Indian Journal of
School Health
& Wellbeing

•Health Services • Life Skills Education •Healthy School Environment

Healthy Schools .... Healthy India

EXPRESSIONS INDIA
The Life Skills Education & School Health Program

विनीत जोशी (आई.ए.एस.)
अध्यक्ष
Vineet Joshi (I.A.S.)
Chairman

Office कार्यालय : 22023737
: 22467263
Fax फैक्स : 22515826
website वेबसाइट : www.cbse.nic.in

केन्द्रीय माध्यमिक शिक्षा बोर्ड
(मानव संसाधन विकास मंत्रालय भारत सरकार के अधीन एक स्व्यायत संगठन)
"शिक्षा केन्द्र", 2, समुदाय केन्द्र, प्रीत विहार, दिल्ली -110092

CENTRAL BOARD OF SECONDARY EDUCATION
(An autonomous organisation under the Union Ministry of Human Resource Development, Govt. of India)
"SHIKSHA KENDRA", 2, COMMUNITY CENTRE, PREET VIHAR, DELHI-110092

CM/CBSE/2012

12th April, 2012

Message

There is tremendous evidence that life skills, school health and wellbeing are valuable indicators of progressive schooling across the globe.

The objectives of introducing Life Skills Education is to empower the affective domain of the learners so that they are able to develop a sense of self-confidence, eco-sensitivity and right approaches to life processes etc. Development of basic Life Skills is central to the transaction of this curriculum so that the learners develop as competent and contributive citizens. In retrospect the committee on school health in India (popularly known as the Renuka Ray committee), set up in 1960, highlighted that "Health education should be included as part of general education in the primary, middle and secondary school". The report of the committee provided guidelines and recommendations for both content and appropriate inclusion of health education and services at various stages of schooling. In the wake of National Health Policy, 1983, and the National Policy on Education, 1986 (Revised 1992), steps were initiated to look at the importance of school health in a more comprehensive manner. The initiation of `Health and Wellness Clubs' by CBSE in 2005 followed by the four volumes (since revised) of Comprehensive School Health Manuals is an important step forward.

As a supplementary step forward, It is indeed encouraging to see Expressions India under the aegis of Dr. Jitendra Nagpal working steadfastly in this direction. Their latest endevour of launching the "Indian Journal Of School Health and Wellbeing" is a torchbearing effort and has my full support and good wishes.

(VINEET JOSHI)

Dr. Sadhana Parashar
Director (Training)

Ph.: (D) 011-23212603
(Fax) 011-23234324
website : www.cbse.nic.in
CENTRAL BOARD OF SECONDARY EDUCATION
(An Autonomous Organisation under the Union Ministry of Human Resource Development, Govt. of India)
"SHIKSHA SADAN", 17, Rouse Avenue, New Delhi - 110002

DIR(TRG)/CBSE/2012

12th April, 2012

Message

With higher school enrolments and the Right to Education in place, schools have become nodal centers for health based programmes. Schools are the key forums for acquisition of health related knowledge, attitudes and Life Skills. They are indeed the wealth of the nations as empower children towards becoming responsible and active citizens. They play a major role in equipping children not just with academic excellence but also with the skills, the attitudes and the knowledge to face challenges in life. Keeping this in mind it has been recommended that health education be included as part of general education in the primary, middle as well as secondary schools. This is essential for the holistic development of a child. The CBSE Comprehensive School Health and Wellness programme is a step in this direction.

In this regard the initiative taken by *`Expression India'* in bringing out *`Indian Journal of School Health and Wellbeing'*, which reiterates this recommendation, is indeed encouraging. The work being done has lived up to its mission to enhance Life Skills education and promote School Health and Wellbeing. I have faith that it would continue to work in this direction and meet challenges of the emerging needs of the education profile in India.

I would like to convey my support and good wishes in this path breaking endeavour to *`Expressions India'*.

Sadhana Parashar

(DR.SADHANA PARASHAR)

EDITOR'S MESSAGE

For a nation in transformation, education and health care are dynamic indicators of progress. Students can learn well in a healthy and safe environment. Looking into the wide spectrum of comprehensive education the schools need a serious and closer appraisal. United Nations Convention on the Rights of the Child (1989) to which India is a signatory, prescribes that, every child has the inherent right to life, survival and development, including the right to the highest attainable standard of health and to facilities for, the treatment of illness and the rehabilitation of health.

The committee on school health (popularly known as the Renuka Ray committee), set up in 1960, recommended that "Health education should be included as part of general education in the primary, middle and secondary school." The report of the committee provided guidelines and recommendations for both content and appropriate inclusion of health at various stages of schooling. In the wake of National Health Policy, 1983, and the National Policy on Education, 1986 (Revised 1992), steps were initiated to look at school health in a more comprehensive manner.

With higher school enrollments and the Right to Education in place, schools have become nodal centers for heath education programmes. It has also been noted that schools are the key forums for acquisition of health related knowledge, attitudes and life skills. They are indeed the wealth of the nation, enriching the empowerment of children towards responsible citizens.

Schools have an important role to play in equipping children with the knowledge, attitudes, and skills they need to protect their health. Skills-based health education is part of the FRESH framework (Focusing Resources on Effective School Health), proposed and supported by WHO, UNICEF, UNESCO, UNFPA, and the World Bank. This document was published jointly by agencies that support the FRESH initiative, and emphasizes the role of schools; however this document will also be relevant to out of school settings. Its purpose is to strengthen efforts to implement quality life skill-based health education on a national scale worldwide.

Therefore a strong need is being felt for a Comprehensive School Health journal that scientifically reinforces the vision of Health Promoting Schools and subsequently gets integrated within the education system in India. **The Indian Journal of School Health & Wellbeing** is a step in this direction.

I have the pleasant task of recording my deep appreciation for and thanks to all the Advisory group, Editorial Board and Members of the Executive Editorial for their valuable contribution, ungrudging cooperation and keen interest taken. I must also thank the Members for making available the benefit of their rich experience and knowledge.

I conclude with the note that, there has to be a ground swell of commitment from the parents, teachers, Government authorities, civil society organizations and students so far as the creation of a healthy, safe and cosseted environment in the school is concerned. It has been rightly and very aptly stated, "If there is to be a light at the end of the tunnel, it is our responsibility to hold the torch high enough to provide a beacon of light bright enough and strong enough for our children to follow."

Dr. Jitendra Nagpal,
M.D., D.N.B.
Program Director–'Expressions India'
The Life Skills Education & School Wellness Program
Sr. Consultant Psychiatrist –
Vimhans & Moolchand Medcity, New Delhi

INDEX

CONTENTS **Page No.**

GUIDELINES

The Indian journal of School health and Wellbeing will facilitate the effective partnership of health and education sectors to promote effective child and adolescent development in schools. The focus would be on publishing good practices, current research, health services, training & development programs, events, etc. It is envisaged to feature articles designed to impart new information and exchange of ideas amongst all practitioners in the field of child care. It is intended for stakeholders in the field of health and education i.e., school counselors, students, parents, teachers, psychologists, teacher educators, educational administrators, research workers, doctors, nurses, policy makers, social activists and teacher trainees.

Indian Journal of School Health is planned to be published quarterly, in January, May, August and November. The journal will be overseen by an editorial board and an advisory board and all submissions will undergo a review process and refining to international standards.

AUTHOR GUIDELINES

- The article should be of 2000 – 3000 words.
- The article should have a clear and information title.
- The article submitted should be original and should not be in the process of consideration by other publication at the same time.
- Begin the article with an abstract of about 150 words summarizing the main points.
- The article should meet the highest standard in terms of the rigor and reliability of the information and provide a deeper level of understanding. At the same time they should also be engaging to read and accessible to non – expert readers.
- Figures and tables should be numbered, with appropriate titles and should be placed on separate pages.
- Reference should be alphabetically arranged at the end of the article.
- Brief information and line of works of the author should be sent as a separate cover note.
- Initial acceptance of an article does not guarantee publication. The editorial board shall do the final selection. The articles received will not be sent back.
- The editor has the right to reject even invited articles without assigning any reason.

If necessary, the editors may edit the manuscript substantially in order to maintain uniformity of presentation and to enhance readability.

TYPES OF MANUSCRIPTS AND WORD LIMITS

1. **Original Research Papers:** These should only include original findings from high-quality planned research studies such as experimental designs, outcome studies, case–control series and surveys with high response rates, randomized controlled trials, intervention studies, studies of screening and diagnostic tests, and cost-effectiveness analyses. The word limit is 5000 excluding references and an abstract (structured format) of not more than 250 words.
2. **Brief Research Communication:** These manuscripts, with not more than 1 table/figure, should contain short reports of original studies or evaluations and service oriented research which may not be methodologically sound but points towards a potential area of scientific research or unique first-time reports. The word limit is 1500 words and up to 20 references, and an abstract (structured format) of not more than 150 words.
3. **Case Reports:** These should contain reports of new/interesting/rare cases of clinical significance or with implications for management. The word limit is 1500 words and up to 10 references, and an abstract of not more than 150 words.
4. **Review Articles (invited):** These are systemic and critical assessments of the literature which will be invited. Review articles should include an abstract of not more than 250 words describing the purpose of the review, collection and analysis of data, with the main conclusions. The word limit is 5000 words excluding references and abstract.
5. **Grand Rounds in child psychiatry/ psychopathology (Case Conference):** This should highlight one or more of the following:

diagnostic processes and discussion, therapeutic difficulties, learning process or content/technique of training. This may be authored by an individual or a team, and may be an actual case conference from an academic department or a simulated one. The word limit is 1500 words and up to 10 references.

6. **Viewpoint:** These should be experience-based views and opinions on debatable or controversial issues that affect the profession. The author should have sufficient, credible experience on the subject. The word limit is 3000 words.
7. **Commentaries:** These papers should address important topics, which may be either multiple or linked to a specific article. The word limit is 3000 words with 1 table/figure and up to 20 references.
8. **Literary child Psychiatry/psychopathology:** Original Contributions are welcome which cover both literature as well as mental health. These can be in the field of poetry, drama, fiction, reviews or any other suitable material. The word limit is 2000 words.
9. **My Voice:** In this section multiple perspectives are provided by patients, caregivers and paraprofessionals. It should encompass how it feels to face a difficult diagnosis and what this does to relationships and the quality of life. Personal narratives, if used in this section, should have relevance to general applications or policies. Articles should underline the need to treat patients, rather than diseases, and to understand the impact such journeys may have on patients' caretakers and families. The word limit is 1000 words.
10. **Announcements:** Information regarding conferences, meetings, courses, awards and other items likely to be of interest to readers should be submitted with the name and address of the person from whom additional information can be obtained (up to 100 words).

Specific innovative/new ideas or newly emerging concepts for the sections are actively encouraged.

SENDING THE MANUSCRIPTS TO THE JOURNAL

Entries are to be submitted via e-mail to:

Dr. Jitendra Nagpal
Programme Director,
'Expressions India" – The Comprehensive Life Skills Education & School Health Programme
Sr. Consultant Psychiatrist, Moolchand Medcity
jnagpal10@gmail.com, expressionsindia@rediffmail.com, priyankag03@hotmail.com

Comprehansive School Health Policy.

Jitendra Nagpal*, Sadhana Prashar, & Cherian Verghese*****

**Senior Counsaltant sychiatrist, VIMHANS Hospital, New Delhi*

***Education Officer, CBSE, New Delhi*

****Cluster Coordinator (Non Communicable Disease and Mental Health, World Health Organisation*

Abstract: *For most children 'going to school's a historic milestone in their lives. It is a place that plays one of the most important roles in their physical, mental and emotional development. School are setting where children learn, where character is moulded, where values are inculcated and where the future citizens of the world are groomed to face life's challenges. School are a strategic means of providing children with educational qualifications that will enable them to find employment and status in life. School can be dynamic setting for promoting health, for enabling children to grow and mature into healthy adults, yet the potential of the school to enhance heath is often underutilized. 'School health' has largely remained confined to medical check-ups of children and / or some hours of health instruction in the curriculum. Today, schools present an extraordinary opportunity to help millions of young people acquire health supportive knowledge, values, attitudes and behaviours pattern. The students can serve as a means of promoting health of other children, their families and community member. There is a growing recognition that the health and psychosocial well-being of children and youth is of fundamental value and that the school setting can provide a strategic means of improving children's health, self-esteem life skills and behaviour. There are various initiative in school health at present, but most of them are topic based and age group specific and often rely on the imitative of the individual school or an agency. The comprehensive and sustainability in these initiatives are not clearly laid out. The need of the time is a comprehensive school health policy integrated within the educational system at the national and state level .This will harmonize the effective partnership of health and education sectors to facilitate the holistic approach to child and adolescent development in school.*

HISTORICAL REVIEW

It has long been recognized that schools provide the most appropriate setting for both health services and health education for children and young persons. Globally, 'school health' has been an important initiative for several decades, comprising largely of school health service and school health education.

In 1960, the government of India set up a committee on school health **(Renuka Ray Committee)** which recommended that "Health education should be included as part of general education in the primary, middle and secondary schools" the reports of the Renuka Ray committee (1961) provided guidelines and recommendations for both the content and the appropriate transaction of health education at various stages of schooling. In the wake of the **National Policy on Education (1986, Revised 1992) and the National Health Policy 1983,** steps were initiated to look at school health education in more comprehensive manner. The **National Health Policy, 2002** envisage giving priority to school health programme which aim at preventive-health education, providing regular health check-ups and promotion of health-seeking behaviour among children. The policy suggests that school health programmes can gainfully adopt specially designed modules in order to disseminate information relating to 'health' and 'family life'. This is expected to be the most cost-effective intervention as it improves the level of awareness not only of the extended family, but the future generation as well. The notes worthy initiatives under this 2002 policy were setting up a well-dispersed network of

Correspondonce: Dr. Jitendra Nagpal*, E-mail: jnagpal10@gmail.com*

comprehensive primary health care services linked with extension and health education. It is widely accepted that school students are the most impressionable targets for imparting information relating to the basic principals of preventive health care. The policy attempted to target this group to improve the general level of awareness in regard to 'health promoting' behaviour. The girl child in the rural belt needed to be targeted right from school level. The policy functioning of the various sectors in the society. The health status of the citizen would, inter alia, be dependent on adequate nutrition, safe drinking water, basic sanitation, a clean environment and primary education, especially for the girl child.

The National curricular framework 2005 by NCERT has categorically stated that health Is a critical input for the overall development of the child and it influence significantly enrolment, retention and completion of school. It advocates a holistic definition of emotional and mental development of a child. Undernurition and communicable diseases are the major health problems faced by majority of children in this country from pre-primary through to the higher secondary school stage. Thus there is a need to address this aspect at all levels of schooling with special attention to vulnerable social groups and children. It has proposed that the mid-day meal programme and medical checkups be made a part of the curriculum and education about health be provided which address the age specific concern at different stages of development.

INTRODUCTION

The idea of a comprehensive school health programme, conceived in the 1940's included the following major components viz. medical care, hygienic school environment and school lunch, health and physical education., these components are important for the overall development of the child and hence need to be included as a part of the curriculum, the more recent addition to the curriculum is yoga. The entire group must be taken together as a comprehensive health and physical education curriculum, rather than the fragmentary approach current in school today. As a core part of the curriculum, time allocated for games and for games and for yoga must not be cut down or taken away under any circumstances.

Given the interdisplinary nature of health, there are many opportunities for cross curricular learning and integration. Activities such as the national services scheme, Bharat Scouts and Guides and the National Cadet Corps, are some such areas. The science provide opportunities to learn about physiology, health and disease and the inter dependencies between various living organism and the physical habitat. Social science could provide insight into communities, health as well as understanding the spread, control and cure of infectious disease, form socio-economic and global perspectives. This subject lends itself for applied learning and innovative approaches can be adopted for transacting the curriculum. The importance of this subject to the overall development needs to be reinforced at the policy level, with administrative recognizing health and physical education as core and compulsory, ensuring the that adequate equipment for sports and yoga instructor are available and that doctors and medical personnel visit schools regularly are some of the step that can be taken.

Further this subject could be offered as an elective at the +2 level. The 'need based approach' could guide the dimensions of physical, psycho-social and mental aspects that to be included at different levels at schooling. A basic understanding of the concern is necessary, but the more important dimension is that of experience and development of health, skills and physique through practical engagement with play, exercises, sports and practices of personal and community hygiene collective and individual responsibilities for health and community living need to be emphasized. Several national health programmes like the reproductive and child health, HIV, AIDS, tuberculoses and mental health have been targeting children as a focus with prevention in view. These demands on children need to be integrated into existing curricular activities rather than adding on.

Yoga could be introduced from the primary level onwards in informal ways, but formal introduction of Asanas and Dhyana should begin only from class VI onwards. Even health and hygiene education must rely on the practical and experiential dimension of children's lives. There can be more emphasis on the inclusion of sports and games from the local area. Indigenous knowledge in this must be reflected at the local level.

Policies make a difference. Appropriate and effective school health policies can have an impact on health behaviours, short-term health outputs learning/academic achievement and social development. There is a need to develop a uniform, effective code of practice for school administrators and educationalists undertaking health promotion in schools.

The 8-components approach was adopted and recommended by the Centers for Disease Control and Prevention, Division of Adolescent and School Health (CDC/DASH) and, via CDC/DASH-funded national organizations and state and local education agencies, became the operative framework in the United States. By

the late 1990s, a version had been adopted by the World Health Organization under its health-promoting schools initiative and implemented in countries across the globe. The 8- components approach, and variants of it, is a very successful innovation that has enjoyed an impressive dissemination and adoption curve. Coordinated school health program is commonly depicted as a series of 8 connected bubbles in orbit around 2 generic students (Figure 1).

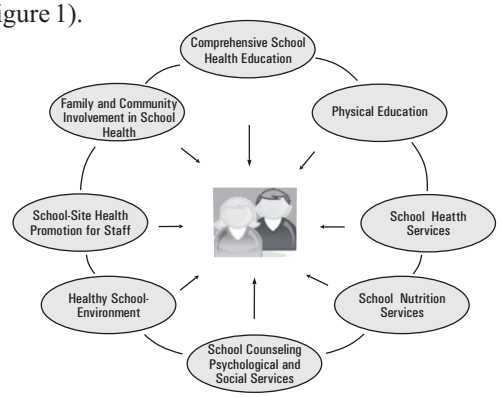


Figure1: *"Bubble" Depiction of a Coordinated School Health Programme (Adopted from [5])*

Somewhat in contrast, the expanded CSHP approach was originally depicted through a diagram (Figure 2) that illustrated the direct impact of 7 components on student health-related behaviors and, subsequently, their health status, cognitive performance, and educational achievement. The eighth component health-promotion program for faculty and staff is shown as initially

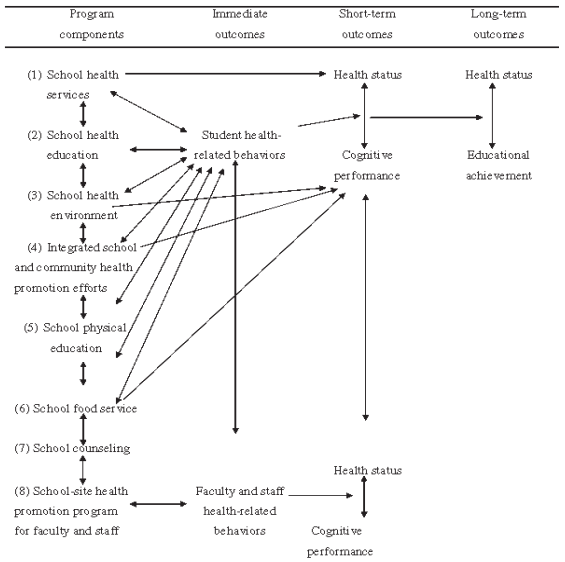


Figure2: *School Health Promotion Components and Outcomes (Adapted from [1])*

influencing employee health behaviors, health status, and cognitive performance and then, via healthy and high-performing employees, student health and educational outcomes. This diagram portrayed true health promotion because it clearly involved health education plus policy, regulatory, organizational, social, economic, and/or political interventions that support actions and conditions of living6 across all components and, thereby, enhanced health, educational, and social outcomes of students and school employees.

COMPREHENSIVE SCHOOL HEALTH POLICY

The WHO defines a health promoting school as one that is constantly strengthening is capacity as a healthy setting for living, learning and working.

School health education is comprehensive and meaningful when it;

- Views health holistically, addressing the inter-relatedness of health problems and the factors that influences health within the context of the human and material environment and other condition of life.
- Utilizes all educational opportunities for the health: formal and informal, standard and innovative approaches in curriculum and pedagogy.
- Strives to harmonize health message from various sources that influence students including messages form the media, advertising the community, the health and development system, family and peer, and the school.
- Empowers children and youth as well their families to act for healthy living and to promote condition supportive of health

WHO IS THE SCHOOL HEALTH POLICY FOR?

This policy is for the central board of secondary education and its affiliated schools and educational organisations. The policy will provide useful information to the community sector and other organization that also have an interest in engaging in school based health initiatives.

WHAT DOES THIS SCHOOL HEALTH POLICY AIM TO DO?

The policy aims to:

- Provide an effective guide for school administrators/ educationalist to assist them in developing health promoting schools.

- Ensure that school health programmes are based on formally assesses and evidence based practice.
- Advocate the value of a comprehensive and planned approach to school health through education sector
- Encourage partnership for school health promotion with key stakeholders, viz students, parents, health professionals, teachers and counsellors.

The overall objective of the policy is to equip the educational sector to develop health promoting schools

COMPONENTS OF THE POLICY

The eight components of the comprehensive school health policy are:

a) A school environment that is safe; that is physically, socially and psychologically healthy; and that promotes health-enhancing behaviours;

b) A sequential health education curriculum taught daily in every grade. Prekindergarten through twelfth, that is designed to motivate and help students maintain and improve their health, prevent disease and avoid health-related risk behaviours and that is taught by well-prepared and well-supported teachers.

c) That involves moderate to vigorous physical activity; that teaches knowledge, motor skill and positive attitudes ; that promotes activity and sports that is taught by well-prepared and well-supported staff; and that is coordinated with the comprehensive school health education curriculum;

d) a nutrition services program that includes a food services program and employs well-prepared staff who efficiently serve appealing choices of nutritious foods; a sequential program of nutrition instruction that is integrated within the comprehensive school health education curriculum and coordinated within the food service program ; and a school environment that encourages student to make healthy food choices;

e) A school health services program that is designed to ensure access or referral to primary health care services; foster appropriate use of health care services; prevent and control communicable disease and other health problem ; provide emergency care for illness or injury; and is provided by well-qualified and well supported health professional;

f) A counseling, psychological and social services program that is designed to ensure access or referral to assessments interventions and other services for student's mental, emotional and social health and whose services are provided by well-qualified and well-supported professionals.

g) Integrated family and community involvement activities that are designed to engage families as active participants in their children's education that support the ability of families to support children's school achievement and that encourage collaboration with community resource and services to respond more effectively to the health-related needs of students and

h) A staff health promotion policy that provides opportunities for school staff to improve their health status through activities such as health assessments, health education and health-related fitness activities.

HOW TO IMPLEMENT THE POLICY

KEY MESSAGE FOR PLAN TO POLICY

Strategy for action at national, state district and community level

A) From interfaces / action groups

B) Review current situation for school promotion

C) Plan and implement school health promotion activities

D) Monitor and evaluate activities

E) Share experience / lessons with others

The school administration should provide the lead for health promotion as a major initiative and should include all the stake holders including parents, teacher, students and the community.

