHD in India is essentially located in the school context with most clinic referrals being linked to academic concerns (Wilcox et al. 2005; Karande et al. 2007). Studies suggesting parent preferences for educational interventions over psychiatric interventions for ADHD coupled with stigma associated in accessing psychiatric services, strongly indicate that there is a need for research that would help mental health professionals restructure information and early intervention paradigms about ADHD within a school context. Schools in general and teachers in particular constitute an integral part of the child’s environment and can play a significant role in recognizing and initiating interventions.

Viewed in context of Bronfenbrenner’s (1979) ecological model of embedded systems and the Developmental Contextualist model (Pellegrini and Horvat 1995) which posits a transactional not unidirectional relation between individual organisms and their environments, the teacher is part of the child’s complex, ecological system and does have an influence in maximizing potential or in mediating the effects of a stressor. Teachers are well placed to identify developmentally inappropriate behaviours in the classroom context and can hence initiate early intervention pathways. The teacher according to Barkley (1995) is the single most important ingredient in an ADHD child’s success in school. With specific reference to the current study, this suggests that if the needs of children displaying ADHD type
behaviours in the classroom are to be better understood with a view to designing and implementing effective classroom intervention programmes, the teacher’s frame of reference in responding to these behaviours and perspectives have to be addressed.

The present study is located in Bangalore Urban district. With an estimated population of 8.5 million in 2011, Bangalore is the third most populous city in India. Bangalore is the capital of Karnataka and is often referred to as the IT capital of India, reflecting a significant developmental, technological and economic shift from the title of ‘Garden City’ that was earlier bestowed upon it. Karnataka state was formed by the merger of nine Kannada-speaking areas bordering the princely state of Mysore that were part of the Bombay Presidency, the Madras Presidency, and the princely states of Hyderabad and Coorg. Bangalore Urban district was formed in the year 1986. Bangalore Urban district has an aerial extent of 850 sq.km and consists of the Bangalore North Taluk, the Bangalore South Taluk, Bangalore East Taluk and Anekal. The city’s population is more cosmopolitan in nature owning to the meteoric growth of the IT industry in the past decade and the educated, upwardly mobile work force that it has attracted. The language of the state is Kannada. Literacy rate of the district is 83.91 percent (Source Wikipedia: Retrieved January 2012). A significant feature of Karnataka’s education system is the presence of a large private sector (Table 1.3). Since 1987 the Government stopped giving grants-in-aid to institutions. However, private unaided schools across the state have increased quite rapidly in the 1990s. In lower primary 21 percent and in upper primary, 28 percent, of students are in private institutions.

**Table 1.3**

<table>
<thead>
<tr>
<th></th>
<th>Aided</th>
<th>Unaided</th>
<th>Total</th>
<th>Total Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lower Primary Schools</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Institution</td>
<td>92.5</td>
<td>1.2</td>
<td>6.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Students</td>
<td>78.5</td>
<td>8.3</td>
<td>13.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Teachers</td>
<td>78.6</td>
<td>5.9</td>
<td>15.5</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Higher Primary Schools</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Institution</td>
<td>79.0</td>
<td>8.2</td>
<td>12.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Students</td>
<td>71.8</td>
<td>13.5</td>
<td>14.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Teachers</td>
<td>72.2</td>
<td>11.5</td>
<td>16.3</td>
<td>100.0</td>
</tr>
</tbody>
</table>


In spite of the recent expansion, private schooling in Karnataka is largely an urban phenomenon. In 1993/94 over half the enrolment in classes 1-5 in urban areas was in private schools (6th All India Education Survey). In contrast, 92 percent of enrolment in rural areas is in government schools. Bangalore Urban has a total of 3765 primary schools. Of these 1756 are unaided schools.
At present, around 95 percent of the expenditure on school education by the State Government goes towards meeting the salaries. There are 71 colleges offering B.Ed. degrees and 133 institutions offering the TCH programme (GOK 2010-2011).

The sample for the present study was drawn from 5 middle income private schools spread across the city and consisted of teachers, identified students and heads of school. The primary respondents were teachers and data was obtained through in-depth interviews, classroom observations, responses to questionnaires and vignettes. Data obtained was subjected to qualitative analysis. The subsequent chapters detail the review of literature and the specific methodology. The results of the study are discussed in terms of significant themes and the development of an early intervention programme for ADHD that can be used by teachers in elementary school.