The global school health survey when undertaken can provide the profile of the students at baseline in the following areas;

- Alcohol and other drug use
- Dietary behaviours
- Hygiene
- Mental health
- Physical activity
- Protective demographic
- Sexual behaviours
- Tobacco use
- Violence and unintentional injury

The school administration can be then take up various initiatives as per the health promotion manual specially designed for the three major age group classes1-4, 5-8 and 9-12. The checklist can be used to understand the current status and to guide the activities. A school health club can be formed and can become the focal point of school health promotion. In addition to specific class room based activities and revising school health curriculum the health promotion programme should encompass the entire school environment and should become a school campus activity. The health promotion programmes should stimulate the teacher's students and parents and should be conceived in a participatory manner. The school should also strive to provide healthy living habits through a conductive environment. The health promotion initiatives can be assessed and based on a scoring system the school can be declared as a health promoting school.

Once the school achieves the status of a health promoting school, it should strive to maintain and excel its initiatives should become a model for other schools.

CHECKLIST FOR SITUATION ANALYSIS OF SCHOOL HEALTH

- What is the status of health education activities in the classroom school and community?
- Does the school have a clear policy on health promotion, jointly prepared by staff and parents?
- Is health taught effectively across the curriculum?
- In particular, are the following topic covered environment health reproductive health and population, personal health ,safety and accident prevention, drug abuse, physical education, emotional health?
- Are the health topic taught at school based on the need in the community?
- Are teaching method leaner-centred , using the environment as well as the school?
- Are education material including visual aids and books available and used on health topic?
- Are the water and sanitation facilities adequate, clean and well maintain?
- Is there at least one teacher in the school trained to give first aid, detect simple health problem and refer children to health committee?
- Is there an effective and committed school health committee?
- Are parent involved in health promotion activities in the school?
- Are there well developed links with the community and local health workers?
- Do policy maker within health, education and other services provide support to school health promotion?

RESPONSIBILITIES OF THE SCHOOL

1. Responsibilities of administrators/ principals

The Administrators/school principals shall be responsible for:

- Preparing a comprehensive plan for eight elements for a coordinated school health program with input from students and their families
- Ensuring that the various components of the school health program are integrated within the basic operation of the school are efficiently managed reinforce one another and present consistent message for student learning
- Developing procedure to ensure compliance with school health policies
- Supervising implementation of school health policies and procedures
- Negotiating provisions of mutually beneficial collaborative arrangements with other agencies, and present organizations and businesses in the community and
- Reporting on program implementation, result and means for improvement to whom and how regularly.

2. Responsibilities of the School Health Coordinator / Teacher / Counselor

Each school shall appoint/ designate a school heatlh coordinator to assist in the implementation and coordination of school health policies and program by:

- Ensuring that the instruction and services provided through various components of the school health programme are mutually reinforcing and present consistent message.
- Facilitating collaboration among school health programme personnel and between them and other school staff
- Assisting the administrator/school principal and other administrative staff with the integration, management and supervision of the school health program.
- Providing or arranging for necessary technical assistance.

- Identifying necessary resources.
- Facilitating collaboration between the school and other agencies and organizations in the community who have an interest in the health and well-being of children and their families and
- Conducting evaluation activities that assess the implementation and result of the school health program as well as assisting with reporting evaluation result.

MONITORING AND EVALUATION

Obtaining baseline data on the health of the children the quality of school health service the environment of the school and the health knowledge skills and practices of students are essential for evaluating the effectiveness of a planned intervention

The nature and quality of school health education programmes should be evaluated by the extent to which they achieve:

a) Instruction intended to motivated health maintenance and promote wellness and not merely the prevention of disease or disability

b) Activities designed to develop decision-making competencies related to health and health behaviour.

c) A planned sequential pre-school to end-of-school curriculum based on student's need and current and emerging health concepts and societal issues

d) Opportunities for all student to develop and apply in real-life situation health related knowledge attitudes and practices individually

One approach to measuring outcomes, which may be particularly applicable to school based health programme, utilizes goal attainment changes as the unit of measurement. The evaluation process is then planned implemented and discussed as to whether or not the goals were met and appropriate modifications made. Information is also needed on whether the improvements are being sustained over a period of time or not

SUSTAINABILITY

Sustainability: that which keeps a programme alive and, eventually passes on ownership to the target group or the community.

- Sustainability at the school level
- Sustainability at home and community level
- Sustainability at district and state level

Several factors identified as important to the sustainability of a school health policy includes;

- Ownership of the programme by the school
- Training of teachers and health workers
- Participation by parents and the community
- The shared involvement of government and NGOs from health education and other community services
- The mobilization of local resources

The main resource comes from teachers, children and parents- there is no school however poor that lacks the resource of children

REFERENCE

Allensworth DD, Kolbe LJ. The comprehensive school health program: exploring an expanded concept. J Sch Health. 1987;57: 409-412.

Centers for Disease Control and Prevention. *Healthy youth! Coordinated school health program.A*vailable at: http://www.cdc.gov/ HealthyYouth/CSHP. Accessed July 30, 2007.

Children's Health Development Foundation(Australia) *Website http:// www.chdf.org.au/*

Division of Adolescent and School Health. Developing Comprehensive School Health Programs to Prevent Important Health Problems and Improve Educational Outcomes. *Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion; 1992.*

Global school-based student health survey (GSHS)

Health oriented programmers and education http://www.hope.org.in/

Kolbe LJ. Education reform and the goals of modern school health programs. State Educ Stand. *2002; Autumn: 4-11.*

Mental health programmes in schools, Division of Mental Health, WHO, Geneva 1993.

National Association of State Boards of Education. Today's Education Policy Environment: Integrating Health into Education. *Atlanta, GA: American Cancer Society; 1992.*

Our Children our future – A report on school health in India, British Council Division, New Delhi, 1995.

Training Manuals of Life Skills Education & School Mental Health Programme of "Expressions", VIMHANS, New Delhi.

WHO information Series on School Health http://www.who.int/school_youth_health/resources/ information_series/en/

World Health Organization. The health promoting school—an investment in education, health and democracy. *Presented at the First Conference of the European Network of Health Promoting Schools. Thessaloniki- Halkidiki, Greece. May 1–5, 1997.*

The Concept of Well Being in the Context of School Education.

Geetesh Nirban

Assistant Professor, Department of Philosophy,
Kamla Nehru College, University of Delhi, India.

"I am always ready to learn but I do not always like being taught"
Winston Churchill

INTRODUCTION

Some interactions with the school students make the mind ponder whether our schools lay more emphasis on the test scores and rankings at the expense of joy, wellness and learning? Do our schools focus only on top academic performers or pay attention to the top learners too? Does school education aims at only academic success or it even promotes curiosity and personal development? Many such questions lead to a view that lately academic excellence has emerged to be the *summun bonum* of school education. Somehow in education we seem to value what we measure more than measuring what we value. Such a scenario compels one to raise further questions—do our schools promote well being of the children? Shouldn't our schools aim at becoming well being habitats for the children of the country?

THE CONCEPT OF WELL BEING

Well being as a word has many definitions and due to this reason it sometimes appears as an indeterminate and abstruse concept. This is as a result of multitude of perceptions that people from varied backgrounds have regarding this concept. Broadly well being can have five dimensions-which actually capture the variance in well being in the present times. They are:

1) Career or occupational well being: How people occupy their time during the day and whether it is fulfilling.
2) Social well being: The quality of relationships in people's lives.
3) Financial Well being: The degrees of financial security people have.
4) Physical well being: the extent to which people can do what they want to do free of pain.
5) Community Well being: the extent to which people feel safe and are involved in giving to their community.[1]

Thus 'Well being can be defined in terms of an individual's physical, mental, social, and environmental status with each aspect interacting with the other and each having differing levels of importance and impact according to each individual'[2]

These days in its popular use, well being is related to health. In this sense health becomes one of the constituents of person's well being but it cannot mean to stand for the over all meaning of well being. In order to understand its more profound meaning, one may turn towards its philosophical use—which though being the oldest interpretation of well being, yet can be of great relevance in the 21st century.

ARISTOTLE ON WELL BEING AND EDUCATION

Well being is generally used in Philosophy to describe the ultimate good of a person. This term is of immense interest in the realm of moral Philosophy. It was Aristotle [3] who gave much thought to well being in his *Nichomachean Ethics*. Ethics, according to Aristotle, is an attempt to explore the highest good of human life. There are umpteenth ends that a person seeks in life but there is one end which is not the means to anything but is an end in itself—*Eudaimonia*, the closest English translation of which is well being. Aristotle clarified that

Correspondonce: Dr. Jitendra Nagpal, *E-mail: jnagpal10@gmail.com*

well being could not be equated with pleasure but with happiness (former being temporal in nature and shared with animals while the latter being a state of permanent nature and being a distinct feature of human beings only). For him, the true happiness lay in active life of a rational being. Prior to Aristotle, Stoics[4] had given their interpretation of *Eudaimonia*. They believed that leading a virtuous life was the only possible means to *Eudaimonia*. Aristotle agreed to this viewpoint but even acknowledged the significance of external goods as health, wealth and beauty as the requirements for *Eudaimonia*. According to him, *Eudaimonia* consisted in living well and doing well by enjoying the goods of the mind (wisdom, moral virtues and happiness), goods of the body (physical beauty, health and pleasure) and external goods (wealth and adequate material resources, good parents and families, peace and security within and between communities and well governed communities).[5]

Elaborating on the concept of well being, Aristotle divides the human soul into-rational and irrational. The rational element is further divided into the calculative faculty and appetitive faculty and the irrational element into appetitive and vegetative. The irrational element is shared with animals and the rational element is distinctly human. The primary irrational element is vegetative

	Calculative--------Intllectual Virtue
	Rational
Soul	Appetitive (desires)--Moral Virtue
	Irrational
	Vegitative--------Nutritional Virtue

faculty which controls growth and nutrition. Mastery of this falls within the category of nutritional virtues. The second level of the soul is the appetitive faculty which takes care of our emotions and desires. The appetitive faculty is both rational and irrational. It is irrational because animals also experience desires. Yet it is also rational in nature because human beings possess a unique ability to control these desires with the help of reason. The human capacity to control these desires is called moral virtue. Aristotle states that there is a pure rational part of the soul-the calculative, which is responsible for the human ability to contemplate, reason logically and formulate scientific principles. The mastery of these abilities is called intellectual virtue.[6]

Intellectual virtues owe both its birth and growth to teaching and moral virtues come as result of habit i.e.

Vice of Deficiency	Virtuous Mean	Vice of Excess
Cowardice	Courage	Rashness
Insensibility	Temperance	Self-indulgence
Illiberality	Liberality	Prodigality
Petiness	Magnificence	Vulgarity
Undue Humility	Pride	Empty Vanity
Unambitiousness	Proper Ambition	Over-ambition
Spiritlessness	Good Temper	Irascibility
Cantankerousness	Friendliness	Obsequiousness
Ironical Depreciation	Sincerity	Boastfulness
Boorishness	Wittiness	Buffoonery
Shamelessness	Modesty	Bashfulness
Spritefulness	Righteous Indignation	Envy

intellectual virtues grow with instruction and moral virtues grow with habituation. Intellectual and moral virtues with special emphasis on the moral virtues lead to the well being of an individual. Virtue for Aristotle is a state of character concerned with choice and he elucidates that a human being has two vices-the deficient and the excess and the virtue lies in between the two. It is only by fluctuating between the two vices and ultimately settling in the mean position through reasoning and habitual practice that a person becomes virtuous and ultimately treads on the path of well being-*Eudaimonia.* Some moral virtues that lie between the two vices are as follows:

For Aristotle *Eudaimonia*-well being/happiness is the supreme good to which all aspire but a happy person is neither a noble savage nor a person in her/his natural state. A happy and a good person is a virtuous person and virtue is acquired precisely through education. A good person is thus a well trained and habituated person. According to Aristotle ethics and education merge at a point with *Eudaimonia* as a common goal of both. Some things are learnt through instructions, while others by habit and reason. It is through education that one acquires virtue, wisdom and happiness. Education functions to 'produce sociable and happy citizens'[iv] and the process of education culminates in the development of reason.

Education begins with physical training which is not a mere training of the body but it has a larger role of character building and instilling the spirit of courage and sense of honor amongst the young minds[v] He further elaborates on the importance of musical education because for him music is a means of influencing the moral character and develops a capacity to listen amongst the youth. Education with its emphasis on physical training, understanding of music, focusing on growth of both intellectual and moral virtues, finally culminates in the study of Philosophy. This type of education is education through reason, experience and habitual practice.

In view of Aristotle, education has a tripartite goal consisting of training of body, mind and soul-it is only through such a system of education that the potential happiness can become truly accessible. Human beings possess many natural aptitudes but it is through education that they learn their role and responsibility of being human. Education does not simply mean instruction and transmission of information but it is an integral process of social, moral, political and intellectual advancement of the citizens. It can be aptly said that Aristotle's ethics is a teaching manual on art of living and education is the touchstone of Aristotelian ethics. In this way Aristotelian philosophy of education focuses on the well being of students, making each one learn the art of living well(both physically and mentally). Thus the study of Aristotle's thoughts on well being as the goal of education and ultimately life proves to be deeply rewarding for educators.

ANCIENT INDIAN EDUCATION SYSTEM AND WELL BEING

If on one side Aristotle called our attention to an all encompassing system of education, concentrating on the well being of the pupils then on the other hand in the ancient Indian *Gurukula*[vi] system, the education was always taken as an intimate relationship between the teachers and the taught. The objective of education was to develop the personality, the innate and latent talents of the students. The guiding principles of education were *satchit*(true knowledge), *ânanda*(bliss), *satyam*(truth), *œivam*(beauty) and *sundaram*(goodness). These were the supreme values of the ancient indigenous culture. The early Indian educational system also aimed at the development of personality by eulogizing the feeling of self-respect, by encouraging the sense of self confidence, by inculcating the virtues of self restraint and fostering the powers of discrimination and judgment.[vii] An all encompassing –holistic education emphasizing both on physical and mental growth, thus aimed at making students understand the meaning of life and living. For an ordered development of human personality, the ancient educational thinkers developed a unique concept, the *puruúârtha*-the meaning of which was explained and elaborated to youth from the early days of their education. The four *puruúârtha*[viii] are *kâma*(physical pleasure-bodily needs-physical well being), *artha* (economic resources-financial needs-material well being), *dharma*(righteousness-moral needs-ethical well being) and *mokœa*(emancipation-mental needs-spiritual well being). The comprehensive understanding of all the four human goals made the students understand the importance of education for well being. The purpose of education was not to produce *sukha* (pleasure) but to realize *ânanda* which can be accurately understood as *Eudaimonia*-well being. A brief exposition of ancient Indian educational pattern spells out that well being remained to be the aim of the education with its focus on the complete development of a student.

This early system of education in India calls for our reflection on the contemporary school education and

poses an important question—are we doing justice to the minds of the future of this nation by overburdening them with the knowledge of facts and figures and by completely ignoring the real life education to them? An observation makes one understand that the present requirement of the school education is to integrate the education for life and the education of livelihood, focusing on the well being as the goal of the education.

WELL BEING AS THE GOAL OF CONTEMPORARY SCHOOL EDUCATION

The contemporary school education in India is strictly structured around the traditional academic subjects, didactic teaching modes, unquestioned submission to authority with a complete focus on excelling in the exams. This system of school education teaches children many things which one wonders when they are used by them in day to day life. Children are taught to write checks and balance budgets when they hardly have bank accounts and no income; they are strained to learn the structure of legislature when they have no say in what is legislated. This sounds very strange but it stands as a tall fact that the very many habits that the school tries hard to inculcate amongst the students are rarely useful for life but are only required for the artificial functioning of the school curriculum and successful conducting of examination procedure. How justified it is to adopt the dictatorial means to teach the democratic citizens? It is most unreasonable (almost ridiculous!) to expect students to learn skills if the skills are outside the domain of application. There is abundant research and material on how a student can fare well in exams and in the class but there is scarcity in the talk on how well being can become the focus of school education system. Some points that can be stressed upon along with academic knowledge (within the domain of school teaching) which helps in augmenting the well being of students are:

a) Social Development and Good Citizenship

A child stands as an individual as well as a member of a society. A school, according to John Dewey[1] has a great moral responsibility towards the society. A school has an important function in maintaining the life and advancing the welfare of society. Dewey categorically asserted, "…the educational system which does not recognize this fact as entailing upon it an ethical responsibility is derelict and a defaulter"[2] One way the school can achieve the well being of the child in school is by focusing on the social development of a child because a child is "…a member of a family, himself responsible…in turn, for rearing and training of future children, and thus maintaining a continuity of society."[3] Social development is possible only when a child is made to learn the spirit of cooperation rather than fierce competition.

The family is the first stage where a child encounters learning for the first time and school is the second stage of learning for the child wherein s/he spends thirteen to fourteen initial years of life. Since the children spend the significant time of their shaping years in the school so it becomes an important habitat of a child. It is like a "miniature community and an embryonic society".[4] The schools have a major role to play in the development of the good persons and thus contributing in the well being of a child. It is at this level that children must encounter a comprehensive moral system where they must learn and understand that their "…enjoyment of freedom for ourselves involves the recognition that it is exercised with others and not in isolation."[5] It is only when the education will equip the young minds to make choices in life, then they will become active participants in their families, communities, societies, in their democracy ultimately making them global citizens. A country can have good citizens if there are many good persons and these good persons can be produced only through a comprehensive educational pattern at a school level, focusing not just on academic grades but on the over all development leading to the well being of a child.

b) Moral virtues

If the present day school education has to have any meaning for life and contribute towards the well being of the students then it must certainly undergo a complete transformation. The school's education pattern plays a momentous role in instilling of moral habits and in this way they can be aptly called as 'moral habitats'[6] wherein the values and the beliefs of the community and further the society and nation are formed and nurtured. When the school will pay attention to the inculcation of moral virtues (as stated by Aristotle) amongst the adolescents then the path for caring relations will be built and the students will become sensitive to the existence and pain of others. The focus of school education must not be just on mastering language and memorizing of facts but to make the students learn life skills, acquire knowledge,

cultivate values, build appropriate attitudes, beliefs and behaviors which in fact would prepare the ground for their sustained personal, social and moral well being. It is only when such an approach is adopted by schools then we can be rest assured to have in future, a society that will be amicable, ethical and admirable, wherein tolerance and mutual coexistence would exist and human life will acquire a more meaningful, healthy and happy existence. Whatever happens in a school, the content, pedagogical methods and the ethos and organization of school –all together play a major role in achieving the well being of all students.

c) Confidence and Character Building

The goal of school education has to be positive youth development with its focus on producing healthy and happy adolescents treading on the path of adorable adulthood. Another way in which well being of the students can be achieved is when confidence building becomes a part of teaching module. It is a very important component in the development of a personality and plays a significant role in the promotion of the mental health of all school goers. Confidence and character are almost the two sides of the same coin. That is why character education somehow helps in confidence building also. Education for the development of the character[7] of a student is possible if the focus is laid on inculcating vitality (good health which ultimately promotes the power of hard work and rational thinking), courage (overcoming fear not only in action but in feeling), sensitiveness (empathy- emotional, cognitive and aesthetic sensitivity) and intelligence (an aptitude for acquiring knowledge and not just storing of knowledge) amongst the young minds. These can be promoted amongst the students through films, dialogues, organizing of excursion visits to social institutions and by making them participate in community service. These sorts of activities encourage the fresh minds to think and reflect which in turn creates sensitivity and understanding of their own selves and the others in a more comprehensive manner resulting in building of both confidence and character. Such qualities, if made to learn during the early years of education paves way for the happy life of an individual.

d) Health literacy

In last few years there has been considerable amount of attention that has been laid on the global health challenges.[8]The health care professionals have started considering some link between education and health (though this existed both during Aristotle and the ancient Indian system of thought). It is felt that the literacy debate cannot just be confined to a simplistic understanding of literacy as the capacity to read, write and have bare numeric skills (the three Rs') but need to account for complexity, culture, individual empowerment and community development. It is high time that literacy must be viewed as including a variety of skills required by an adult to function in a society. Health being associated with well being is the new emerging trend which cannot be overlooked in the present context. Well being in the sphere of education has to focus on the creating favorable and friendly environment for health literacy. The point to be emphasized is that the health education must be realistic and relevant to various groups of children and to ever changing experiences of the adolescents, and thus be dynamic in nature.

Health education must be taken as a source of self empowerment wherein 'every subject is open to rational debate and to a consideration in a scientific manner'[9]. It can become successful if the students are given patient listening and their doubts and queries are respected and valued. It is only in a comfortable environment and with some support from the teachers that the adolescents will be able to share the anxiety related to their mind and body functions. If the health experiences of children have to be understood, all concerned with teaching need to be sensitive and imaginative about the lives of students which are very often different from their own lives. They need to cultivate the spirit of calm hearing and dialogue with students. Within the framework of health education for the well being of the children, it is significant that there is a complete involvement of children and they be allowed to define their own health agenda. It is only when this much freedom is given to the students then we can expect the success of health literacy for their well being.

e) Role of a teacher

A teacher has a significant role to play if education has to focus on the well being of the students. Most often a teacher is taken as an instructor, someone who transmits knowledge from the book to the minds of the children but in the context of new focus, the teacher's responsibility lies in 'facilitating the learning processes'[10] according to the need of the time, place and environment of the students. A teacher cannot continuously be thundering instructions into the ears of the students as if pouring it through the tunnel. Her/his task lies in inducing the child to think, to observe , to imagine and to distinguish- sometimes clearing the way and at other times leaving it for the students to clear up based upon their reasoning,

reflection and judgment. "Teachers offer an excellent opportunity to children to develop their abilities to think, reason and to argue."[11] It is a pressing need to introduce those activities in the schools that can enhance the children's abilities to critically analyze situations, take independent decisions, empathize with people and work cooperatively towards the well being of all.

A teacher's responsibility lies in teaching students to see the vitality and beauty in themselves and in assisting them in learning rather than just merely teaching. The teachers need to descend from the throne where they are treated as the objects of reverence and be available to offer guidance to those who are in the process of ascending the throne of learning. Mindless injection of knowledge will not open the gateway of well being of students. Instead the school education will have to make efforts towards the development of the humanistic processes that can help in nurturing wisdom and enabling every student's potential to bloom to the fullest.

Aristotle who gave utmost importance to the role of teacher in the well being education of a student said that those who educate children well are more to be honored than even their parents because parents only give the children life but it is the teacher who teaches them the art of living well-the art of well being.[12] In the new role of a facilitator, the teacher becomes 'the guide on the side' rather than 'the sage on the stage.'[13]

Thus the purpose of school education is securing the well being of each and every student. The system of education needs to make it crystal clear that no one's well being can be achieved in utter isolation but in working for the well being of others i.e. in complete harmony with others. Education is always an unending search for the best that is yet to be known. It is an adventure within that is endless, ceaseless and exhilarating. It is only when there is complete harmony amongst all the components of well being for the students that the true worth of school education will come forth. Time for all of us to ponder!

REFERENCES

Aristotle (1992) *The Politics,* London: Penguin Classics.

Aristotle (1998) *The Nichomachean Ethics,* New York: Oxford University Press.

Barrow, Robin (1975) *Plato, Utilitarianism and Education,* London and Boston: Routledge & Kegan Paul.

Costello. Patrick, J.M. (2000) *Thinking Skills and Early Childhood Education,* London: David Fulton Publishers.

Cornelissen, Goele (2010) 'The Public Role of Teaching: To keep the door closed', *Educational Philosophy and Theory,* vol.42, nos.5-6, pp.524-539.

Desjardins, Richard (2008) 'Researching the Links between Education and Well-being', *European Journal of Education,* vol.43, no.1, pp.24-35.

Dewey, John (1972) 'Ethical principles underlying education' in Boydston, J. A. (ed.) *John Dewey:The early works,1882-1898,* vol. 5., pp.54-83, Carbondale: Southern Illinois University Press.

Dewey, John (2008) *The School And Society, (Indian Edition),* Delhi: Aakar Books.

King, Alison (1993) 'From Sage on the Stage to Guide on the Side', *College Teaching,* vol. 41, no. 1 (Winter), pp.30-35.

Kickbusch, I. and Buse, K. (2000) 'Global influences and global responses: international health at the turn of the 21 st century' in Merson, M.H., Black, R.E. and Mills, A. J., (eds.) *International Health: A Textbook. New York:Aspen, pp.701-732.*

Mookerji, Radhakumud (1989) *Ancient Indian Education-Brahminical and Buddhist,* Delhi:Motilal Banarsidass.

Ozoliò , Jânis (Jhon) Tâlivaldis (2010) 'Creating Public Values: Schools as moral habitats' *Education Philosophy and Theory,* vol.42, no.4, pp. 411-423

Rath,Tom and Harter,Jim (2010) *Well Being: The Five Essential Elements,* New York: Gallup Press

Russell, Bertrand (2010a) *On Education,* London and New York: Routledge.

Russell, Bertrand (2010b) *Education and the Social Order,* London and New York: Routledge.

Ruth, Ann Kiefer, RN, MSN, CRNN (2008) 'An Integrated Review of the Concept of Well-Being' *Holistic Nursing Practice, September/October,* vol.22, no.15, pp.244-252.

Varma, Vishwanath Prasad (1977) *Studies In The Philosophy Of Education,* Patna: Jnananda Prakashan.

Life Style Stress Altering Immunity Resulting In Poor Health

Anil Suri

Convener, Cancer Research Program, Cancer Microarray, Genes and Proteins Laboratory, National Institute of Immunology, Aruna Asaf Ali Marg, New Delhi

Abstract: *Although the direct casual relationship between immune response and nervous system is yet to be established, there are growing evidences that stress is indeed involved in weakening of immune response (immunosuppression) which further leads to poor health and affects individual's performance in various aspects of life. This brief review throws more light on the link between immune system and stress and helps in strengthening our knowledge regarding the association between the stressors, immune system and physical health.*

INTRODUCTION

What is the reason being deprived of happiness in life? If we try to find out the answer to this question, we have to first analyze our lifestyle. Life is not as complicated as we have made it by our thinking, deeds and lifestyle. A little bit of stress is an in built process that keeps our body and mind active but long term stress may lead to unhealthy habits such as smoking, eating a poor diet, drinking too much alcohol and not getting enough exercise - adding to the risk of developing health problems. Therefore, there is an urgent need to understand the causes of stress and learn to cope with it. Here an attempt is made to unravel the underlying physiological and psychological link between immune system and nervous system. This article defines the symptoms, causes and management strategies of lifestyle stresses and also touches upon the effect of long term stress on immune system of the body.

WHAT IS STRESS –LIFE OR DEATH?

Stress is defined as body's response to any situation or demand. The stress causing situation or pressure is known as stressor. Although a certain level of stress is actually good for individual growth as a person, because it helps us in accelerating the magnitude and quality of efforts in achieving the desired goal. During stress, our endocrine system and nervous system orchestrates to combat the situation leading to the rise in pulse rate, building of tension in muscles and rise in blood pressure (commonly known as Flight-or-Fight response). All these body's responses help to cope with the difficult situations. When these stress hormones continue to circulate in the bloodstream and perturbs the person's psychological homeostasis, it becomes detrimental to health. Long term stress can contribute to weak immunity, resulting in health problems such as depression, anxiety, heart disease, stroke and high blood pressure.

WHAT ARE LIFESTYLE STRESSES AND HOW TO RECOGNIZE THEM?

Lifestyle stress is a common problem caused by unhealthy lifestyle, time mismanagement, disorganized work schedule and eating habits. People have different responses towards different situations. A situation or event which is very stressful for someone may not be as difficult for others. Some people are at high risk towards stress related physical problems. For example, people who drive them hard and are impatient are more prone to the psychological and physical disorders. Moreover, stressed individuals become more susceptible to various infection, cancer, high blood pressure, heart attack, stroke, autoimmunity disorders. The most common life stressors are bereavement, academic exams, marital strain and divorce, social isolation, work, mental traps and lifestyle behaviors. The symptoms of lifestyle stress may present symptoms such as irritability, anxiety, lack of concentration, confusion resulting in lack of decision making process, poor judgment, frustration, emotional withdrawal and anger. Suffering from lifestyle-related stress can also affect one's ability to meet deadlines, make decisions, and manage professional relationships

Correspondonce: Anil Suri, *E-mail: anil@nii.res.in*

at the academic and professional front.

WHAT ARE THE FACTORS INFLUENCING THE STRESS SUSCEPTIBILITY?

A person's susceptibility to stress can be affected by many factors and may not be constant throughout his/her life. Childhood experiences, personality traits, emotional instability, genetics and lifestyle are some of the factors which determine the person's tolerance to stress.

WHAT HAPPENS TO YOUR BODY WHEN YOU ARE STRESSED?

Our body has a well defined physiological mechanism to cope with stress. However, if these mechanisms are in activated state for a long time, it may result in to psychological disorders such as depression and anxiety. There are two types of stress responses which are:

- **Acute Stress Response:** The acute stress response is an immediate physiological response to a situation resulting in a stressful event. The body's immediate response in such situation is to release chemicals, called "stress hormones," which alters body's physiological process in positive loop to cope up with such stresses. These physiological processes mainly act at muscle and brain tissues, and certain cells of the immune system which in turn become more active.
- **Chronic Stress Response:** Chronic stress occurs when a person has continuous acute stress responses. Chronic stress results in more sustained changes in the body resulting in high blood pressure and weakening the immune system responses to various infections. This also changes the pathways for continuous increase in stress hormones, which result in suppression of the immune system's white blood cells, leading to an increased risk of infections.

STRESS AND IMMUNE FUNCTION

How does stress affect immune response?

Immune system is a kind of a "body fighting machine" that almost reflects the harmonics of the way we perceive our outer and inner environment. Internal factors such as stress have been implicated in causing a deficient immune system. It is now being recognized that psychological stress influences inflammatory responses which cause inflammation of various mucosal system and mood. There is increasing understanding that social and psychological stressors such as anxiety, social isolation or insecurity affect health. Depression, for example, was the 4th leading contributor to the global burden of disease in 2000 and is projected to be in second place in 2020[1].

Frequent activation of stress hormones in the case of chronic stresses results in weakening of the immune response. A study in the New England Journal of Medicine actually found that higher psychological stress levels resulted in a higher likelihood of catching the common cold[2, 3]. The conclusion made in this regard is quite astonishing which details that stress is indeed directly associated with weak immunity in spite of the reason associated with are various such as, the season; alcohol use; quality of diet, exercise, and sleep; and levels of antibodies before exposure to the virus. In addition some people who have a chronic illness may find that the symptoms of their illness flare up under an overload of stress. Markers of immune function provide a useful window onto the study of psychosocial stress, as a key pathway through which stress influences health status is through suppression of immune function. A growing body of literature has documented the links between immunosuppression and a range of life stressors[4-6].

Immune system is basically a well coordinated system which takes care of the body by killing the foreign pathogens and abnormal body cells. It comprises of leucocytes (white blood cells) which can be divided in to three classes: Lymphocytes, Monocytes and Granulocytes. Each type of cell performs its own function and orchestrates with each to kill pathogens. These various types of cells communicate with each other by certain chemical messengers called as cytokines. Lymphoid organs are parts of the immune system which are the functional site for antigen presentation, activation of B and T lymphocytes and polarization of cytokine responses[7]. These lymphoid organs are innervated by sympathetic division of autonomic nervous system[8]. Sympathetic nervous system (SNS) is part of the autonomic nervous system that acts as a control system functioning largely below the level of consciousness, and controls various vital physiological functions. It affects heart rate, digestion, respiration rate, salivation, perspiration, and diameter of the pupils. It is mainly responsible for inducing Flight-or-Fight response. Molecular pathways for neural–immune interaction are well defined[9] and their functional capacity is increasingly recognized [10], but their physiological role remains unclear. Recent studies have shown that stressors can alter the lymph node neural structure resulting in changes in secretion of chemicals called "cytokines" profiling of the organ[11] and which in turn causes immune-suppression[7]. The suppression of

immune system cannot cope up with various communicable infections which attack our body and further results in poor health and performance.

This coordination between immune system and nervous system is under highly controlled homeostasis and balance[12]. Both physiological and psychological components are equally important to maintain this balance. Long term stress may perturb this homeostasis leading to the various psychological and physical disorders[13].

WHAT ARE THE IMPACTS OF STRESS ON OUR HEALTH AND INFECTION RATES?

Stress may influence body's immune response either through the involvement of the central nervous system (CNS) and immune system (nerves terminating in lymphoid organs), or through neuro-endocrine-immune pathways (release of hormones). It is important to remember that there are many factors involved in getting an infectious disease. The distraction of stress on the mind interferes with focus and concentration, which can contribute to poor health, absenteeism and even to higher infection rates. Having a positive attitude seems to correlate with an increased ability of the immune system in fighting diseases. Psychological stress is known to affect immune function that may assist in predicting infectious disease susceptibility, as reported in both humans and animals[14]. A UNC-Chapel Hill study, published in 2000, found that men with HIV progressed to AIDS faster if they had chronic stress in their lives[15]. For each increased stressful event, the risk for AIDS progression doubled in these patients. Other studies have linked chronic stress with tuberculosis, herpes simplex virus reactivation, shingles, ulcers (caused by infectious *Helicobacter pylori* bacteria) and other infectious diseases[16-18]. Some studies of vaccinations have shown a decrease in effectiveness in individuals with high chronic stress[19].

STRESS MANAGEMENT

What can be done to treat the stress?

The best thing we can do to maintain the stress free life is to adopt positive attitude and access psychological first aid. The stressed patient needs continual positive reinforcement to improve their self-confidence. In the long-term, behavioral therapy or medication might be beneficial based on the individual.

What can be done to minimize the stress?

No doubt, stress is an integral part of life. The key of managing stress in life is to be able to recognize stressors and understand whether they come from an outside sources or whether they are self provoked. Effective stress management is a lifestyle and we must learn to incorporate into our daily lives. A commitment to live a healthier lifestyle should never take a back seat, especially not to stress. Stress management is not only an urgent need in today's fast-paced lifestyle, but an important factor in both physical and mental health. The purpose of stress management is to help in recognition of root causes of stress in life and find ways of managing the pressures without compromising with health.

- **Sharing the feelings:** Suppressing of emotions could be a stress factor which could affect our health. This in fact results in lowering the response of our immune system. It has been observed that individuals who disclosed and share a tragic event seemed to have a better immunity in terms of immune response and generally are healthier than those who inhibit expression of such emotions. There is considerable evidence in the literature that discussing about such problems improves the immunity in terms of fighting with day to day infections and has better health, self confidence, and mental health[20].
- **Be Clear On Priorities:** People become overscheduled because they add activities to their schedules for the wrong reasons, and end up spending their days doing things that don't reflect their values and priorities. Then they find themselves struggling to fit in what's important to them. Necessities like adequate sleep and other healthy habits fall by the wayside. Therefore, it's important to set up the priorities and move accordingly.
- **Time-management and organization skills** are crucial for fighting stress and are not often taught in the schools. This is most important aspect which should be taught especially when kids are in their formative phase. Help your kids stay on track after school and at night, allowing short breaks but no TV until the work is finished. Provide your child with a planner to schedule assignments; create a quiet space to study free of distractions; bump up homework to after school rather than after dinner.
- **Lifestyle stress in children:** Inferiority complex, superiority complex, identity crisis and depression play an important role in bringing negativity in children. Most of these aspects are consciously or inadvertently thrust on children by adults. The rising influence of media influences children watching TV serials and fashion shows with skinny models, to live on adult levels prematurely. It is imperative that

parents, elders or guardians recognize these stress symptoms and address the stressful situation so that the child gets to lead a normal, happy life.

- **Nutrition** : Diet is an influential and very important constituent of health factor that determines one's ability to function mentally and physically. We must ensure that a balanced amount of nutrients having diverse types of foods should be taken to keep our bodily functions in proper order. Food selection during early school years has an impact in people's future eating habits and overall performance. Thus, it is important for kids to learn how to get proper nutrition to keep their cognitive performance at its peak once they embark into the stressful life.
- **Sleep** is a natural way to recharge the tired body. Research revealed that sleep deprivation can cause drowsiness during the day. Sleep is an important physiological process where most of the organ's regeneration and growth takes place. Especially children who don't sleep well cannot perform well because of lack of concentration and thinking process. This prevents them from being productive. Since the physical state is intertwined with mental well-being, sleep-deprived students tend to suffer from poor mental performance as well.

SUMMARY

In summary, developing the ability to learn from your mistakes is one of life's most important skills. When facing potential stressors, the way we view what we're experiencing can accelerate our stress. What one needs is to handle the stresses by seeking the help of psychologist-recommended methods for looking at things in ways that may result in feeling of less stress and also encourage a greater sense of self control with peace. Reversing negative ideas and learning to focus on positive outcomes helps in reducing stress and improves performance.

REFERENCES

Bellinger DL , Millar BA et al. Innervations of lymphoid organs: Clinical implications *Clini Neurosci Res 2006; 6 (1-2): 3-33.*

Cohen S, Tyrrell DA. Psychological stress and susceptibility to the common cold. *N Engl J Med* 199; 325: 606-12.

Freestone PP, Sandrini SM et al. Microbial endocrinology: how stress influences susceptibility to infection. *Trends Microbiol. 2008; 16(2):55-64.*

Glaser R, Rabin B et al. Stress-induced immunomodulation-implications for infectious diseases? *JAMA* 1999; 281: 2268-70.

Jackson AC, Kammouni W et al. Role of oxidative stress in rabies virus infection of adult mouse dorsal root ganglion neurons. *J. Virol.* 2010; 84(9): 4697-4705.

Kiank C, Zeden J et al. Psychological stress-induced, IDO1-dependent tryptophan catabolism: implications on immunosuppression in mice and humans. *Plos one* 2010; 5(7): 1-11.

Leserman J, Petitto JM et al. Impact of stressful life events, depression, social support, coping, and cortisol on progression to AIDS. *Am J Psychiatry* 2000; 157: 1221-28.

Madden KS, Moynihan KS et al. Sympathetic nervous system modulation of the immune system.III. Alterations in T and B cell proliferation and differentiation in vitro following chemical sympathectomy. *J. Neuroimmunol.* 1994; 49:77-87.

Marslanda AL, Bachen EA et al. Stress, immune reactivity and susceptibility to infectious disease. *Physiol. Behav.* 2002; 77: 711–16.

Miller GE, Cohen S et al. Psychological stress and antibody response to influenza vaccination: when is the critical period for stress, and how does it get inside the body? *Psychosom Med.* 2004; 66(2): 215-23.

Neu J. Use of nutrition to prevent stress-induced immunosuppression in the pediatric intensive care unit: a clinical trials minefield. *J Parenter Enteral Nutr* 2009; 33(4): 440-41.

O'Leary A. Stress, emotion, and human immune function. *Psychol Bull.* 1990; 108(3):363-82.

Patel V, Prince M. Global mental health: a new global health field comes of age. *JAMA* 2010; 303(19): 1976-7.

Pedersen A, Zachariae R et al. Influence of psychological stress on upper respiratory infection—a meta-analysis of prospective studies. *Psychosom Med* 2010; 72: 823-32.

Ronald Glaser et al. Stress-induced immune dysfunction: implications for health. *Nat Rev Immunol* 2005; 5: 243-51.

Schwab CL, Fan R et al. Modeling and predicting stress-induced immunosuppression in miceusing blood parameters. *Toxicol Sci* 2005; 83: 101–13.

Schubert C, Schussler G. Psychoneuroimmunology: an update. *Z Psychosom Med Psychother* 2009; 55(1): 3-26.

Sloan EK, Capitanio JP et al. Social stress enhances sympathetic innervations of primatelymph nodes: mechanisms and implications for viral pathogenesis. *J. Neurosci.* 2007;27(33): 8857-65.

Sloan EK, Capitanio et al. Invited minireview: Stress-induced remodeling of lymphoid innervations, *Brain Behav Immun.* 2008; 22(1): 15-21.

Willard-Mack CL. Normal structure, function, and histology of lymph nodes. *Toxicol Pathol* 2006; 34: 409-24.

Be Cholesterol Fit in Young Age (To have Healthy Heart and Healthy Brain)

H.K. Chopra

Chief Cardiologist, Moolchand Medcity; Editor-in-Chief Indian Heart Journal; Chairman, World Heart Academy (WHA); Vice President, CSI DB; Co-Chairman Health Committee, ASSOCHAM; Vice Chairman, WASS;

Abstract: *It is very important for all of us to understand about the beneficial and harmful effects of cholesterol. In fact, cholesterol is just one of the many substances created and used by our bodies to keep ourselves healthy. Cholesterol promotes synthesis of cell membranes and is a very important component of many hormones in our body. It is also an important component of bile acids, which are required for digestion. Unfortunately, cholesterol does not get processed in a beneficial way every time. In other words, an elevated level of bad cholesterol is a major risk factor for the rising epidemic of heart attack, brain attack, leg attack and metabolic syndrome in our country.*

INTRODUCTION

What is Cholesterol and Metabolic Syndrome?

Cholesterol is a waxy, soft, fat-like substance found in all body cells and it does not dissolve in blood plasma. Most of the cholesterol found in the body is produced in the liver. 20-30% comes from the food we eat, which is necessary for the body, but having too much of it in your body can cause problems. Cholesterol is essential for life, cell membranes, growth hormones and sex hormones. However, high levels of bad cholesterol such as total cholesterol (CH), triglycerides (TG) and low density lipoproteins (LDL) may lead to premature hardening of the arteries in the heart, brain, peripheral arteries, aorta, kidney arteries, mesenteric arteries, carotid arteries or arteries in the eyes, etc. Narrowing of the arteries reduces the blood supply to the tissues, thereby reducing oxygen and causing tissue damage. High levels of bad cholesterol and low levels of good cholesterol (HDL – High Density Lipoproteins) may be responsible for premature heart attack, brain attack or leg attack in the younger population, especially those who are obese, smokers and diabetics and suffering from metabolic syndrome.

Metabolic syndrome is a cluster of potbelly (>90 cm in men and >80 cm in women), hypertension, high TG (>150 mg %), low HDL (<40 in men and <50 in women) and high fasting blood sugar (>110 mg %). I firmly believe that metabolic syndrome is an occult terrorist in South-East Asia, which sows the seed of premature heart attacks and brain attacks in our country. Metabolic syndrome prevalence, as documented in different parts of the world in community-based data, varies from 40-45%. In our own study from Moolchand Medcity Metabolic Syndrome Study (MMMSS 2007) published in Indian Heart Journal, we have shown that there is a rising trend of metabolic syndrome in in-hospital population; the overall prevalence is 65%. It is more in women, up to 70% and is 60% in men. It is highly prevalent in the age group of 40-50, because of faulty lifestyle including lack of exercise, eating the wrong food rich in cholesterol, at a wrong time, in the wrong place, in the wrong manner, in the wrong environment and because of negative stress such as negative competition, feelings of hatred, vengeance, vindictiveness, cynicism, hostility, excessive smoking and consumption of excessive alcohol, consuming less fruits, vegetables and nuts.

I firmly believe that "most of us are walking emotional time-bombs of metabolic syndrome with seeds of

Correspondonce: H.K. Chopra*, E-mail: drhkchopra@yahoo.com*

premature CVD (Cardiovascular Disease) including heart attack, brain attack and leg attack in us. The time to combat is now by lifestyle optimization and timely, effective medicalisation".

What are the sources of cholesterol?

Cholesterol is derived from two sources: it is manufactured in our body mostly in the liver and is found in foods from animal sources such as meat, egg yolk and milk products. Triglycerides (TG) are derived only from diet sources. Cholesterol derived from dietary sources is called as exogenous and the one synthesized in the liver is called as endogenous cholesterol. Please remember, any food from plant sources does not contain cholesterol.

What are the types of cholesterol?

Cholesterol can be classified as Bad Cholesterol and Good Cholesterol. The bad cholesterols are total cholesterol (CH), triglycerides (TG), low density lipoproteins (LDL) and very low density lipoproteins (VLDL). Good cholesterols are high density lipoproteins (HDL), which can be HDL-1, 2 & 3. The Bad Cholesterol increases the risk of heart attack, brain attack (paralysis) and leg attack (peripheral vascular disease). Oxidised high LDL cholesterol in excess forms plaque in the arteries and increases the risk of atherosclerosis (hardening of the arteries). Lp cholesterol is a genetic variation of LDL (Bad Cholesterol). A high level of Lp (a) is a significant risk factor for the premature development of fatty deposits in the arteries. On the other hand, Good Cholesterol (HDL) is protective to the heart and brain and removes excess of cholesterol from the plaque and slows their growth, sometimes even decreasing its size. It lowers the risk of heart attack and brain attack.

What is the relationship of cholesterol and your arteries?

Cholesterol and other fats can build up in the walls of your blood vessels (arteries), feeding the heart and the brain. This condition is called as atherosclerosis, which is a type of arteriosclerosis. The name comes from the Greek words athero (meaning gruel or paste) and sclerosis (meaning hardness). It is the term for the process of fatty substances, cholesterol, cellular waste products, calcium and fibrin (a clotting material in the blood) building up in the inner lining of the artery. The buildup that results is called plaque. These plaques may be vulnerable or non-vulnerable. Vulnerable plaques may rupture, as they have thin fibrous cap, with high lipid core, and it promotes clot formation. This in turn narrows the arteries and diminishes blood supply to the heart, thereby causing heart attack, reducing blood supply to the brain, causing brain attack (paralysis), reducing blood supply to the lower limbs, causing leg attack. Cholesterol and other fats are transported in the blood to and from the cells by special carriers called lipoproteins. There are several kinds of lipoproteins. We are most concerned with two of them, i.e., Low Density Lipoproteins (LDL) and High Density Lipoproteins (HDL), both of which are carriers for cholesterol.

What are the normal and risk levels of cholesterol?

Normal range of blood cholesterol is 150-250 mg/dl. Ideally, the recommended levels of blood cholesterol in an adult should be <150 mg/dl. The cholesterol levels <200 mg/dl are desirable, 200-239 mg/dl are borderline-high risk, and >240 mg/dl are high risk levels.

The LDL cholesterol levels range from 70-150 mg/dl. Ideally, the recommended levels of LDL in adults should be <70 mg/dl. The LDL levels of <100 mg/dl are considered as optimal, 100-129 mg/dl are near optimal, 130-159 mg/dl are borderline high risk, 160-189 mg/dl are high risk and >190 mg/dl are very high risk.

The triglyceride levels normal level is <150mg/dl, 150-199 mg/dl is borderline high risk, 200-499 mg/dl is high risk, and >500 mg/dl is very high risk.

The recommended level of VLDL in adults should be 24-45 mg/dl.

Higher levels of HDL cholesterol are better. The normal HDL cholesterol levels should be >40 mg/dl in males and >50 mg/dl in females. Lower levels of HDL (<40 mg/dl for men and <50 mg/dl for women) puts you at higher risk for heart attack and brain attack.

The cholesterol/HDL ratio should be <4 and LDL/HDL ratio should be <3. Similarly, cholesterol/HDL ratio of >4, LDL/HDL ratio of >3 and LDL levels of >150 mg/dl have higher risk for brain attack and heart attack.

Is cholesterol harmful or beneficial?

Cholesterol is very important for life. It promotes synthesis of cell membranes, growth hormones, sex hormones and various other hormones. It is also necessary for synthesis of bile salts. However, in certain situations in which cholesterol levels are higher than normal, it may get deposited in the arteries, supplying

blood to the heart muscle, causing angina of effort, followed by angina at rest or heart attack (complete blockage of the artery supplying blood to the heart. Similarly, it may diminish blood supply to the brain, causing TIA (Transient Ischemic Attack) or Brain Attack (Paralysis).

How is high triglyceride level harmful to the body?

The source of triglycerides is diet. If high, it may be an independent risk factor for heart attack and brain attack. Individuals with high levels of triglycerides of >200 mg/dl are two times more vulnerable to suffer from atherosclerosis than those with lower levels. The main strategy to reduce triglyceride levels is by optimizing the lifestyle by eating low fat, low sugar and low cholesterol diet, regular exercise, reduce alcohol consumption, sometimes drugs may be required to reduce the triglyceride levels with the help of the treating physician.

What are the facts about fats?

Saturated fats are solid at room temperature. They are found in fats of animal origin such as beef, butter and cream. Coconut oil, though of plant origin, is solid at room temperature and has high saturated fat content. Increase in consumption of saturated fat increases cholesterol levels. On the contrary, unsaturated fats are liquid at room temperature. The sources of polyunsaturated fats are plants such as sunflower, corn and soyabean. Consumption of polyunsaturated fat oils lowers the blood cholesterol levels. Monounsaturated fats are in olive, peanut and avocado oils, which also lower cholesterol levels.

What is the relationship between cholesterol and alcohol?

Drinking too much alcohol can raise the blood pressure, cause heart failure and lead to brain attack and heart attack. It can contribute to high triglycerides, high blood pressure and irregular heartbeats and may also contribute to obesity. Alcohol excess increases tendencies for metabolic syndrome, suicides and accidents. Alcohol consumption of 1-1.5 ounces per day may increase the levels of HDL. However, there are many other methods to increase the levels of HDL. The dangers of alcohol outweigh its benefits. It is, therefore, not recommended that non-drinkers should start using alcohol or that drinker's increase the amount they drink.

What is the relationship between smoking and cholesterol?

Smoking or tobacco consumption in any form lowers the level of HDL. The HDL level decline is greater in women smokers, as compared to men.

What is the relationship between stress and cholesterol?

Stress is a well-known killer. A number of studies have shown that cholesterol levels are high during different types of stresses such as facing an interview, before examinations, during training, loss of jobs, during surgery, difficult labor and many other stressful situations.

What is the relationship between age and cholesterol?

Advanced age is usually associated with high levels of cholesterol.

What is the relationship between sex of an individual and cholesterol?

It has been shown that before menopause, women tend to have fewer incidences of heart attacks than men. This is because women have high levels of HDL and low ratio of Cholesterol/HDL.

What is the relationship between coffee and cholesterol?

It has been shown in various research studies that excess of coffee consumption (>4 cups per day) is associated with lower levels of HDL and higher levels of triglycerides and cholesterol. Excessive coffee drinking is seen in stressful individuals.

What are the precautions one should undertake before undergoing lipid profile test?

It is important that one should be fasting, at least for 12 hours, before undergoing blood test for lipids. One can take only water. Triglyceride levels may be elevated if one does not fast. It has been shown that cholesterol values may be high if high intake of saturated fats or cholesterol-laden food or excess of alcohol is consumed 24 to 48 hours prior to the test.

What is the role of diet in reducing cholesterol?

Change in diet is the first step to control high blood cholesterol. The recommendations are to reduce the fat intake, so that less than 10% of total calories come from saturated fat and not more than 10% from

polyunsaturated fats. Eat more of vegetables, fruits and nuts. One can have fish or chicken, but no red meat. One should avoid yolk of an egg. However, one can have egg white. One should avoid junk food, over fried food such as puri, halwa, paratha, samosa, pakora, cutlets, butter naan, fried potato chips, etc.

What are the benefits of exercise?

Regular heart-friendly exercises such as walking, wogging, jogging, swimming, dancing, cycling and treadmill are excellent for a healthy heart and reduce the level oF bad cholesterol and increase the level of good cholesterol. 30 minutes of exercise daily is a must.

In general, reducing the total levels of cholesterol by 1% will reduce the risk of heart attack by 2%. For example, lowering blood cholesterol from 250 to 200 mg/dl reduces the risk of heart attack by 40%.

What should be the type of lifestyle optimization to have healthy heart, healthy brain and cholesterol-fitness?

- Exercise regularly, 30 minutes every day.
- Do not smoke or chew tobacco.
- Do not eat junk food.
- Eat more of fruits, vegetables, salads, sprouts and nuts.
- Do not consume excess of alcohol.
- Learn to cope with stress by practicing yoga and meditation on a regular basis.
- Maintain your abdominal girth at <90 cm in men and <80 cm in women.
- Eat the right food at the right time, in the right place, in the right dose, in the right environment.
- Have an annual health check-up after the age of 30.

CONCLUSION

I firmly believe that optimization of lifestyle in a disciplined manner, right from the childhood, including regular exercise, abstinence from smoking/excessive alcohol, junk and fast food, coping with negative stress by practice of yoga and meditation, will enhance cholesterol fitness with healthy heart and healthy brain.

REFERENCES

Ahluwalia N, Drouet L, Ruidavets JB, et al. Metabolic syndrome is associated with markers of subclinical atherosclerosis in a French population-based sample. *Atherosclerosis,* 2006; 186:345–353.

Haffner S M, Lehto S, Ronnemaa T, et al. Mortality from coronary heart disease in subjects with type 2 diabetes and in non-diabetic subjects with and without prior myocardial infarction. *NEJM,* 1998; 339: 229-234.

H. K. Chopra K. K. Aggarwal, Krishna C. K, Ravinder S. Sambi, [1]S.K.Parashar, Rakesh Gupta, R.R.Kasliwal, Sanjay Mittal, Manish Bansal, A.K.Gaur, V. Anand, A.Vermani, Jagadeesh. K.N, Sandeep Mishra, [1]Navin C Nanda.et al. 3D Echocardiography: The Most Powerful Predictor of Masked CVD in Metabolic Syndrome, *Indian Heart Journal,* March 2010

Hu G, Qiao Q, Tuomilehto J, et al. DECODE Study Group. Prevalence of the metabolic syndrome and its relation to all-cause and cardiovascular mortality in nondiabetic european men and women. *Arch Intern Med. 2*004; 164: 1066–1076.

Isomaa B, et al. Cardiovascular morbidity and mortality associated with the metabolic syndrome. *Diabetes Care, 2*001; 24:683-689.

Lakka T A, et al. The metabolic syndrome and total and cardiovascular disease mortality in middle-aged men. *JAMA,* 2002; 288:2709-2716.

FIRST AID: MOUNTING CONCERN IN SCHOOLS

Jitendra Nagpal* , Priyanka Gera, Satish Bhardwaj***, Rupinder Sharma******

** Program Director, Expression India, New Delhi*

*** Senior Resourse Person, Expression India, New Delhi*

**** Director Goodmans Rescue Services, New Delhi*

***** Senior Resourse Person, Expression India, New Delhi*

Abstract: *First aid can save lives and prevent minor injuries becoming major ones. Every management employer should ensure that there are adequate and appropriate equipments and facilities for providing first aid in the workplace.*

It is for schools to enhance their own policies and procedures, based on an assessment of local needs. Most schools will already have first-aid arrangements in place, and this guidance draws on existing good practice. It provides advice for schools on drawing up first-aid practices and ensuring that they are meeting their promise of a healthy environment and in particular, includes a checklist of issues which schools may find helpful when undertaking a risk assessment.

INTRODUCTION

List of the items which should be in a standard first-aid kit are:

- a suitably stocked first-aid container /box
- Appointed person to take charge of first-aid arrangements
- Information for staff and employees on first-aid arrangements

This minimum provision must be supplemented with a risk assessment to determine any additional provision. First-aid provision must be available at all times while people are on school premises, and also off the premises whilst on school visits.

FIRST AID IN SCHOOLS - WHO IS RESPONSIBLE?

a) The Management/authorities

It is a moral and legal duty of the management to take care of the health and safety of their staff, employees and anyone else on the premises. In schools this includes responsibility for the head of the institution and teachers, non-teaching staff, pupils and visitors. Schools should have the health and safety policy in place. This should include arrangements for first aid, based on a risk assessment of the school, and should cover:

- Numbers of first aiders / appointed persons;
- Numbers and locations of first-aid containers;
- Arrangements for off-site activities/trips;
- Out of school hour's arrangements e g boarding houses, annual day, sports day, other events.

It is the management's responsibility to make sure that the all requirements for provision of first aiders are met, that appropriate training is provided and recommended procedures are followed. The management should be satisfied that the training given to the staff is sufficient and ensure their understanding, confidence and expertise.

b) The Head of the Institution - Principal

The head of the institution is responsible for putting the policy into practice and for developing detailed procedures. The head of the institution should also make sure that parents are aware of the school's health and safety policies, including arrangements for first aid.

c) Teachers and Other School Staff

Teachers' conditions of employment do not include giving first aid, although any member of staff may volunteer to undertake these tasks. Teachers and other staff in charge of pupils are expected to use their best endeavours at all times, particularly in emergencies, to secure the welfare of the pupils at the school in the same

***Correspondonce: Dr. Jitendra Nagpal**, E-mail: jnagpal10@gmail.com*

way that parents might be expected to act towards their children. The head of the institution must arrange adequate and appropriate training and guidance for staff who volunteer to be first aiders/appointed persons.

WHO IS AN APPOINTED PERSON AND WHAT ARE HIS MAIN DUTIES?

An appointed person is someone who:

- Takes charge when someone is injured or becomes ill;
- Looks after the first-aid equipment e. g. restocking the first-aid container;
- Ensures that an ambulance or other professional medical help is summoned when appropriate.

ambulance or other professional medical help is summoned when appropriate.

Appointed persons may not be first aiders. They should not give first aid treatment without training. However, it is a good practice to ensure that appointed persons have emergency first aid training/refresher training. The course should cover the following topics:

s may not be first aiders. They should not give first aid treatment without training. However, it is a good practice to ensure that appointed persons have emergency first aid training/refresher training. The course should cover the following topics:

- What to do in an emergency;
- Cardiopulmonary resuscitation (CPR);
- First aid for the unconscious casualty;
- First aid for the wounded or bleeding.

At school, the main duties of a first aider are to:

- Give immediate help to casualties with common injuries or illnesses and those arising from specific hazards at school;
- When necessary, ensure that an ambulance or other professional medical help is called.

Emergency first-aid training should help an appointed person cope with an emergency and improve their competence and confidence.

First Aid - What do Schools Need to do?

- Provide adequate and appropriate equipment, facilities and qualified first aid personnel.
- Make suitable and sufficient assessment of the risks to the health and safety of their staff at work, and others who may be affected by their undertaking.
- To identify what measures they need to take to prevent or control these risks.
- The Management and/or head of institution should regularly review the school's first-aid needs (at least annually), and make subsequent changes at the earliest.
- The head of the institution must inform all staff (including those with reading and language difficulties) about the first-aid arrangements. This should include the location of equipment, facilities and first-aid personnel, and the procedures for monitoring and reviewing the school's first-aid needs.
- A simple method of keeping staff and pupils informed is by displaying first-aid notices in staff/common rooms. The information should be clear and easily understood. Including first-aid information in induction programmes will help ensure that new staff and pupils are told about the first-aid arrangements. It is a good practice to include such information in a staff handbook and student's almanac also.

RISK ASSESSMENT OF FIRST-AID NEEDS – WHAT SHOULD SCHOOLS CONSIDER?

Schools normally include staff, pupils and visitors when carrying out risk assessments for first-aid needs.

POINTS TO CONSIDER

a) Location and size of the school

- **Is it remote from emergency services?**
  It is good practice to inform the local emergency services, in writing, of the school's location and any particular circumstances that may affect access to the school. Size of the school is also important. The governing body/head of institution needs to consider additional first aid provision if there is more than one building, how many first-aid personnel are needed to provide adequate cover on each floor on a split-level site and outlying buildings, and on each site of a split-site school.
- **Are there any specific hazards or risks on the site?**
  Hazardous substances such as dangerous tools and machinery or Temporary hazards, such as building or maintenance work, should also be considered and suitable short-term measures must be put in place.

- **Accident statistics**
  Accident statistics can indicate the most common injuries, times, locations and activities at a particular site. These can be a useful tool in risk assessment, highlighting areas to concentrate on and tailor first-aid provision to.
- **How many first-aid personnel are required?**
  There are no rules on exact numbers. Management has to make a judgement based on its own circumstances and a suitable and sufficient risk assessment. School Authorities should consider the likely risks to students as well as staff and employees, when drawing up policies and deciding on the numbers of first-aid personnel. As a general guide, they recommend that:
  i. A lower risk place of work (e.g. shops, offices, libraries), with 50-100 employees, should consider having at least one first aider;
  ii. A medium risk place of work (e.g. light engineering and assembly work, food processing) with 100-500 employees or people on campus, should consider having at least one first aider for every 50 employees (or part thereof).
  iii. A high risk place of work (e.g. manufacturing units) with 500-1000 or more employees or people on campus, should consider having at least one first aider for every 50 employees (or part thereof).
  iv. Schools generally fall into the medium risk category, but some schools or areas of activity may fall into the high risk category. Schools should base their provision on the results of their risk assessment. If there are parts of the school where different levels of risk can be identified, the employer should consider the need to make different levels of provision in different areas/departments.

b) Selection of first aiders

Unless first-aid cover is part of a member of staff's contract of employment, people who agree to become first-aiders do so, on a **voluntary basis.** When selecting first aiders, school authorities should consider the individual's:

1. A proactive interest in Health Education.
2. Learn new skills like Reliability and Communication skills, Aptitude and ability to absorb new knowledge
3. Ability to cope with stressful and physically demanding emergency procedures and situations.
4. Must be readily available and accessible

c) Contacting first-aid personnel

Do all school staff know how to contact a first aider? Are there agreed procedures in place if an emergency occurs in an isolated area, e.g. on the playing field? Governing bodies/head of institutions should consider how best to let everyone know the school's first-aid arrangements. Procedures need to be in place that are known, understood and accepted by all. Information should be given about the location of first-aid equipment, facilities and personnel. First-aid notices should be displayed which are clear and easily understood by all.

First Aid Training: Procedures and Refreshers

Training courses cover a range of first aid competencies. The school should arrange appropriate training for their first-aid personnel. Technical organisations/ Hospitals/Health Education providers will often tailor courses specifically to schools' needs. It is helpful to let the training organisation know in advance of any particular areas that should be covered. School authorities should arrange refresher trainings and retesting of competence to the First Aiders. Schools should keep a record of the First Aiders and their training updates.

First-Aid Materials, Equipment and First Aid Facilities

School authorities must provide the proper materials, equipment and facilities at all times. First-aid equipment must be clearly labelled and easily accessible.

- **How many first-aid boxes should a school have?**
  Every school should provide at least one fully stocked first-aid container for each site. The assessment of a school's first-aid needs should include the number of first-aid containers. Additional first-aid containers will be needed for split-sites/levels, distant sports fields or playgrounds, any other high risk areas and any offsite activities.

  The sitting of first-aid boxes is a crucial element in the school's policy and should be given careful consideration. If possible, first-aid containers should be kept near to hand washing facilities.

- **Contents of a first-aid container (Refer to Annexure VII)**
- **First-Aid containers for travel**
  Before undertaking any off-site activities, the head of institution should assess what level of first-aid provision is needed. It is recommended that, where there is no special risk identified, a **minimum** stock of first-aid items for travelling first-aid containers is:
- A leaflet giving general advice on first aid
- Six individually wrapped sterile adhesive dressings;
- One large sterile unmedicated wound dressing - approximately 18cm x 18cm;
- Two triangular bandages;
- Two safety pins;
- Individually wrapped moist cleansing wipes;
- One pair of disposable gloves.

Equivalent or additional items are acceptable. Additional items may be necessary for specialized activities and schools should be geared up for the same

- **School Transport/Public Service Vehicles**
  Transport Regulations require that all minibuses and public service vehicles used either as a school vehicle or contract carriage have on board a first-aid container with the following items:
  - Ten antiseptic wipes, foil packaged;
  - One conforming disposable bandage (not less than7.5 cms wide);
  - Two triangular bandages;
  - One packet of 24 assorted adhesive dressings;
  - Three large sterile unmediated ambulance dressings (not less than 15 cm x 20 cm);
  - Two sterile eye pads, with attachments;
  - Twelve assorted safety pins;
  - One pair of rustless blunt-ended scissors.

This first-aid box/container shall be:

- Maintained in a good condition;
- Suitable for the purpose of keeping the items referred to above in good condition;
- Readily available for use; and
- Prominently marked as a first-aid container.

HYGIENE / INFECTION CONTROL

All staff should take precautions to avoid infection and must follow basic hygiene procedures. Staff should have access to single-use disposable gloves and hand washing facilities, and should take care when dealing with blood or other body fluids and disposing of dressings or equipment.

REFERENCES

A Sigh of Relief, The First-Aid Handbook for Childhood Emergencies, Martin I. Green (1984)

American Red Cross; Community CPR, USA (1988)

CBSE, *School Health Manuals, Comprehensive School Health Programme Activity Manuals. (Vol. I – IV), (2007)*

Document of the Committee on School Health, Renuka Ray committee (1960,1962),

"Expressions India" – The Life Skills Education & School Wellness Program (2001), *Common Developmental, Behavioural & Learning Problems in Children (Vol. I – III),* New Delhi, India. (2004-2006)

First Aid Manual, Dorling Kindersley Limited, London (1999)

First Aid for Children Fast – Emergency Procedures for all parents and Carers, Sir Peter Beale, London (1999)

National Health Policy, Govt. of India. (1983)

National Policy on Education (1986, Revised 1992)

Ohio Department of Public Safety, Emergency Guidelines for Schools, Division of Emergency Medical Services, *Emergency Medical Services for Children Program,* Columbus, OH. (2001)

Practical First Aid – The Basic Guide to Emergency Aid for home, School & Work, Sir Cameron Moffat, London (1996)

School Health – A Guide for Primary School Teachers, Published by the Directorate General of Health Services, Ministry of Health & Family Welfare, Govt.of India. (1984)

Standard Emergency Procedures for Schools, Los Angeles Unified School District, Office of Environmental Health and Safety. (2001)

Towards Health Promoting Schools, WHO country office in India, (2008)

UN Convention on Child Rights. (1992)

Strategies to Improvise Teacher Tasking for Children with Attention Deficit Hyperactive Disorder (ADHD).

Priyanka Gera

Doctoral Student, Department of Psychology, University of Delhi, North Campus, Delhi, India

Abstract: *The purpose of this present article is to review the empirical support for teachers to provide strategies for tackling students with ADHD. Three major aspects discussed are alarming rise of ADHD among children, entangling issues with teaching students with ADHD and unleashing strategies for tackling such children. Practical implications of the school-based outcome literature will be delineated, including the need for the following: (a) technical-support mediated strategies; (b) classroom strategies; (c) Activity-based strategies; and (d) Peer tutoring strategies and (e) Homework strategies. It is suggested on bridging the gap between the empirical literature and actual practices employed in schools. School-based professionals are urged to implement empirically supported strategies through individualising interventions based on assessment data. Through long-term implementation of such evidence based strategies, it is hoped that the deficits characteristic of ADHD will be minimised and the likelihood of school success for these students optimised.*

INTRODUCTION

"Attention makes genius; all learning, fancy, and science depend upon it. Newton traced back his discoveries to its unwearied employment. It builds bridges, open new worlds, and heals diseases; without it taste is useless, and the beauties of literature are unobserved."

Robert Aris Willmott, English author

ALARMING RISE OF ATTENTION DEFICIT HYPERACTIVE DISORDER AMONG CHILDREN

The review of various research shows that, Attention deficit hyperactive disorder (ADHD) is one of the major public health problems afflicted a large number of children. However, this disorder has been described neither as a disease nor as an emotional disorder but a cluster of personality traits that appear normally in all children but more intensely in some children. ADHD occurs between 2 and 9.5 per cent of school age children worldwide in the age group of 6 to 12 years (Sharma & Sinha, 1997).

Correspondonce: Priyanka Gera*, E-mail: priyanka03@hotmail.com*

ADHD has been characterized as a "brain-damage syndrome" (Strauss & Lehtinen, 1947), "minimal brain damage (Gesell & Amatruda, 1947), "minimal brain dysfunction" (Clements, 1966), "hyperkinetic syndrome" (Cantwell, 1975), and "hyperactive child syndrome" (Stewart, Pitts, Craig, & Dieruf, 1966). Thus with increase in the years of research, the causal terminology associated with it underwent a transition from brain to behavior manifestations.

There is a plethora of research to identify the salient characteristics of ADHD over the years. Recently Barkley (1998) reported that ADHD syndrome could be broadly classified into two categories i.e. inattention and a combination of hyperactive and impulsive behavior. Similarly DSM-IV TR, classified ADHD under the 'Attention-Deficit and Disruptive Behavior Disorders'. ICD-10 used a generally similar description to DSM-IV TR, but the placement of ADHD differs between the two. ICD-10 is broader than DSM-IV TR and has given a different terminology for the classification of ADHD that is, Hyperkinetic Disorder.

Beiderman (1991) confirmed that ADHD is a highly prevalent disorder which has an onset in early childhood,

and persists into adolescence and adulthood. The majority of studies of ADHD children had highlighted the early onset as compared to other disorders especially in India.

Also in a recent study, Barkley (1998) observed that boys were three times more likely to develop ADHD than girls with a ratio of 9 to 1 presumably because boys were genetically more prone to disorders of the nervous system. In India, Chawla, Sahasi, Sundaram, & Mehta (1981) reported a ratio of 7:4.47 for males and females suffering from ADHD. Singh & Sabat (2002) suggested that cultural factors may predispose more males towards hyperactivity than females. This gender difference may have been based on the fact that males are considered more active and restless than females. In general boys are more prone to suffer from ADHD, both in clinics and in the community.

The research showed that Female cases had a high rate of medical illness, which affected their brain leading to language delay and intellectual retardation. Surprisingly, ADHD has been often overlooked in females because the symptoms in females are complicated and can be easily misinterpreted. As a result, majority of girls in India do not undergo a routine medical check-up (Singh, & Sabat, 2002).

Epidemiologic studies had noted that this syndrome varies from 5 to 10 per cent in pre-pubertal children, and the boy-girl ratio varies from 4:1 to 6:1. Follow up studies of these children revealed that they are prone to develop psychiatric problems in adolescence as well as later in life (Singh, & Sabat, 2002). Javorsky and Gussin (1994) studied college students suffering from ADHD and argued that adolescents and adults with this disorder were at risk to develop behavioral and emotional problems such as substance abuse, financial mismanagement, poor employment performance, difficulty in career selection and legal problems.

Review of literature also emphasized that ADHD has been linked to a variety of causal factors but the direct and immediate causes of the problems experienced by ADHD children remains a mystery. A variety of potential factors, ranging from biological to psychosocial, may produce ADHD. Several efforts had been made to establish the aetiology of hyperactivity using various groups of children. However, no single cause of ADHD had been identified. The majority of research indicated the possibility of brain damage as the major cause of ADHD. The aetiological factors studied so far included neurobiological, genetic brain damage, maturation lag and psychosocial factors (Singh, & Sabat, 2002).

Studies on Psychosocial factors highlighted aggressiveness and noncompliant behavior that are related to family and social factors may be seen in children who are diagnosed as ADHD (Barkley, 2005). Hence a plethora of research indicates that an important role is played by the school and teachers, needs to be highlighted so as to improvise their teaching strategies in tackling children with ADHD.

ENTANGLING ISSUES WHILE TEACHING STUDENTS WITH ADHD

Although it is among the most noble and often most satisfying professions, teaching can be an overwhelming job. In most general education classrooms, the teacher has a broad spectrum of learners. Educators are responsible for analyzing, knowing, and understanding each individual student's strengths, interest, and needs. They are responsible for knowing their school system's and individual school's policies and procedures, national standards, curriculum demands and requirements, educational theory, assorted instructional strategies, resources and material, psychology, and child development(Silverman, Iseman & Jeweler, 2009). When teachers have students with ADHD in their classroom, they are further responsible for knowing and understanding the strategic and efficient ways of tackling such children.

Problems attending to classroom instruction are common in children (DuPaul, Stoner & O'Reilly 2002) with as many as 16% of elementary school students displaying frequent inattention and/or poor concentration (Wolraich, Hannah, Baumgaertel & Feurer 1998). Among students who meet criteria for Attention Deficit Hyperactivity Disorder (ADHD), up to 80% exhibit academic performance problems (Cantwell and Baker 1991) and these students are at increased risk for grade retention, placement in special education, and dropping out of school (Barkley, Fischer, Smallish & Fletcher 2006; Murphy, Barkley & Bush 2002). Attention problems also compromise achievement in children not formally diagnosed with ADHD (Merrell and Tymms 2001, 2005; Rabiner, Murray, Schmid & Malone 2004), predict the onset of reading difficulties (Rabiner, Coie & CPPRG. 2000), and undermine

traditional academic interventions such as tutoring (Rabiner, Malone & CPPRG. 2004).

Another research indicates that middle and high school teachers feel that the adolescent with ADHD also may be faced with the following issues: completing and submitting homework on time; forgetting homework assignments; disorganization; motivation and persistence; specific academic challenges; issues with planning ahead; disruptive behavior; issues with following directions; difficulty understanding expectations and executive functioning deficits (Dendy, 2000, 2006; Dendy & Zeigler, 2003).These findings indicate a strong need to develop more effective classroom interventions for inattentive students.

STRATEGIES FOR EFFECTIVE TACKLING OF STUDENTS WITH ADHD

Educators selecting evidence-based interventions for students with ADHD are often interested in interventions with known effectiveness for increasing academic performance. The core symptoms of ADHD are chronic inattention, impulsivity, and hyperactivity (American Psychiatric Association, 2000; Reif, 2005), and in schools this often translates to interference with academic achievement and performance (Atkins & Pelham, 1991; Raggi & Chronis, 2006).

The review of literature indicates following strategies for improvisation teacher tasking for children with ADHD:

TECHNICAL SUPPORT-MEDIATED STRATERGIES

Computer-aided instruction has intuitive appeal as a universal design feature and for children with ADHD because of its interactive format, use of multiple sensory modalities, and ability to provide specific instructional objectives and immediate feedback. Computer-aided instruction has not been well studied in children with ADHD (Hoffman, J. B., & DuPaul, G. J., 2000; Xu, C., Reid, R., & Steckelberg, A., 2002). Studies with small numbers of subjects showed promising initial results (Ford, M. P., V; & Cox, J. (1993) but did not examine the effects on academic achievement. A small study of 3 children with ADHD that used a game-format math program found increases in academic achievement and increased task engagement (Ota, K. R., & DuPaul, G. J., 2002).

- Computer-assisted instruction (CAI) entails the presentation of specific instructional objectives, highlighting of essential material, use of multiple sensory modalities, division of content into smaller chunks of information, use of repeated trials, and provision of immediate feedback about response accuracy (Ford et al., 1993; Kleiman et al., 1981; Mautone et al., 2005; Ota and DuPaul, 2002). This method has been suggested as a way to improve the sustained attention and work performance of children with ADHD. Aspects of CAI may help teachers plan individualized activities for students with shorter attention spans, allowing these students to be more actively involved in learning, and increasing confidence and motivation (Fitzgerald, 1994)

CLASSROOM STRATERGIES

Typically, classroom interventions for students with ADHD focus on reducing problematic behaviours and enhancing task engagement. Although these are worthy treatment targets, the reduction of disruptive activity does not ensure that students are making adequate academic progress. Stated differently, although a student is less disruptive and impulsive, it does not necessarily mean that the student is doing better schoolwork or obtaining higher academic grades. Because ADHD symptoms frequently are associated with academic impairment, academic achievement should be targeted directly in a comprehensive treatment plan (DuPaul, G. J. & Weyandt, L.L., 2006). The table-1 shows the behavioural function along with the different kinds of interventional strategies to be used by the teacher to obtain desired behaviour.

One possible academic intervention is to modify instruction to directly address putative academic deficits. Specifically, direct instruction can be used to pinpoint academic behaviours to increase and to provide students with multiple opportunities to acquire and practice new

Table 1. Classroom interventions linked to behavioural function

Behavioural function	Antecedent-based intervention	Consequent-based intervention
Obtain teacher attention	Remind of class rules and state connection between appropriate behaviour and receipt of teacher attention	Provide attention contingent on appropriate behaviour while ignoring disruptive behaviour; time out from positive reinforcement contingent on disruptive behaviour
Obtain peer attention	Remind of class rules and encourage classroom peers to ignore disruptive behaviour	Provide peer attention contingent on appropriate behaviour (e.g., peer tutoring)
Avoid/escape effortful tasks	Increase stimulation value of task; reduce size of task	Provide brief "attention breaks" when sub-units of task are completed

academic skills (Slocum, 2004). Direct instruction has been used successfully with a variety of disability populations and age groups (Grossen, 2004; Jitendra, Edwards, Sacks, & Jacobson, 2004; Shippen, Houchins, Steventon, & Sartor, 2005). Another example of a teacher-mediated academic intervention is the use of interspersal approaches for the acquisition of mathematics skills (e.g., Skinner, Johnson, Larkin, Lessley, & Glowacki, 1995). A final example of instructional modifications is to alter how tasks and instructional materials are presented to students. Zentall (1989) has shown that children with ADHD are more likely to attend to and complete tasks that include engaging stimuli within the task, as opposed to assignments that include extra-task stimuli (e.g., in the margins).

ACTIVITY-BASED STRATERGIES

Task or instructional modifications involve implementing procedures such as reducing task length, dividing tasks into subunits and setting goals for the child to achieve in shorter time intervals, using increased stimulation of the task (e.g., color or texture), giving explicit instructions, and modifying the delivery or modality of instruction depending on the student's individual learning style (e.g., fast-paced versus slow-paced, visual versus auditory) (Dubey and O'Leary 1975; Dunlap et al., 1994; Ervin et al., 1998; Zentall and Leib, 1985). These methods focus on increasing the structure and organization of the child's environment, making goals and tasks appear more manageable to reduce frustration and increase persistence, and increasing relevant stimulation to help sustain attention.

An important task modification that has been explored and found effective for students with developmental disabilities is that of choice making (Newton et al., 1993). Choice making allows the child a certain level of individual decision-making and personal control over the nature of the task. This consists of allowing the child to select academic tasks or materials from a number of pertinent and structured alternatives. This technique may be beneficial not only in increasing task performance and productivity, but also in improving social relatedness (Koegel et al., 1987).

PEER MEDIATED STRATERGIES

Peer tutoring is a method of instruction in which children with ADHD are paired with a peer tutor that aids them in learning academic material (Raggi, V. L., & Chronis, A. M., 2006). This method allows for one-to-one instruction that is individually tailored to the child's academic ability and is delivered at the student's own pace (DuPaul and Stoner, 1994). It requires active responding on the part of the student, and frequent, immediate feedback in the form of prompts and praise is provided by the tutor. Peer tutoring has been found to be effective in a variety of academic areas for students with a wide range of cognitive and academic abilities (Greenwood et al., 1991).

Class Wide Peer Tutoring (CWPT) (Greenwood, Delquadri, & Carta, 1988) is one of the most widely researched and implemented peer tutoring models. CWPT has been found to enhance the mathematics, reading, and spelling skills of students of all achievement levels (for a review see Greenwood et al., 2002). This form of peer tutoring includes the following steps: (a) dividing the class into two teams; (b) forming tutoring pairs within each team; (c) students take turns tutoring each other; (d) providing tutors with academic scripts (e.g., mathematics problems with answers); (e) tutors providing praise and points contingent on correct answers; (f) tutors correcting errors immediately with an opportunity for practicing the correct answer; (g) teacher monitoring tutoring pairs, and providing bonus points for pairs that are following prescribed procedures; and (h) tallying points by each individual student at the conclusion of each session. Tutoring sessions typically last 20 min with an additional 5 min for charting progress and putting materials away (DuPaul, G. J. & Weyandt, L.L., 2006).

Advantages of this approach include one-to-one individualized instruction, frequent and immediate feedback, active participation of students, and high levels of practicality and acceptability (Raggi, V. L., & Chronis, A. M., 2006). Peer tutoring can be implemented by teachers in a general education setting with a high level of fidelity using a resource (i.e., peer tutors) that is readily available in the classroom (DuPaul and Henningson, 1993).

Peer tutoring may also provide opportunities for the development of prosocial behaviour in children with ADHD, as they are encouraged to interact with peers who may not otherwise choose to interact with them socially (Raggi, V. L., & Chronis, A. M., 2006).

HOME WORK STRATERGIES

A particularly important academic target for the treatment of children and adolescents with ADHD is

homework completion and accuracy. Large-sample educational research has shown that, aside from ability, time spent on homework is the best predictor of student grades and achievement (Cooper et al., 1998; Keith, 1982).

Research on homework interventions for students with general academic problems have suggested that the use of goal setting and contingency contracting, parent training in structuring the home setting, and parent–teacher consultation are beneficial in the remediation of homework difficulties (Anesko and O'Leary, 1982; Bergan and Kratochwill, 1990; Kahle and Kelley, 1994; Miller and Kelley, 1994; Weiner et al., 1998). In homework-specific parent training programs, parents are taught to identify and target specific behaviors and establish a consistent homework routine (i.e., determining a quiet setting with minimal distractions, starting the process early, providing aid when needed, breaking down assignments, and prioritizing tasks) (Anesko and O'Leary, 1982). Given the frequent difficulties children and adolescents with ADHD experience in the areas of planning ahead, prioritizing, filtering out distractions, and focusing on one task at a time, it makes sense that a homework intervention specifically targeting these areas would be particularly beneficial for this group.

Another parent-implemented intervention designed to target homework difficulties is the use of goal setting procedures. Goal setting consists of the comparison of performance goals against present performance level, and may be viewed as a form of self-monitoring in which children evaluate their own performance (Bandura, 1977).

CONCLUSION

ADHD is a multifaceted, chronic disorder that is associated with deficits in multiple areas of functioning. As such, psychotropic medication and home-based behavioural strategies, while effective, rarely are sufficient in decreasing ADHD symptoms over the long term. Empirical studies of school-based interventions have supported the efficacy of strategies for teacher tasking for children with ADHD. Furthermore, some promising interventions for addressing social relationship difficulties among students with this disorder have been developed. School-based professionals are urged to implement empirically supported strategies through individualising interventions based on assessment data. Furthermore, a long-term approach to treatment across school years will necessitate ongoing, consistent communication among parents, teachers, physicians, and other health professionals. Through long-term implementation of evidence based strategies, it is hoped that the deficits characteristic of ADHD will be minimised and the likelihood of school success for these students optimised.

REFERENCES

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington DC: Author.

American Psychiatric Association (2005). *Diagnostic and Statistical Manual of Mental Disorders: Text Revision, 4th Ed. (DSM-IV TR). Washington DC: APA. Barkley, R.A.(1998). Attention deficit hyperactivity disorder. Scientific American, 9, 44-49.*

Anesko, K. M., and O'Leary, S. G. (1982). The effectiveness of brief parent training for the management of children's homework problems. *Child and Family Behavior Therapy* 4: 113–126.

Atkins, M. S., & Pelham, W. E. (1991). School-based assessment of attention deficit disorder. *Journal of Learning Disabilities,* 24, 197–204.

Bandura, A. (1977). *Social learning theory,* Prentice-Hall, Englewood Cliffs, NJ.

Barkley, R. A. (2005). *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment (3rd Edn.).* New York: Guilford.

Bergan, J. R., and Kratochwill, T. R. (1990). *Behavioral consultation and therapy,* Plenum Press, New York.

Biederman, J. (1991). Attention deficit hyperactivity disorder. *Annuals of Clinical Psychiatry,* 3(1), 9-22.

Cantawell, D. (1975). Genetic studies of hyperactive children: Psychiatric illness in biologic and adopting parents. In R. Fieve, D. Rosenthal, & H. Brill (Eds), *Genetic research in psychiatry,* Baltimore: Johns Hopkinsons University Press.

Cantwell, D. P., & Baker, L. (1991). Association between attention deficit/hyperactivity disorder and learning disorders. *Journal of Learning Disabilities,* 24, 88–95.

Chawla, P.L., Sahasi, G., Sundaram, K.R., & Mehta, M. (1981). A study of prevalence and pattern of hyperactive syndrome in primary school children. *Indian Journal of Psychiatry,* 23, 313-322.

Clements, S. (1966). *Minimal brain damage in children. NINDB Monograph No.3,* Washington, DC: US Public Health Services.

Cooper, H., Lindsay, J. J., Nye, B., and Greathouse, S. (1998). Relationships among attitudes about amount of homework assigned and completed, and student achievement. *Journal of Educational Psychology* 90: 70–83.

Dubey, D. R., and O'Leary, S. G (1975). Increasing reading comprehension of two hyperactive children: Preliminary investigation. *Perceptual Motor Skills* 41: 691–694.

Dunlap, G., dePerczel, M., Clarke, S., Wilson, D., Wright, S., and White, R. et al., (1994).Choice making to promote adaptive behavior for students with emotional and behavioural challenges. *Journal of Applied Behavior Analysis* 27: 505–518.

DuPaul, G. J., & Henningson, P. N. (1993). Peer tutoring effects on the classroom performance of children with attention deficit hyperactivity disorder. *School Psychol Rev,* 22, 134–143.

DuPaul, G. J., & Stoner, G. (2003). *ADHD in the schools: Assessment and intervention strategies (2nd ed.).* New York: Guilford.

DuPaul, G. J., Stoner, G., & O'Reilly, M. J. (2002). Best practices in classroom interventions for attention problems. In A. Thomas & J. Grimes (Eds.), *Best practices in school psychology, vol. 2 (pp. 1115–1127).* Washington, DC: National Association of School Psychologists.

DuPaul, G. J. & Weyandt, L.L. (2006). School-based Intervention for Children with Attention Deficit Hyperactivity Disorder: Effects on academic, social, and behavioural functioning. *International Journal of Disability, Development and Education* Vol. 53, No. 2, pp. 161–176

Ervin, R. A., DuPaul, G. J., Kern, L., and Friman, P. C. (1998). Classroom-based functional and adjunctive assessments: Proactive approaches to intervention selection for adolescents with attention deficit hyperactivity disorder. *Journal of Applied Behavior Analysis* 31: 65–78.

Ford, M. P., V; & Cox, J. (1993). Attending behaviors of children with ADHD in math and reading using various types of software. *J Computers Childhood Educ,* 4, 183–196.

Gesell, A., & Amatruda, C.S. (1947). *In Developmental Diagnosis (2nd Ed.).* New York: Hoeber-Harpe.

Greenwood, C. R., Delquadri, J., & Carta, J. J. (1988). *Classwide peer tutoring.* Seattle, WA: Educational Achievement Systems.

Greenwood, C. R., Maheady, L., & Delquadri, J. (2002). Classwide peer tutoring programs. In M. R. Shinn, H. M. Walker, & G. Stoner (Eds.), *Interventions for academic and behavior problems II: Preventive and remedial approaches (pp. 611–649).* Bethesda, MD: National Association of School Psychologists.

Greenwood, C. R., Maheady, L., and Carta, J. J. (1991). Peer tutoring programs in the regular education classroom. In Stoner G., Shinn M., and Walker H. (Eds.), *Interventions for achievement and behavior problems (pp. 179–200).* Silver Spring, MD: National Association of School Psychologists.

Grossen, B. (2004). Success of a direct instruction model at a secondary level school with high-risk students. *Reading & Writing Quarterly: Overcoming Learning Difficulties,* 20, 161–178.

Hoffman, J. B., & DuPaul, G. J. (2000). Psychoeducational interventions for children and adolescents with attention-deficit/hyperactivity disorder. *Clinical N Am,* 9, 647–661.

Javorsky, J., & Gussin, B. (1994). College students with ADHD: An overview and description of services. *Journal of College Student Development,* 35(3), 170-177.

Jitendra, A. K., Edwards, L. L., Sacks, G., & Jacobson, L. A. (2004). What research says? about vocabulary instruction for students with learning disabilities. *Exceptional Children,* 70, 299–322.

Kahle, A. L., and Kelley, M. L. (1994). Children's homework problems: A comparison of goal setting and parent training. *Behavior Therapy* 25: 275–290.

Keith, T. Z. (1982). Time spent on homework and high school grades: A large sample path analysis. *Journal of Educational Psychology* 74: 248–253.

Ko. R. Jr., and Horner, R. H. (1993). Validating predicted activity preferences of individuals with severe disabilities. *Journal of Applied Behavior Analysis* 26: 239–245.

Ota, K. R., & DuPaul, G. J. (2002). Task engagement and mathematics performance in children with attention-deficit hyperactivity disorder: effects of supplemental computer instruction. *School Psychology Q,* 17, 242–257.

Raggi, V. L., & Chronis, A. M. (2006). Interventions to address the academic impairment of children and adolescents with ADHD. *Clinical Child and Family Psychology Review,* 9, 85–111.

Reif, S. F. (2005). *How to reach and teach children with ADD/ ADHD (2nd ed.).* San Francisco: Jossey-Bass.

Sharma, A., & Sinha, S.P. (1997). A comparative study of prevalence of ADHD among male and female school children. *Indian Journal of psychology,* 72 (1 & 2), 21-25.

Shippen, M. E., Houchins, D. E., Steventon, C., & Sartor, D. (2005). A comparison of two direct instruction reading programs for urban middle school students. *Remedial and Special Education,* 26, 175–182.

Silverman, M. S., Iseman, S. J. & Jeweler, S. (2009). *School success for kids with ADHD.* Waco, TX: Prufrock Press.

Singh, L., I. & Sabat, N., N. (2002). *Attention Deficit Hyperactive Disorder: A conceptual overview. Indian Psychological Abstracts and Reviews,* 9:2, 215-242.

Skinner, C. H., Johnson, C. W., Larkin, M. J., Lessley, D. J., & Glowacki, M. L. (1995). The influence of rate of presentation during taped-words interventions on reading performance. *Journal of Emotional and Behavior Disorders,* 4, 214–223.

Stewart, M.A., Pitts, F., Craig, A., & Dieruf, W. (1966). The *hyperactive child syndrome. American Journal of Orthopsychiatry,* 36, 861-867.

Strauss, A.A., & Lehtinen, L.E. (1947). *Psychopathology and education of the brain-injured child.* New York: Grune & Stratton.

Weiner, R. K., Sheridan, S. M., and Jenson, W. R. (1998). The effects of conjoint behavioral consultation and a structured homework program on math completion and accuracy in junior high school students. *School Psychology Quarterly* 13:281–309.

Wolraich, M. L., Hannah, J. N., Baumgaertel, A., & Feurer, I. D. (1998). Examination of DSM-IV criteria for attention-deficit/ hyperactivity disorder in a county-wide sample.*Journal of Developmental and Behavioral Pediatrics,* 19, 192–168.

World Health Organization (1993). *The ICD-10 Classification of Mental and Behavioral Disorders: Diagnostic criteria for research.* Geneva: WHO.

Xu, C., Reid, R., & Steckelberg, A. (2002). Technology applications for children with ADHD: assessing the empirical support. *Educ Treatment Child,* 25, 224–248.

Zentall, S. S. (1989). Attentional cuing in spelling tasks for hyperactive and comparison regular classroom children. *The Journal of Special Education,* 23, 83–93.

Zentall, S. S., and Leib, S. L (1985). Structured tasks: Effects on activity and performance ofhyperactive and comparison children. *Journal of Educational Research* 79: 91–95.

School Mental Health In India: An Emerging Paradigm On School Counseling Services

Divya S. Prasad*, Amulya Khurana, Jitendra Nagpal*****

**Clinical Psychologist, Moolchand Medcity, New Delhi.*

*** Professor, Department of Humanities and Social Sciences. IIT, Delhi*

**** Consultant Psychiatrist, Moolchand Medcity*

Abstract: *We have entered the new millennium and as we introspect issues that matter to us as part of a rapidly changing society, it is imperative that an appraisal be made of the psychosocial needs of the children and adolescents who are leading the baton of human chain into the 21st Century.*

CHILDHOOD AND ADOLESCENCE..... A time in life span when children realize who they are? What they would like to be? It's time to forge an identity. Career choices to be made, meaningful relationships to be formed and sustained technological advances tackled, attitudes and roles chiseled. Isn't this process of transition fraught with trials and tribulations? Information overload, mixed messages from media, press, teachers, and family and from society at large add to the confusing scenario of the assimilating young mind.

INTRODUCTION

MENTAL HEALTH OF OUR CHILDREN- A CHILD RIGHTS PERSPECTIVE

Children are the most important assets of any country and the most important human resource for overall development. Schools are one of the settings outside the home where children can acquire new knowledge and skills to grow into productive and capable citizens, who can involve, support and help their communities to grow and prosper. A Health Promoting School is a setting where education and health programmers create a "Joyful and Happy" environment that promotes diversity in learning and evolving. Don't the children have the right for this?

Majority of the public schools have no counselors or a social workers, yet schools are being asked to deal with more of the mental health needs of their students. In addition, reports of increased bullying and school violence account the importance of recognizing and responding to the psychic agony of the school campus.

In the last decade, School mental health has expanded to address school violence, sexual harassment, bullying, substance abuse, discrimination and healthy discipline. Psychiatrists and other mental health professionals continue to refine their role in schools, incorporating the corporate and education principles in effecting change and improving system functioning. Modern school consultation focuses more on early identification and intervention at the individual and systems level to help attain immediate educational and behavioral goals and to prevent long term negative outcomes in the overall personality of children.

Also a few of these youngsters seem to be in vague kind of disturbances, of having lost something, of a sense of betrayal, a gnawing frustration that often blazes into aggression, insecurity, loneliness, boredom, defiance and a feeling of being on the brink of crisis-symptoms that are spreading through the nervous system of the entire generation. It's time for a closer mind watch at the school.

IT IS WORTH REMEMBERING.....

- India - Children and adolescents constitute 40% - 44% of over 1000 million populations.
- ICMR (2001) study found 12.8% of the children and adolescents suffering from Mental & Behavioral Disorders.

Child mental health care has received scant attention in service, research and training aspects in the national context, despite has sound policy guidelines.

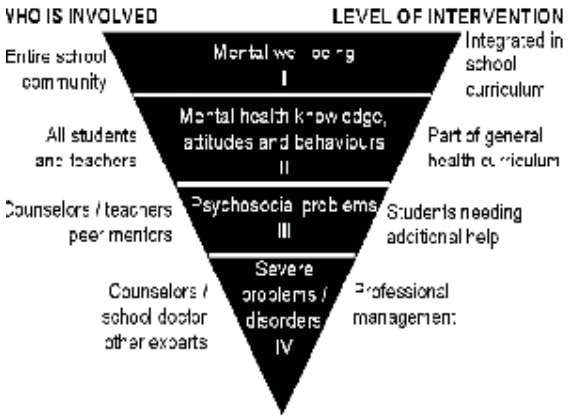
Correspondonce: Divya S. Prasad, *E-mail: jnagpal10@gmail.com*

TYPES OF MENTAL HEALTH INTERVENTIONS IN SCHOOLS

1. **MENTAL HEALTH PROMOTION -**to build awareness and resilience
2. **UNIVERSAL AND SELECTIVE PREVENTION-**to reduce risk and vulnerability factors and build protective factors
3. **PREVENTION AND EARLY INTERVENTION STRATEGIES-**for those with early signs of disorder

A FRAMEWORK FOR SCHOOL MENTAL HEALTH PROGRAMMES

The following diagram illustrates the psychosocial and mental health concerns of the schools and indicates who is likely to be affected:



Children who are not doing well in school may be suffering depression, anxiety, aggression or\psychosomatic disorders. Their families may come to the attention of schools due to disruptive and disturbing psychosocial problems. Children with poor mental health skills and / or environmental stress such as family or emotional problems or the feeling that nobody cares – are unlikely to perform well in school or later in life.

INTERVENTION MODEL -AN EXPLANATION

Levels I through IV can be likened to primary, secondary, and tertiary prevention efforts. Primary prevention and health promotion (**Levels I and II**) target the causes of healthy and unhealthy conditions with interventions which to promote healthy behaviors and prevent a disorder from developing. Secondary prevention (**Level III**) targets a more selected population of high-risk people to protect against the onset of the disorder. Tertiary prevention (**Level IV**) targets people who already have developed the disorder with the intent of treating the disorder, reducing the impairment from the disorder, and / or preventing relapse.

FUNDAMENTAL GUIDELINES FOR IMPLEMENTATION

School-based mental health programmes can be **Environment-Centered** or **Child-Centered**.

1. ENVIRONMENT-CENTRED APPROACHES

In this approach the aim is to improve the educational climate of the school and to provide opportunities for the child to utilize the healthy school programme. The positive mental health atmosphere includes the amount of time spent in school, the structuring of playground activities, the physical structure of the school and the classroom decoration.

Programmes the school can conduct are as follows:-

(a) Programmes/workshops can be organized to enhance the ability of administrators, teachers and support staff to deal with the specific areas of emotional or behavioral disturbance that they encounter.

(b) Programme for improving teachers capacity to understand how to make use of other agencies providing mental health services for children.

(c) National campaigns to reduce the incidence of certain mental health damaging behaviors e.g., bullying, raging, corporal punishment etc.

(d) Improvement in the school's social environment can be brought about by encouraging parent participation through parent programme in support of school activities.

(e) A multidisciplinary mental health team can be established in the school to provide consultation in the management of student behavior problems.

(f) The mental health team can include representatives from the governing body, teachers, support staff, and parents. The governing body can identify and rate problems and opportunities within the school.

(g) The school mental health team can monitor and evaluate the outcome and provide feedback so that appropriate modifications can be made to the programme.

(h) Schools can be the centre for community enhancement projects including programmes to improve health and mental health. They can serve as

training centers for parenting skills where parents learn more about child development and parent effectiveness skills and receive support to enhance feelings of self worth and competence.

Such a programme provides a coordinated, collaborative effort to improve communication, understanding, and respect between staff, students and parents. This provides a sense of direction and ownership of the programme.

2. CHILD-CENTRED APPROACH

Child-centre approach includes individual mental health consultations and specific problem-focused interventions as well as more general classroom programmes to improve coping skills, social support, and self-esteem.

Programmes the school can conduct are as follows:-

(a) Particular child and family having difficulty can be referred to the school counselor or mental health professionals

(b) The counselor is involved in giving recommendations to the parents, the teachers and in some cases referral for treatment outside the classroom.

(c) Maladjustment can be prevented by locating at-risk children and involving them in an intensive goal-directed intervention that should include close contact with non-professional child-aides such as special educator, resource room teachers and peer mentors.

(d) The use of parents as teacher's aides can be a helpful learning experience for the parents, the teacher and the child. Working in the classroom provides parents with a new perspective of their child as they observe other children and talk with other parents and the teacher.

(e) Early intervention programmes with high risk behaviors such as aggressiveness, smoking, precocious sexuality, excessive shyness, poor worsening of interpersonal relationship, poor school attendance, declining academic performances, irritable and fluctuating moods, and changes in peer groups can prevent serious consequences.

(f) Schools can also use screening tools for identification of psychosocial problems and mental disorder. This can help the schools in determining if children have (or are at risk of having) significant mental health problems. Although, there is a danger of "labeling" and stigma nevertheless, the instruments can be very useful in planning management strategies.

(g) **School based health centers- or clubs** located within the school have an important role in supporting better health care for children and adolescents. The mental health services in these school-based health clinics can provide screening, counseling for common child and adolescent concerns, information about substance abuse, sexuality, HIV / AIDS, reproductive health, depression, stress, anxiety, etc. Because these clinics are located within the daily environment of the children most youth, they offer particular benefit to young people who might not otherwise receive assistance, by decreasing the economic and psychological barriers. Clinics can facilitate and support positive relationships among students, their families, the schools, and other community services.

KEY STEPS IN SETTING UP SCHOOL MENTAL HEALTH SERVICES

STEP I: ESTABLISHMENT OF A TEAM

Planning for a comprehensive school mental health programme begins with the collaboration of school personnel, family members, community members, predations mental health professionals and students who work together to create an environment that is productive, positive and supportive.

STEP 2: ASSESSMENT OF SCHOOL & COMMUNITY ENVIRONMENT

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

STEP 3: DEVELOPMENT OF A PLAN

Once the needs and potentials for school mental health programmes are assessed and most suitable elements of the model framework are chosen after discussions with parents, educators, students, community members, and mental health professionals, the next task is to develop a specific plan of action including clearly stated objectives, assignment of responsibilities, a time-line and a coordinating mechanisms with outside agency.

STEP 4: MONITORING AND EVALUATION

Obtaining baseline data on the mental health of the children, the quality of school health services, the

environment of the school and the health knowledge, skills and practices of students, are all essential for evaluating the effectiveness of a planned intervention involving standouts and their participation is a continuous process at all steps for the progress to the program.

MENTAL HEALTH ORIENTATION & COUNSELING SKILLS

Before we formulate an interventional programmed the need of the hour is to recognize the mental health related disorders in the school children.

IDENTIFICATON OF PSYCHIATRIC DISORDERS IN SCHOOL CHILDREN

Like adults, children may experience disturbance in emotions, behavior and relationships, which impairs their functioning. It is distressing to the child as well as parents and community. *Judicious early identification would curtail needless suffering and avoid spiraling of problems.*

There is no one cause for these disturbances. Reasons are often multiple: genetic, environmental, chromosomal and socio-cultural. Factors like child's temperament, parental health, family relationships and parenting styles are important. Despite these environmental influences and stressors certain children are more vulnerable while some are less. Children differ in their personality character or temperament. A "difficult child" is much more likely to show emotional problems during the pre-school period than an "easy child".

Comprehensive evaluation of the child should include:

- Clinical Interviews
- School Report
- Intellectual Functioning
- Development Tests
- Neurological Assessment

Therefore school forms an integral part of the child's assessment regarding his/her mental and development related issues. Some of the **most common problems** seen in school children are as follows:

1. THE HYPERACTIVE CHILD (Attention Deficit Hyperactivity Disorder)

All children are active, but a few are extraordinarily so and are considered hyperactive. They are constantly in motion, darting from one activity to another. Often failing to sustain attention in simple tasks or play activities. Complaints regarding these children by parents and teachers are that the children do not seem to listen, cannot concentrate, are easily distracted, fail to finish assignments, daydream and change activities as compared to other children. Attention Deficit Hyperactivity Disorder (ADHD) affects between 3 and 10 percent of all school-age children. ADHD is four to eight times more common in boys than it is in girls.

Core Symptoms		
Inattention	**Hyperactivity**	**Impulsivity**
• Failing to give close attention to details • Difficulty sustaining attention • Not listening • Easily become distracted • Forgetfulness	• Fidgeting • Inability to sit at one place • Difficulty playing quietly • Always 'on the go' or 'driven by motor' • Excessive talking	• Blurting • Difficulty awaiting a turn • Interrupting or intruding on others

ROLE OF TEACHERS

If you are sensitized to the common symptoms of this condition, your observations about the intensity, frequency and associated problems would be very helpful in thorough evaluation of the child. As the first step, a **Behavior Checklist** for ADHD should be filled out by parents and teachers to provide information on types and severity of ADHD symptoms at home and at school, as well as other emotional and behavior problems.

2. CONDUCT AND RELATED DISORDERS

A conduct disorder child is repeatedly aggressive and his behavior violates the rights of others. They show excessive levels of fighting, hostility, verbal abuse, defiance, and cruelty to animals, destruction of property, lying, stealing and truancy. It appears to be more prevalent in urban than rural settings. It is about 3 times more common in boys than in girls. The prevalence rates for boys under the age of 18 are 6-16%; for girls, rates range from 2-9%.

Core Symptoms	
• Stealing without confronting a victim • Running from home • Lying • Setting Fires • Truancy • Breaking into someone's house, building or car	• Use of a weapon • Initiating physical fights • Stealing when confronting a victim • Physical cruelty to people • Physical cruelty to animals • Forcing someone into sexual activity • Deliberate destruction of another's property

Conduct disorder is associated with family instability, including victimization by physical or sexual abuse. Propensity for violence correlates with child abuse, family violence, alcoholism, and signs of severe psychopathology, e.g., paranoia and cognitive or subtle neurological deficits. It is crucial to explore for these signs; findings can guide treatment.

3. ANXIETY AS A SYMPTOM AND A DISORDER

The feeling of anxiety is generally characterized as diffuse and unpleasant. There is a sense of apprehension or worry, along with physical symptoms that may include headache, muscle tension, sweating, restlessness, tension in the chest and mild stomach discomfort. Anxiety becomes a disorder when the symptoms are severe, pervasive, lasting and interfere with normal life. Anxiety disorders can develop gradually over long periods of time or very quickly. These disorders can become disabling and interfere with school, relationships, social activities and work.

GROWING UP: DIFFERENT TYPES OF ANXIETY

Fears and phobias

Very young children often develop fears and phobias. These usually happen in particular situations, such as going to nursery or settling down at night, and can result from the fear of separation from parents or familiar adults. Sometimes, particular things such as dogs, spiders or snakes set off the anxieties. Fears like this are very common in early childhood, but with some encouragement and support, most children learn to overcome their anxiety.

General anxiety

Some youngsters feel anxious most of the time for no apparent reason. It may be part of their temperament, or it may be part of a pattern of behavior that is shared with other members of the family. If the anxiety becomes very severe, it can interfere with the child's ability to go to school, to concentrate and learn, and to be confident with others.

School-related anxiety or school refusal

Refusing to go to school can also be caused by anxiety. However, worries about going to school can be caused by a number of things. Children may refuse to go to school due to a physical illness. Some may be truants and choose not to go to school as a form of a rebellion. Another group stays away from school because they are anxious or miserable when there.

Core Symptoms		
• Experience of fear • Restlessness • Irritability • Avoidance • Rapid labored breathing • Sweating or perspiring • Trembling or "shaking" • Weakness • Poor memory	• Rapid heart beat • Chest pain or tension • Muscle tension • Indigestion or diarrhea • Dizziness or feeling "light-headed" • Racing thoughts • Neglecting responsibilities • Impatience	• Dwelling on fearful possibilities • Problems performing tasks • Frightening images • Thoughts of danger • Increased energy • Frustration • Problems concentrating

4. DEPRESSIVE DISORDERS IN CHILDREN

Feeling sad and upset occasionally is a phenomenon that everyone goes through. But there is reason to be concerned when symptoms of depression are severe, prolonged, unexpected, seem unusual or have no apparent cause.

CORE SYMPTOMS FOUND IN YOUNGER CHILDREN

- Emotionally brittle, temperamental, irritable or easily annoyed
- Loosing friends
- Repeated rejection by other children
- Inability to sit still, fidgeting or pacing
- Stays in room and isolates himself
- Repeated emotional outbursts, shouting or complaining
- Avoids and doesn't talk to other children
- Irregular sleep habits (up at night and sleep during the day)
- Recent emergence of bed wetting

CORE SYMPTOMS FOUND IN OLDER CHILDREN

- Loss of interest or pleasure in others or most activities
- Feeling discouraged or worthless
- A significant drop in performance in school
- Fatigue or loss of energy most of the time
- Restlessness, fidgeting or pacing
- Crying, feeling sad, helpless or hopeless
- Episodes of fear, tension or anxiety
- Frustration, irritability, emotional outbursts
- Excessive guilt or inappropriate self-blame
- Repeated medical complaints without a known medical cause (headaches, stomach aches, pain in arms or legs)
- Too much or too little sleep
- Significant increase or decrease in appetite

5. MENTAL RETARDATION AND RELATED ISSUES

In mental retardation the child operates at a level significantly below the intellectual functioning of the general population, resulting in difficulties of problem solving the adaptation in several areas of functioning. It is separated into mild, moderate, severe, and profound subgroups based on the degree of intellectual impairment defined by the IQ and the level of adaptive functioning.

DEGREES OF MENTAL RETARDATION

- Mild Mental Retardation - IQ: 50-55 to approximately 70
- Moderate Mental Retardation - IQ: 35-40 to 50-55
- Severe Mental Retardation - IQ: 20-25 to 35-40
- Profound Mental Retardation - IQ: Below 20 or 25

ROLE OF TEACHERS

- Collect information from the parents about early history e.g., did the mother have significant difficulties during pregnancy (diabetes, infections, thyroids etc.).
- Check if the mother had problems at the time of the child's birth e.g., premature baby, delayed birth cry, blue baby, severe jaundice and respiratory problems in the child.
- Suggest to the parent to meet a general physician, pediatrician or visit a Child Development Centre if available.

6. LEARNING DISABILITY

It is not a medical, neurological or psychological problem. Learning disability manifests itself in the school as:

DYSLEXIA may be defined as organizing or learning difficulties affecting language, line co-ordination skills & working memory skills. It is independent of overall ability and conventional teaching.

DYSCALCULIA - The child's performance in arithmetic is significantly below the level expected on the basis of his age, intelligence, and schooling. It has been seen that children with this disorder have problems in visuo-spatial and visual perceptual skills.

DYSGRAPHIA – refers to difficulty in hand writing. Children are unable to execute the motor movements to write or copy a written letter or form. They may be unable to transfer visual information into output of fine motor movements. They may be weak in visual motor function and in activities requiring visual and spatial judgment.

Writing requires

- Muscular control
- Eye hand coordination
- Visual Discrimination
- Smooth control of arms, hands and finger muscles
- Adequate perceptions of the letter and word formation

7. AUTISM

Autism is developmental disability in which there is significant impairment in social relatedness, communication, and the quality, variety, and frequency of various activities and behaviors. The onset of autism generally is before age 3 and impairment persists throughout the lifespan.

Primary symptoms include the following:

- ***Abnormal social relatedness:*** This is always impaired in autism. The degree of impairment however may range from oddness in social interaction, to an almost complete detachment and lack of responsiveness to other's social initiations. Social abnormalities may include poor use of eye contact, emotional cues, and social smile; lack of social initiation and disorganized patterns of reactions to strangers and separations. Children with autism demonstrate a particular inability to imitate others. They may disregard the other or, sometimes, inappropriately mirror the other's behavior.
- ***Abnormal communicative development:*** Much of the literature on autism has focused on deviance in the development of spoken language. However, the communication deficit is much more profound than impaired language alone.
- ***Abnormal capacity for symbolic play:*** Children with autism are particularly lacking in the pretend play typical of preschool-aged children, including doll pay, role play, and dramatic play. They rarely seek out play partners.
- ***Restricted and odd behavioral repertoire:*** Typical play, involving curiosity, exploration, interest in novelty, and goal directedness is lacking in children with autism. Much time is spent in a very limited range of activities, which may consist of a few highly ritualized or repetitive ways of handling a few object (e.g. sucking, shaking arranging, carrying around). Age-appropriate play skills may be present, but are often inappropriately repetitive.

GUIDELINES FOR SCHOOL COUNSELORS

- The school counselor/teacher counselor is informed, who assess the gravity of the situation.
- Empathetically tries to initiate a dialogue with the needy and tries to understand the situation from child's perspective.
- Collects basic information from the teacher and peer group of the student.
- Initiates a dialogue with the parents and formulates individualized management plan for the student.
- Family environment parenting practices are identified if any, and positive parenting strategies are suggested.
- Also, behavior strategies like CBT techniques etc could be utilized. Suggestions are given to peer group as well.
- Regular follow ups are carried out by the counselor afterwards.
- Administrative decisions to de-escalate the tension are worked upon with the school health committee.

Inputs for identification, intervention if possible at the school level along with the liaison of the physician/pediatrician or mental health professional, referral to mental health professional if intervention is not possible at the school level and regular follow ups for identified children and adolescents with be the process that needs to be in place towards this. This would ideal program for population at risk – at risk due to bio-socio-economic-psychological reasons (children with cancer, HIV/AIDS, street children, children affected by disasters and conflicts, divorced or single parents etc.) and children/adolescents identified to be psychologically ill.

CONCLUSION

The school plays a crucial role in the development of cognitive, linguistic, social, emotional and moral functions and competencies in a child. Schools have profound influence on children, their families and the community. Schools can act as a safety net, protecting children from hazards that 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 programmers are effective in improving learning, mental well-being, and channelizing management of mental disorders. When teachers are actively involved in mental health programmers, the interventions can reach generations of children. Make further recommendations to encourage mental health professionals to establish good practices in schools. School counselors and their profile need a revisit for enhancing their role and responsibility.

REFERENCES

Annual Status of Education – Report 2003, Department of Education.

Bass.E & Davis, L. (1993) *Beginning to Heal: A first book for Survivors of Child sexual abuse.* Harper Collins, New York.

Bharath S & Kumar KVK - *Health Promotion using Life Skills Approach for Adolescents in Schools:* A District Model – NIMHANS DSERT Collaboration - A Report, NIMHANS, 2007.

Bharath S, Kumar KVK, Vranda MN - *Health Promotion using Life Skills Approach for Adolescents in Schools : Development of a Model – WHO- NIMHANS Collaboration - A Report,* NIMHANS, 2003.

Botvin GJ, Eng A, Williams CL: Preventing the onset of cigarette smoking through Life Skills Training. *Preventive Medicine.* 11, 199-211, 1980.

Botvin GJ, Baker E, Botvin EM, Filazzola AD & Millman RB: Alcohol abuse prevention through the development of personal and social competence: A pilot study. *J. Studies on Alcohol.* 45, 550-552, 1984a

Botvin GJ, Baker E, Renick NL, Filazzola AD & Millman RB: A cognitive-behavioral approach to substance abuse prevention. *Addictive Behaviors.* 9, 137-147, 1984b.

Browlby J: *Child care and the growth of love.* London, penguin books, 1950.

Caplan G; *The Theory and practice of Mental Health Consultation.* New York, Basic Book, 1970.

Comer JP: *School Power: Implications of an Intervention Project.* New York, Free Press, 1980.

Cremlin L: *The transformation of the school.* New York, Vintae, 1961.

Davison, G.C. (1998). *Abnormal Psychology.* John wiley and sons, Inc.

Erikson E: *Childhood and Society.* New York, Norton, 1950.

Finkelhor, D. (1986). *A source book on child abuse.* Sage publishers, New Delhi.

Gutkin TB, Krtis Mj; School based consultation. In: Reynolds CR, Gutkin TB (eds): *The handbook of School Psychology.* New York, Wiley, 1982.

Iowa Department of Education & Youth Development: *Developing our Youth: Fulfilling a Promise, Investing in Iowa's Future: Iowa* 2004

Jellinek Ms: *School consultation: Evolving issues: Child Adolescent Psychiatry* 1990.

Kapur M. & Bhola P – *Psychological Therapies with Children and Adolescents.* NIMHANS Publications, Bangalore, 2001.

Kapur M. – *Mental Health in Indian Schools.* Sage Publications, New Delhi, 1997

Malhotra S. Malhotra A. Varma V. – *Child Mental Health in India.* Macmillan India Ltd, Delhi. 1992.

Mehta M & Chugh G- Enhancing Mental Health in Adolescents and Young People. In Rao K (ed)

Mindscapes – global Perspectives on Psychology in Mental Health, Bangalore, NIMHANS Publication, 132-141, 2007

Manual for counsellors: Counselling services for child survivors of trafficking (2006) ministry of women & child development, Govt. of India.

Mental disorders in Children and Adolescents – Need and strategies for intervention, Savita Malhotra, 2005.

Mubbasher MH, Saraf TY, Afghan S, Wig MN: Promotion of mental health through school health program. *EMR Health Serv. J.* 6, 14-19, 1989.

NCERT: *National Curriculum Framework for School Education,* New Delhi 2000.

NCERT - *7th All India Educational Survey - 2002.*

Olweus D: *A national campaign in Norway to reduce the prevalence of bullying behaviour. Paper presented to the Society of Research on Adolescence, Biennial Meeting,* Atlanta, Dec 10-12, 1990.

Offord DR, Boyle MH, Szatmari P et al: The Ontario Child Health Study II: Six month prevalence of disorder and rates of service utilization. *Arch.Gen. Psychiatry.* 44, 832-836, 1987.

Olweus D: Victimization among school children: intervention and prevention. In *Improving Children's Lives: Global Perspectives on Prevention.* Albee GW, Bond LA, Monsey TVC (eds) Newbury Park, Sage Publications, 275-295, 1992.

Orley.J: Weisen B.R.: Hendren R.: *Mental Health Programmes in Schools.* WHO, Geneva. 1994.

Parsons C, Hunter D, Warne Y: *Skills for Adolescence: An Analysis of the Project Material,*

Training and Implementation. Christ Church College, Evaluation Unit, Canterbury, UK 1988.

Pellaux D, Sprunger BE: *Skills for Adolescence: Experience with the International Lions-Quest*

Program. Crisis: International J. Suicide and Crisis Studies. 10, 88-104, 1989.

Pentz MA: *Prevention of adolescent substance use through social skills development.* In *Glynn et al (Eds) Preventing Adolescent drug abuse: Intervention Strategies.NIDA Research Monograph,* Washington DC, 47, 195-235, 1983.

Psychosocial support for children & Adolescents in Disaster situations (2005), Expressions India, world health organization.

Rekha DP. *– Life Skills Education for Single Parent Children – M. Phil Dissertation* – NIMHANS University, Bangalore 2001 (unpublished)

Senson, B. (2006). *Child & Adolescent Psychiatry. 2nd Edition,* Replica Press Pvt. Ltd, India.

Srinath S. et al (2005) Epidemiological Study of Child & Adolescent Psychiatric Disorders in Urban and Rural areas of Bangalore*, India. Indian J. Med. Res,* 122, 67-79.

Srinivasamurthy R. *Child Mental Health: Policies in India – Perspectives and Developments in the National Context in Child Mental Health* – Proceedings of the Indo-US Symposium Kapur M. Kellam S., Tarter R., Wilson R. (eds) NIMHANS – ADAMHA Collaboration 1993.

Weissberg RP, Caplan MMZ, Sivo PJ: *A new conceptual framework for establishing school based social competence promotion programs. In Bond LA & Compas BE 9eds) Primary Prevention and promotion in schools.* Newbury Park CA. Sage, 1989.

Weissberg RP & Bell: A Meta analytic review of primary prevention programs for children and adolescents: contributions and caveats *Amer. J. Comm. Psychology,* 25 (2), 207-214, 1997.

WHO/SEARO: *A Manual on Child Mental Health and Psychosocial Development. Part I: For Primary Health Care Physicians, Part II: For the Primary Health Worker, Part III: For Teachers, Part IV: For Workers in Children's Homes.* (SEA/Ment/65, SEA/Ment/66, SEA/Ment/67, SEA/Ment/68) WHO South East Asia Regional Office, New Delhi, 1982.

WHO/UNESCO/UNICEF: *Comprehensive School Health Education: Suggested Guidelines for Action.* World Health Organization, Geneva, 1992.

WHO: *Skills for Life Newsletter* (WHO, Division of Mental Health, Geneva) WHO/MNH/NLSL/92.1, 1992.

WHO: *Consultation on School Mental Health Programs.* Eastern Mediterranean Regional Office, Islamabad, Pakistan. 14-17, November 1993.

WHO: *Life Skills Education in Schools (WHO/MNH/PSF/ 93.7A.Rev.2* World Health Organization, Geneva 1997

WHO: *Programming for Adolescent Health and Development – A Report of a WHO/UNFPA/UNICEF Study Group on Programming for Adolescent Health* (WHO Tech. Series – 886) Geneva, 1999.

Wolff S: *The School's Potential for Promoting Mental Health. Unpublished Manuscript,* WHO, June 1992.

Young I, Williams T: *The Healthy School. Scottish Health Education Group.* ISBN 0-906323-68-1, Edinburgh, 1989.

Emerging need for Media Literacy in schools

Seema Khanna

Consultant and Resource person on Youth, Gender and Media related issues; Member of the 'National Adolescent Resource Team' of Rajiv Gandhi National Institute for Youth Development and President, Association for Social Welfare and Human Development

INTRODUCTION

Media is the most important tool to provide information, education and entertainment. It shapes and mobilizes public opinion and also acts as the forum for public discussion and debate. Looking at media's reach and impact on human psyche, way of thinking and actions, it can play positive role in children and young people's growth, development and character building. Although not much research is done in our country regarding the kind of content being made available to children and young people via media and the effect it can have on their psyche, behaviour and overall growth and development, available data (both global and Indian), reports and analysis indicate that since the advent of globalization and satellite boom, media seems to have deviated from its role of a socially responsible medium. Growing number of parents, educators and child advocates are alarmed about the lack of quality media for young people and increasing availability of low quality entertainment featuring violence, sexual content, undesirable role models and lack of diversity. Serious questions have been raised about the short and long term effects of this material.

This paper is an attempt to probe into the issues stated above. On one hand it explores the content available to young people and the impact it can have on young people's overall growth and development, while on the other, it recommends media literacy in schools as a way out and the need of the hour.

CHILDREN/YOUNG PEOPLE & MEDIA IN THE WORLD TODAY

As per the report* (Ref 1) 'Children, Youth and Media Around the World: An Overview of Trends and Issues', prepared & compiled by Susan Gigli for Unicef, a look at the world media landscape for children and youth immediately presents two opposing themes: opportunities and risks. In many countries, youth have access to a greater number of multi-media choices than ever before—conventional, satellite and cable TV channels; radio stations; newspapers and magazines; the internet and computer and video games. Today there is greater availability of foreign programming and media, and less official censorship and control in many parts of the world. Information, email and images flow around the world faster and more freely than ever.

The Unicef research, which was conducted in the age group 15 to 19 years old in various countries[1] including India further reveals that television is the dominant medium for young people—and adults—around the world. While in industrialized countries there have been recent outcries over rising levels of aggression, obesity, substance abuse, eating disorders and unsafe sexual behavior among youth, increasingly attributed to commercial media aimed at children and youth, in developing countries, where resources limit domestic productions, majority of programs for children and youth are imported. Unfortunately, much of the content contains characters and messages that, at best, are simply not relevant to local cultures, and at worst convey violent images and mass marketing messages.

The report **'Sex on TV - 4' released by Kaiser Foundation***[2], based on a study, which tracked the broad outlines of sexual content on TV since 1998, indicates that the amount of sexual content on television has increased dramatically. There are nearly twice as many scenes with sex today as there were seven years ago in the same sample of television programming. One in every nine shows across the TV landscape – excluding daily newscasts, sports events and children's shows – includes scenes of sexual intercourse either depicted or strongly

***Correspondonce: Seema Khanna**, E-mail: seemarkhanna@gmail.com*

implied. Studies [2] also show that: Of the roughly 14,000 references to sex a teen would see on TV each year, only a small fraction (165) will include any reference to abstinence or delay of sex, birth control, risk of pregnancy, or sexually transmitted disease (American Academy of Pediatarics, Sexuality, Contraception, and the Media, 2001).

The report '**Generation M, Media in the lives of 8 to 18 years old'*** [4] concludes that the sheer amount of time young people spend using media—an average of nearly 61/2 hours a day—makes it plain that the potential of media to impact virtually every aspect of young people's lives cannot be ignored. The report highlights that media use begets media use: those young people who spend most time using computers or playing video games also spend more time watching TV and listening to music.

LACK OF PARENTAL SUPERVISION

Fueling concerns is the decline of parental supervision over young people's media habits. The Unicef Report [1] reveals that many parents are simply too busy to be closely involved in what their children are consuming**.** Also, youth programming is sometimes not scheduled when most youth are actually watching, so they end up watching adult material. In addition, it is increasingly difficult for adults to know what young people are consuming. They can't keep up with the changing television fare, electronic games and websites, and they also cannot track where their children are consuming media—in their rooms, at school, at friends' houses, in internet cafes or even just hanging out. In Japan, for example, the majority of young people possess mobile phones and more than three-quarters of them access the internet via their phone. The same concern is also highlighted in the survey conducted in 2004 by Kaiser family foundation, **'Parents media and public policy'*** [5]. The report presents a highly paradoxical situation. It says that, without a doubt, Parents are very concerned that their children are exposed to too much sexual content, violence and adult language on TV yet they are not doing anything regarding it. It concludes that the modern parent has a conflicted relationship with TV: deeply concerned about the impact it is having on their children, yet inviting it into their homes, their children's bedrooms, and even their automobiles; favoring limits on sex and violence in TV shows, but opposing restrictions on junk food ads in children's shows, despite being convinced that such ads influence children's food choices. These and other seeming contradictions are simply part of today's media landscape, an important but not always clear background against which policymakers, advocates and the television industry itself must seek common ground.

EFFECT OF MEDIA ON YOUNG VIEWERS

In the article **Women and Media*** [3], published in Farzaneh, Journal of women's studies and research in Iran, Dr Shirin Ahmad-Nia discusses Media's effect on gender identity. She says that the presence or absence of role models, how women and men, girls and boys are presented, and what activities they participate in on the screen powerfully affect how girls and boys view their role in the world. Studies looking at cartoons, regular television, and commercials show that although many changes have occurred and girls, in particular have a wider range of role models, for girls "how they look" is more important than "what they do."

The article quotes from a report by the American Psychological Association, made after analyzing some 300 studies which studied effect of variety of media, from television and movies to song lyrics, and looked at advertising showing body-baring doll clothes for pre-schoolers, tweens posing in suggestive ways in magazines and the sexual antics of young celebrity role models. The report highlights that such images may make girls think of and treat their own bodies as sexual objects.

The article also mentions another recent study on media's impact on adolescent body dissatisfaction which found that:

1. Teens who watched soaps and TV shows that emphasized the ideal body type reported a higher sense of body dissatisfaction. This was also true for girls who watched music videos.
2. Reading magazines for teen girls or women also correlated with body dissatisfaction for girls.
3. Identification with television stars (for girls and boys), and models (girls) or athletes (boys), positively correlated with body dissatisfaction (Hofschire & Greenberg, 2002).

As per the article, some studies show that repeated exposure to media with sexual content may influence teens to have sex earlier. But here's the scary part: those same studies show that the younger a girl is when she has

sex, the more likely she did it under peer pressure, or even coercion."

Research on the influence of media violence on youth by Craig A. Anderson and others[6] makes conclusions after studying various previous researches. The report mentions that the research on violent television and films, video games, and music reveals unequivocal evidence that media violence increases the likelihood of aggressive and violent behaviour in both immediate and long-term contexts. The evidence is clearest within the most extensively researched domain, 'Television and film violence'. Short-term exposure increases the likelihood of physically and verbally aggressive behavior, aggressive thoughts, and aggressive emotions. Recent large-scale longitudinal studies provide converging evidence linking frequent exposure to violent media in childhood with aggression later in life, including physical assaults and spouse abuse.

Similarly various studies point out towards direct and indirect effects of media on adolescent smoking and alcoholism. As per JAMA and Archives Journals young people who view more alcohol advertisements tend to drink more alcohol. According to a another study published in the of Archives of Pediatrics & Adolescent Medicine, Young people are beginning to drink at an earlier age than ever before and their actions can have consequences ranging from poor grades to alcoholism and car accidents[7].

INDIAN SCENARIO

Although not much research has been done regarding the kind of content available to Indian youth belonging to various regions and socio economic background and the effect it can have on their thoughts, behavior and overall growth and development, the following articles and data reflect a concerning situation.

In the discussion forum initiated at dimdima.com on **'Role of media in the society'*** [8] Amarendra Kishore mentions, "Today television channels and newspapers are making fast money by cashing on the news in wrong sense and wrong way. In the race to become more popular and to make money they have broken all the limits media must follow while serving to build a healthy and progressive society."

Justice Markandey Katju a Judge of the Supreme Court of India in his article, **'Ideal and reality: media's role in India'*** [9] *writes,* 'What do we see on television these days'. According to him, some channels show film stars, pop music, disco and fashion parades (often with scantily clad young women), astrology or cricket. He thinks it is a cruel irony and an affront to our poor people that so much time and money are being spent on showing cricket, film stars, disco-dancing, and pop music. Some TV channels show cricket day in and day out. What is important is not the price rise or unemployment or poverty or lack of housing or medicines. What is important is whether India has beaten New Zealand (or better still, Pakistan) in a cricket match, or whether Tendulkar or Ganguly has scored a century. Is this not sheer escapism?

In the article **'Electronic Media Misleading youth'*** [10] published in The Hindu, noted film director, Mr G V Iyer comments that electronic media is misleading the youth by imparting a kind of culture that is unacceptable to our society. "We should create an atmosphere that is conducive to the pursuit of self-evaluation, rather than one that seeks self-pleasure."

*In the article '**Trivial Pursuit'*** [11]*, Seema Khanna shares the experiences she had while addressing gathering of adults and parents in various programmes regarding media and young people. She writes,* 'Head of institutions, teachers, counsellors, parents and others asked several questions. How could children be protected from smoking, drinking and pre-marital sex? Who would they approach to protest against the exploitation of nudity and implicit and explicit sex? Globalisation and satellite TV expose Indians to Western lifestyles. The media accords space for vulgarity, nudity and consumerism to compete with others, unconcerned about the fact crass materialism destabilises the economic situation and value system of most of its middle class patrons. Women are encouraged to dress indecently in the name of high fashion. Columns dwell on quirky subjects: How many times should one have sex? What is the right age and way to kiss or to initiate a physical relationship? How can one keep one's partner? Should cricketers' wives be allowed to accompany their husbands on the World Cup tour? Should cricketers have sex the night before a match? Provocative headlines are common, even on front pages. Reams are written glorifying homosexuality, pre-marital sex and promiscuity.'

The article says, 'The 'hip and happening' crowd might argue that the media reflects society's tastes. If society

wants sex and sleaze, why should the media not cater to this demand? The question is, at what cost?'

The article, 'Media must introspect'[12], mentions about the public interest litigation filed in the Supreme court against two newspapers. The PIL* outlined how newspapers today are publishing titillating SMS jokes, articles on pornography, sex and other adult material like obscene pictures and advertisements of massage parlours. Because newspapers are readily available to minors, and due to guardians' inability to monitor their children against such exposure, the PIL proposed that newspapers be classified as 'adults' and 'universal'.

OPINION OF YOUNG PEOPLE REGARDING MEDIA

As per a study done by VIMHANS*[12] on 1240 school children in the age group 14 to 17 years, nearly 92% said that they were confused and dissatisfied with the media. Nearly 17% felt that media propagated negative responses by showing frequent drug and alcohol abuse. In a survey done by the organization, Association for Social Welfare and Human Development*[13] on 'Projection of women in media', 65% respondents comprising educated men and women (including youth) felt that increasing display of sex and sleaze in media is negatively affecting the psyche, values and beliefs of young people. 80% wanted women development issues related to rural and urban women to be given more importance than models, actresses and glossy stuff. 62% wanted television channels to be more gender sensitive and true in the perception on actual status of women and achievements.

In a pilot study carried out by Association for Social Welfare and Human Development in collaboration with Department of Women Studies, NCERT on 'Effect of media on adolescents sexual beliefs/ behaviour' in the states of Delhi and Manipur, 75 percent of the 133 students, in the age group 13 to 16 years, belonging to urban, rural/semi urban background felt that sexual content including display of nudity and female form in newspapers, magazines, movies, music videos is increasing. More than 80% of students found such kind of display sexually provoking, vulgar and obscene. Approximately 85% respondents of Delhi and 65% of Imphal felt that increasing sexual content in movies can push boys and girls of their age to indulge in sex. 80% boys and 90% girls in Delhi and 77% boys and 86% girls in Imphal felt that sexually explicit pictures displayed via columns of newspapers as advertisements or news related to Bollywood and Hollywood film actors can push young people of their age into sex. In group discussions both girls and boys felt that today's media including news papers and news channels are not playing a positive role. They are presenting information in such a way that the message they are trying to convey becomes unclear and misleading. There is a lot of drama and sensationalism. Most of them emphasized that since the impact and influence of media is immense on adolescents, thus media and media persons should act responsibly.

CONCLUSION AND RECOMMENDATIONS

The above data and findings conclude that media plays a major role in the life of young people and has tremendous power to impact upon their psyche, thoughts and behaviour; although varied kind of content is available for youth via media, a substantial amount might prove to be detrimental and harmful for their overall growth and development and media needs to exercise restraint and understand its social responsibility.

The findings also focus upon the need for better understanding and research into the issues related to Media and young people in our country, especially related to the content available via media and its effect on them. They stress upon the need for immediate measures to be taken by the government and media itself, towards decreasing the content containing sex, consumerism, violence, glamour, fashion, celebrities as it can have a negative effect on psycho-social well being of the young people.

Most importantly the above facts and findings emphasize upon the need for parents to pay a lot of attention on their children's media habits and schools to focus upon counseling both parents and students regarding the same. Last but not the least, the need for initiating 'Media Literacy' workshops in schools, related to creating awareness and promoting critical thinking regarding media content is strongly indicated.

Why Media literacy?

Media literacy can be defined as the process of understanding and using mass media in an assertive and non-passive way. It is the ability to effectively and efficiently comprehend and utilize mass communication. It also gives all consumers the ability to access, analyze, evaluate and create media messages.

Media literacy consists of three stages:

The first stage is to become aware and realize the importance of managing one's own media diet, that is self analysing as to how much time is being spent with television, video games, films, magazines etc and if needed, reducing it willingly.

The second stage is to do critical analysis of the content that one is reading or watching. This would include questions like how it is constructed, what is in the frame etc.

The third stage is to go behind the frame and explore deeper issues. Questions like who produces the media we have interest in, for what purpose is it being produced? What profits would he/she gain from it?

Although 'Media Literacy' is a new concept in our country, global reports suggest that it does have a positive impact. There is evidence to suggest that it can not only help in understanding media and its functioning but also help shatter myths and illusions about glamour, consumerism, fashion, and celebrities to a large extent. By critically analysing media content and messages, a young person can experience media without getting negatively affected by it. Thus, schools should organize workshops on 'Media Literacy' for students, teachers and parents with the help of various experts including communication/media experts, counselors, mental health professionals and doctors so that the negative media influence on young people can be lessened. Also 'Media Literacy' should be made an integral part of all awareness programmes started by the government and other organizations which aim at educating young people and providing them with skills and information related to their development and well being.

SUMMARY

In today's age of information explosion and satellite invasion, young people are bombarded by thousands of media messages be it via television or radio or internet, posters, billboards etc. Number of researches done all over the world on media content and its effect on young people highlight that substantial percentage of the content available via media and the messages conveyed through it might prove to be detrimental towards their overall development and well being. Thus it becomes important for young people to realize that there is an intended purpose for which the content is developed and that creative techniques have been applied by professionals and technicians in order to fetch their attention. That is why they should not accept the messages given via media at face value and be critical of each and every one of them before accepting. Since Media literacy can provide them with skills to analyze media, and decide whether they should accept the messages being offered or reject them, it needs to be propagated in the schools.

REFERENCES

'Children, Youth and Media Around the World: An Overview of Trends and Issues', prepared & compiled by Susan Gigli, InterMedia Survey Institute for UNICEF for the 4th World Summit on Media for Children and Adolescents held in Rio de Janeiro, Brazil / April 2004.

(Source: http://www.unicef.org/voy/media/Inter Media 2004_textversion.pdf) (Website last searched in Dec; 2009)

Note: The research was conducted in various countries including Macedonia, Serbia, Albania, Georgia, Ukraine, Uzbekistan, Uganda, Nigeria, Zambia, Cambodia, China, Indonesia, India, Bangladesh, Pakistan, Columbia, Venezuela, Ecquador, Egypt, Jordan and Qatar.

Website: Kaiser Family Foundation: Sex on TV 4 — November 2005 http://www.kff.org/entmedia/index.cfm) (website last searched-Dec;09)

Women and Media, By: Dr Shirin Ahmad-Nia (Ph.D) website: http://www.farzanehjournal.com/archive/farvol13/arti04.htm (website last searched-Dec;09)

The report Generation M, Media in the lives of 8 to 18 years old (website:http://www.kff.org/entmedia

entmedia030905pkg.cfm) published published by Kaiser Foundation in March, 2005 (website last searched-Dec;09)

Report: Parents, Media and Public Policy, published by Kaiser Family Foundation (year 2004) : Website address- http://www.kff.org/entmedia/upload/Parents-Media-and-Public-Policy-A-Kaiser-Family-Foundation-Survey-Report.pdf (website last searched Dec; 09)

Research on the influence of media violence on youth by Craig A. Anderson, Leonard Berkowitz,Edward Donnerstein,L. Rowell Huesmann, James D. Johnson,Daniel Linz,Neil M. Malamuth, and EllenWartella (http://www.psychologicalscience.org/pdf/psp/psp;43.pdf)://www.mediaawareness.ca/english/issues/violence/violence_entertainment.cfm (website last searched-April;09) Indirect effects of media on adolescent smoking and alcoholism,.website: (http://www.journalism.wisc.edu/mpi/gunther/smokin g.pdf) and (www.jamamedia.org) website last searched-April;09)

Role of media in the society' ,by Amarendra Kishore, (http://dimdima.com/forumnwmessage.asp?Tid=1043&q_title=Role+of+media+in+the+society

Ideal and reality: media's role in India (The Hindu, August 19, 2008) *Website: The Hindu. http://www.hinduonnet.com/2008/08/19/ (website last searched-Dec;09)*

'Electronic Media Misleading youth', The Hindu, Feb 12, 2001) website: http://www.hinduonnet.com/2001/02/12/stories/0412210n.htm last visited- Feb,2009 (website last searched-Dec;09) (website last searched-Dec;09)

Trivial Pursuit', Edit page, second opinion column, 5th march, 2003, Seema Khanna

'Media must introspect' (10th sep, 05, The Pioneer, Second opinion column, Edit Page), Seema Khanna

Life Skills Based Capacity Building For Young Film Makers In Schools

– An Innovative Methodology for Participatory Learning -

Jitendra Nagpal* & Priyanka Gera**

**Program Director, Expressions India; Sr. Consultant Psychiatrist, Moolchand Medcity & VIMHANS, New Delhi,*

***Academic Coordinator, Expressions India; Research Scholar, Department of Psychology, University of Delhi*

ABSTRACT: *Adolescence is a critical time for children because it highlights themes of identity, belonging and attachment. The International Young Film Makers Festival by "Expressions India", Delhi announced an innovative and path-breaking crusade for adolescents, in which they created a film dealing with current issues. This was embarked with building life skills capacity in students through the art of film-making. The group process assisted participants to explore and enrich their narratives of varied issues in the company of their peers. To tell a coherent story moving one's life is developmentally important and closely tied with identity formation, life skills enhancement and resilience. The authors present key themes that arose from the film-making project and explain why narratives are important in a student's life.*

INTRODUCTION

"Film-making is a chance to live many lifetimes."

• *Robert Altman*

Adolescence is a critical time as children indulge with building identity, belonging and attachment. However, children are not only learners caught up in pre-existing knowledge

Systems, but are also active contributors and participants who form their own sense of society. By interacting with others in social systems children can learn much about themselves and the world through exposure to it, by actively participating in its organization and establishment of their unique perspectives.

An important role played in formation of this coherent identity is by, ***Media literacy and Advocacy***, means "the ability to access, analyze, evaluate and communicate messages in a wide variety of forms". Media literacy emphasizes both analyzing media and creating media.

CREATING MEDIA: FILM-MAKING

One of the ways of creating media is through, ***Film-making***. It is a process of "telling-stories". The stories we tell about our lives are the basis of our sense of self. What make a difference are not life events and circumstances, but the way we make sense of them. This view is echoed by diverse but complementary sources. Attachment theory tells us of the healing possibility of telling coherent and resolved stories, even when the stories are of loss and grief. Resilience studies show how some people move on from adversity by finding a productive way to make sense of their stories.

The challenge of the film-making project helps teenagers, find the most enabling and coherent story to meet their specific developmental needs. Developmentally, it makes sense that for adolescents the peer group is a fitting conduit for change. This process brings into awareness about different possibilities and new ways of interpreting stories. Our scripts both reveal and determine the way we see ourselves and the way we live our lives. The direction, editing and production, shows how we understand our past and how we use this to make sense of present and future. Our creation *is* our identity.

Correspondonce: Priyanka Gera, *E-mail: priyanka03@hotmail.com*

ANALYZING MEDIA: LIFE SKILLS

The process of analyzing media is through the education of *Life skills*. The term **life skills** according to UNICEF (2008) refers to a large group of psycho-social and interpersonal skills which can help individuals make informed decisions, communicate effectively, and develop coping and self-management skills that may help them lead a healthy and productive life. Life skills may be directed toward personal actions and actions toward others, as well as actions to change the surrounding environment to make it conducive to health and daily living (Obiozor, E. W., 2008).

Media literacy with Life skill education is beginning to be recognized as one dimension of the essential competencies required for healthy development of children in an information age. Educators must distinguish between learning skills or Life Skills, such as those process-oriented cognitive, communication, and problem-solving skills and learning tools, which include information and communication technologies such as films, computers, networking, audio, video, and other media tools. 21stcentury comprehensive education programme must emphasize the development of students' life skills such as critical thinking, communication, collaboration, and creativity (Hobbs, R., 2004).

The life Skill development facilitated through creating media that is, Film-making is as follows:-

TABLE 1: 21ST-CENTURY LEARNING SKILLS

Information and Communication Skills	**INFORMATION AND MEDIA LITERACY** Accessing, analyzing, managing, integrating, evaluting and creating information in a variety of forms and media; understanding the role of media in society. **COMMUNICATION** Understanding, managing and creating effective oral, written and multimedia communication in a variety of forms and contexts.
Thinking and Problem solving skills	**CRITICAL THINKING AND SYSTEMS THINKING** Exercising sound reasoning in understanding and making complex choice; understanding the interconnections among systems. **PROBLEM IDENTIFICATION, FORMULATION AND SOLUTION** Abality to frame, analyze and solve problems. **CREATIVITY AND INTELLECTUAL CURIOSITY** Developing, implementing and communicating newideas to others; staying open and responsive to newand diverse perspectives.
Interpersonal and Self-Directional Skills	**INTERPERSONAL AND COLLABORATIVE** Demonastrating team work and leadership; adapting to varied roles and responsibilities; working productively with others; exercising empathy; respecting diverse perspectives. **SELF-DIRECTION** Monitoring one's own understanding and learning needs; locating appropriate resources, transferring learning from one domain to another. **ACCOUNTABILITY AND ADAPTABILITY** Exercising personal responsibility and flexibility in personal, workplace and community contexts; setting and meeting standards and goals for oneself and others; tolerating ambiguity. **SOCIAL RESPONSIBILITY** Acting resposibily with the intrests of the larger community in mind; demonstrating ethical behaviour in personal, workplace and community contexts.

Source : Partenership for 21st Century Skills (2003).

PURSUIT OF LIFE SKILL CAPACITY BUILDING THROUGH FILM-MAKING

International Young Film Makers Festival (IYFMF), a path breaking crusade for empowering adolescents, "*Expression's India*" team announced the festival to endeavour media literacy and advocacy. Global and Indian experiences have shown that educational interventions that focus on life skills' enrichment, through the medium of arts, music, theatre and other aesthetic forms like short, educational films, have proven very effective for the overall excellence in schools. IYFMF was a unique innovation in the pursuit of that excellence.

The festival was embarked by varied films offering an excellent introduction to different issues, cultures and cultural norms. As the characters carry on their activities in the broader context of their society, friendships and culture, the viewer is helped to identify with the story and its protagonists. Thus the films portraying different prevailing social, political and economic mores helped adolescent identify current pressures and responses on them. It was divided into two categories, "Ahsaas", one minute duration and "Manthan", 10 minutes duration.

A sneak preview into the entangling young talents in the festival enfolded-

A movie on **Child Rights**, under "Manthan" category, named- "Thought in Time", *the documentary was an attempt to highlight the rights which children are entitled to. As the human race, the children are also categorized into two – 'the haves and the have not's. The haves are privileged enough to exercise their rights without even having the slightest knowledge of it. They enjoy all the luxuries of life, which "the have not's" might have just dreamt of. For the majority, the family incomes are too low, that the parents force the children to go out and work following the belief of "more hands – more income". The children then get exploited in many ways be it child labour, trafficking, small scale crimes, begging and so on. Most of them don't attend school and the ones who do, go because of the major attractions like the mid-day meal in the government schools. When asked, a child said "ek waqt ka khaana toh milega school jaane se". The documentary aimed at making people aware of the condition of children in our society, and making them aware that something needs to be done. It highlighted that, "We have to change to change the world. We can make difference."*

Comments from the students team included- *"Making of this was more of a learning experience for us. We somehow discovered ourselves. We, belonging to well off families who have an adequate amount of income to fulfil our basic needs and even much more, are unaware of what the majority of the children population is going through and always used to take everything for granted. This movie has changed our perspective of looking at things and may be it has even made us a better human being than what we were before."*

Another movie created by school students was, "**Impact of Media on Youth**" under the "Ahsaas" category, named "My Plight". Summary about the movie included- "The *media today is explosive and more interactive than ever. It influences every sphere of our life, our emotions, thoughts, and opinions. With the onslaught of information brought in by the media came a variety of new information, like contraceptive pills. We see a lot of advertisements about emergency contraceptive pills, all giving us the idea that there's always another way out of our problems. These pills have harmful side effects, including headache, body ache, swelling of body parts, etc., which are not advertised. And there is also no medical information supporting the claim that these pills are foolproof against pregnancy. In rare cases, the embryo slips into the oviduct and develops there, which can be fatal for both child and mother. We tried to focus on this serious issue, depicting how these advertisements for these pills promote irresponsible behaviour amongst youth. Our simple slogan at the end of the movie also conveys this message that the youth should be aware and informed, but they should act responsibly regarding how they use such information.*

Comments from the film crew highlighted that, "*It was a great experience, working together on such a project. This is the first time I've tried to make a film.", "I had a great time working on this project with my friends", "It was hard work, but the end result was well worth It." and "I'm glad that I got the opportunity to work on this. It was enriching."*

Therefore, the stories we tell about our lives are the basis of our sense of self. What make a difference are not life events and circumstances, but the way we make sense of them. This view is echoed by diverse but complementary sources. Attachment theory tells us of the healing

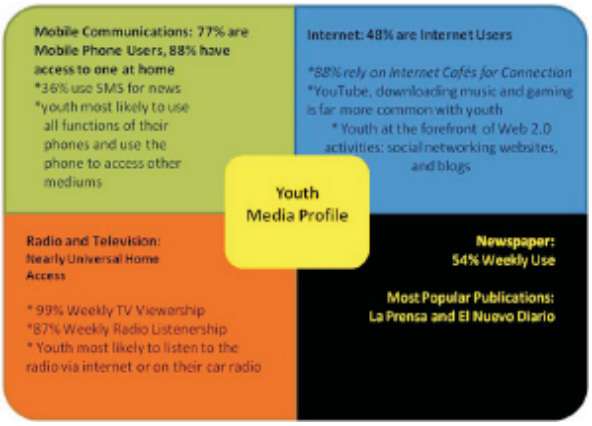
possibility of telling coherent and resolved stories, even when the stories are of loss and grief. Resilience studies show how some people move on from adversity by finding a productive way to make sense of their stories. For adoptees, building a coherent narrative is made more difficult by troubling facts, a lack of facts and reluctance to share these struggles within adoptive families (Fitzhardinge, H., 2008).

In teenage years, children need a richer and more complex way of understanding themselves and their stories. The challenge of the film-making project was to help teenagers find the most enabling and coherent story to meet their specific developmental needs. Not only was it important for these teenage students to consider their personal narratives around current issues, it was also important for them to experience their narrative within the context of other narratives. It was the sharing and layering of these narratives that most effectively led to the enriching of individual stories (Fitzhardinge, H., 2008).

People present at the festival were moved through feeling connected under similar narratives and also by seeing differences between student's narratives – different stories and different ways of making sense of them. The group allowed a canvas of narratives to be explored concurrently, each affected by and affecting another. Developmentally, it makes sense that for adolescents the peer group is a fitting conduit for change. This process brought into awareness different possibilities and new ways of interpreting stories. Our narratives both reveal and determine the way we see ourselves and the way we live our lives (Bruner, 1987). They show how we understand our past and how we use this to make sense of present and future. Our narrative *is* our identity. Within their stories, adoptees reveal perceptions and beliefs, internal working models of relationship, hopes and fantasies. Putting language and story to these fragmentary ideas reveals, both to the listener and to the self, what lies beneath. Once made conscious, it is then available for review, challenge and adjustment (Fitzhardinge, H., 2008).

ROLE OF MEDIA STUDIES

Table: 2- Statistical overviews of the consumption of valuable time spend into the access of media by our YOUTH:



Media Studies or literacy turns the passive act of receiving media messages into action through the practice of decoding, reflecting, questioning, and ultimately creating media. It encompasses the ability to recognize propaganda and bias in the news, understand the impact of media ownership and sponsorship, and identify stereotypes and misrepresentations of gender, race, and class. Commercial and entertainment content targets young people as consumers, yet many youth feel that mainstream media do not reflect their lives as they truly live them. Their peers and communities are often portrayed in a stereotypical, negative fashion, and stories in the news are rarely more than crime reports. When youth find or fail to find themselves reflected in the media, there is an opportunity to discuss feelings of isolation and address issues of disparity, bias, class, and equity. Media-literate young people define their relationship to media content rather than let the content dictate their place in society.

Media-literate young people ask critical questions that help them better understand the intent behind a media work. When listening or viewing media, youth may ask:

- Who produced this work?
- Where are they from?
- What are their attitudes and values relative to my own?
- What are they attempting to achieve through this work?
- Are they trying to change my perspective in some way?
- Do I agree with their point of view?
- How can I respond to their work?

Media literacy fundamentals

Building upon ideas from communication, literary theory, cultural and media studies, and semiotics, educators internationally have developed key concepts (with slight differences in different places):

- All messages are constructions, created by authors for specific purposes.
- People use their knowledge, skills, beliefs, and experiences to construct meaning from messages.
- Different forms and genres of communication use specific codes, conventions, and symbolic forms.
- Values and ideologies are conveyed in media messages in ways that represent certain worldviews, shaping perceptions of social reality.
- Media messages, media industries, and technologies of communication exist within a larger aesthetic, cultural, historical, political, economic, and regulatory framework.

CORE PEDAGOGICAL PRINCIPLES

Media literacy education:

- Requires active inquiry and critical thinking about the messages we receive and create
- Expands the concept of literacy to include all forms of media
- Builds and reinforces skills for learners of all ages with integrated, interactive, and repeated practice
- Recognizes that media are part of culture and function as agents of socialization
- Affirms that people use their individual skills, beliefs, and experiences to construct their own meanings from media messages

Core teaching methods practiced by media literacy educators include:

- Close analysis and deconstruction
- Formal and informal media production

CONCLUSION

The schools that encourage the young minds in authentic journey through film making "discover" media literacy as an instructional tool, to motivate students' attention and interest in learning. It offers teachers to transform the culture of the school into a place where students' voices are valued and respected, where classroom learning is linked to students' lived experience, and where students can develop the confidence to express themselves in a wide variety of forms using language, imagery, and multimedia technology. Therefore by promoting media creations such as film-making by young minds, the children's meaning-making in response to the popular culture, school as well as the education system can seize on what they want to say, learn, and do in their classrooms. The paper will deliberate on the emerging research and innovative methodologies.

Also young children's inquiry of popular culture can be seen as an effective way of deliberating the social issues by connecting school learning to their real life experiences. Therefore by promoting media creations such as film-making by young minds, the children's meaning-making in response to the popular culture, school as well as the education system can seize on what they want to say, learn, and do in their classrooms.

Thus, including young children's astute creations and their perspectives on it can be a critical approach toward multicultural education by means of which teachers can make an effort to give a voice to every child in making decisions about his or her own learning and knowledge.

The tall-order need is to create many platforms so as to promote media creations such as film-making by young minds so as to provide learning experiences where students strengthen Life skills to reach their own understandings about how to fully participate as citizens and consumers in a media-saturated society.

REFERENCES

Bhugra, D. (2003). Using film and literature for cultural competence training. *Psychiatric Bulletin,* 27, 427-428.

Bruner, J. (1987). *Life as narrative.* Social Research, Vol. *54, No.1, pp 11–32.*

Fitzhardinge, H. (2008). Adoption, resilience and the importance of stories: The making of a film about teenage adoptees. *Adoption & Fostering,* Vol. 32, No. 1.

Hobbs, R. (2004). A review of school-based initiatives in media literacy education. *American Behavioral Scientist,* Vol.48; No. 1, 42-59.

Obiozor, E. W. (2008). *The use of music to teach life skilled to students with emotional disabilities in the classroom. Northeastern Educational Research Association (NERA) Annual Conference. University of Connecticut, USA.*

Partnership for 21st Century Skills. (2003). learning for the 21st century: A report and mile guide for 21st century skills. Washington, DC: Author.

UNICEF (2008). *Definition of terms. Retrieved February 22, 2008, from* http://www.unicef.org/lifeskills/index_7308.html

Attitude towards substance use: A comparative analysis of male & female school students

Divya S. Prasad*, Amulya Khurana, Jitendra Nagpal*****

Clinical Psychologist, Moolchand Medcity, New Delhi.

**** Professor, Department of Humanities and Social Sciences. IIT, Delhi***

***** Consultant Psychiatrist, Moolchand Medcity***

Abstract: *The aim of the research was to study and compare the attitude of male and female school students, towards substance use. Survey research design was followed in the study. A purposive sample of 373 (boys=199, girls=174) students was drawn from 2 government schools and 2 public schools, in Delhi. A 28 item Likert type scale, with score ranging from 28 to 140, was designed to measure the attitude towards substance (alcohol, tobacco and other drugs) use. Higher score represented a more favourable attitude towards substance use. Data analysis was done by using descriptive and inferential statistics. Results indicate that boys have a more favourable attitude towards substance use as compared to girls (t=6.909, df = 371, p<.05). From the results it can be concluded that although girls have a more negative attitude towards substance use, boys seem to be in a state of dissonance.*

Keywords: *substance use, school students, attitude*

INTRODUCTION

Communities in India are in a state of transition amidst changing states of growth and development. While societies are undergoing continues dynamic changes due to macro and micro level influences, people are embracing new life styles, cultures and practices. The impact of globalization, industrialization, migration, media invasion is gradually replacing the traditional societies and resulting in different life styles and behaviours as compared to yesteryears. There has been a gradual and significant decline in communicable, nutritional and infectious diseases. However, the burden of non communicable diseases which are linked with behaviour and life styles such as increased tobacco use, alcohol abuse, lack of physical activity, high risk sexual behaviour and many another are contributing substantially to the morbidity, disability and diminished quality of life (WHO, 2006). The use of alcohol, tobacco and other drugs (ATOD) poses tremendous health risks. According to WHO (2002), worldwide, the use of alcohol and tobacco is amongst the top ten risk factors to good health. In addition to the damaging health consequences, substance use also often results in severe social and psychological problems. Many school aged children and adolescents experiment with drugs, and the eventual use and misuse of drugs can cause serious health, personal and social problems. It has been well established that the prevalence of drug use generally increases with age and progresses in a well defined sequence. Drug use typically begins with the use of alcohol and tobacco first, progressing later to the use of marijuana, and, for some, to the use of stimulants, opiates, hallucinogens, and other illicit substances. This progression corresponds exactly to the prevalence and availability of these substances. Because alcohol, tobacco and marijuana are among the first substances used they are referred to as "gateway" substances. The use of gateway substances significantly increases the risk of using illicit drugs.

Saxena (1997) reported that studies in the late 1970s and early 1980s found 12.7 % of high school students, 32.6 % of university students, 40 to 60 % of medical students and 31.6 % of non student young people used alcohol.

There is evidence that drinking is being initiated at

Correspondonce: Divya S. Prasad, Clinical Psychologist, Moolchand Medcity, New Delhi*;*
E-mail: jnagpal10@gmail.com

progressively younger ages in India. Data from Karnataka showed a drop from a mean age of 28 years to 20 years between the birth cohorts of 1920 –1930 & 1980 – 1990 (Benegal, 2005).

Sinha & Gupta (2004) conducted a study in northeastern India amongst 13-15 year old school students and concluded that the prevalence of smoking and drinking was 8.5%-19.6% amongst boys and 2.9-7.7% amongst girls. This high rate of smoking and drinking among such young children is alarming. Another study of drinking habits conducted in Bangalore city (Kumar, 1997) reported that a fifth of young people who frequented pubs on weekends were girls aged between 13-19 years.

Between 1977 and 1987 two large studies were carried out among senior high school students. One was a multicenter study carried out in 4 metropolitan cities. Alcohol was the most commonly abused substance (4-13%), followed by tobacco (3-6%), and minor tranquilizers (1-4%). There were no reports of cannabis or opiate use (Mohan et al, 1985).

A project named Drug Abuse Monitoring System 1989-91, was carried out in three cities (Delhi, Jodhpur, Lucknow) on behalf of Ministry of Health and Family Welfare and sponsored by ICMR. The data generated the profile of drug users, their drug use history, drug related problems and treatment history. The consolidated report of data spanning three years showed that out of 10, 321 patients, 65% were initiated into drug use between the ages of 15- 25 years. (Mohan et al, 1993)

AIM

The aim of the research was to study and compare the attitude of male and female school students, towards substance use.

METHOD

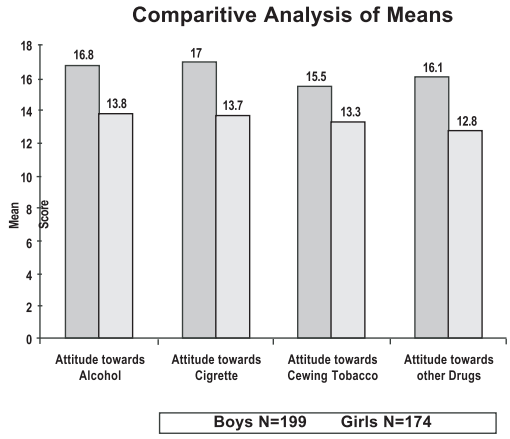
A 28 item Likert type five point scale was designed for measuring the attitude towards substance use (alcohol, tobacco and other drugs). The score on the scale could range from 28 to 140. High score represented a more favourable attitude towards substance use.

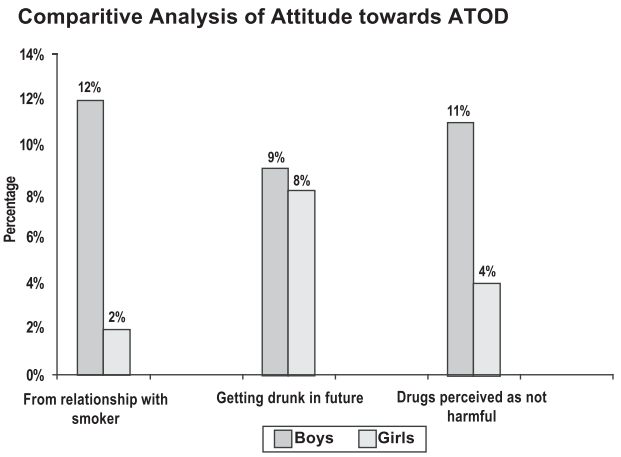
Sample

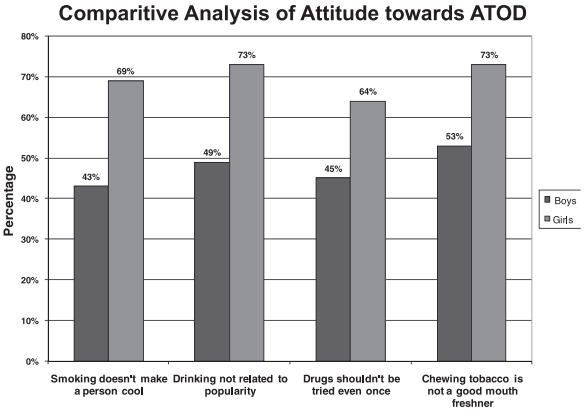
A purposive sample of 373 students from 10th and 11th class was selected from 2 government and 2 private schools in Delhi. The sample consisted of 199 boys (Mean Age = 15.5 years) and 174 girls (Mean age = 15.2 years)

RESULTS

Results showed that boys obtained a mean score of 65.14 (SD=17.2) as compared to mean score of 53.85 (SD=14.2) obtained by girls, on the scale of attitude towards substance use.







This indicates that boys have a more favourable attitude towards substance use as compared to girls ($t = 6.909$, $df = 371$, $p<.05$).

Analysis of some specific questions reveals that 16% boys felt that drinking alcohol was not looked down upon by society as compared to 26% girls, who felt likewise. Only 40% boys strongly felt that smoking did not fit in their life style as opposed to 59% girls, who had similar views. 68% girls felt that they were not in favour of having close relationship with a smoker. In comparison, only 43% boys were opposed to having close relationship with a smoker.

Only 46% boys strongly felt that people need not take the help of alcohol to feel comfortable at parties, whereas, 63% of girls felt in the same manner.

46% of boys felt that smoking did not make one look cool as compared to 69% girls, who felt likewise.19% boys and 13% girls felt that use of drugs should be legalized.

CONCLUSION

From the results it can be concluded that although girls have a more negative attitude towards substance use, boys seem to be in a state of dissonance. This implies that male students are perhaps, more vulnerable to experimentation and susceptible to health compromising habits than their female counterparts. However, there is further need to investigate the effect of some other background variables such as age, socio-economic status, family environment, substance use status, type of school etc., on students' attitude towards substance use. Such studies, especially in the Indian context, can help in understanding the issues related to substance abuse, so that effective prevention programmes can be formulated.

REFERENCES

Benegal, V., Gururaj, G., Murthy, P., Taly, A. B., Kiran, S., Chandrashekar, R., Chandrashekar, H. (2002). *Report for the WHO injury & alcohol: emergency department study. Bangalore (http://www.nimhans.kar.nic.in/Deaddiction/lit/Alcohol./.20)*

Kumar, V. S. (1997). Behavioural malignancy: alcoholism, a bleak future? In Isidore, S. Obot & Room, R., (eds), *Alcohol, Gender & Drinking problems – Perspectives from Low and Middle Income Countries.* WHO 2005.

Mohan, D., Ray, R., Sharma, H.K., Desai, N.G., Tripathi, B.M., Purohit, D.R., Sharma, D.K., Sethi, B.B., Sitholey, P. & Tewary, S.C. (1993). *Collaborative Study on Narcotic Drugs and Psychotropic Substances.* Report submitted to ICMR (Indian Council of Medical Research)

Mohan, D., Sethi, H.S., & Tongue, E. (Eds) (1985). *Current research in Drug Abuse in India, Series II,* JayPee Brothers, New Delhi in Drug Demand Reduction Report, UNDCP Regional Office

How Can We Offer Education To Young People That Give Them The Happiness, Passion, Challenge And Satisfaction?
Indian Music the reservoir of Education

Priyanka Gera

Doctoral Student, Department of Psychology, University of Delhi, North Campus, Delhi-110007, India

Abstract: *Indian musical pathway is an approach to attain balance in one self, of spiritual and psych-emotional intricacies via the holistic approach which does not separate individual. It involves exploration of holistically engaging all human faculties- different aspects of mind, body, spirit, intuition and memory. This study focuses on the Indian students and demonstrates the potency in the context of studies investigating the music as essential aspect of affective human experience. This was mediated through Kabir's poetic endeavours sung by Sufi singers. The study is based using the principles of grounded theory. It is a method consisting of set of inductive strategies for analysing data. The qualitative analysis of the Kabir's musical poetry, "Bahar Kyon Bhatke?" and "Heli, Kin Sang Karan Sneh?" shows that the "Essence of the Teaching is to Encourage Self Journey." This indicates that Indian music, poetry and the creative arts in general, are integral to our wellbeing, yet we still often relegate the arts to the periphery or search for 'instrumental' reasons to defend their existence in public schools. Therefore, erudition of arts may provide a space in schools for students to express their identities in a freer and more creative way than is generally seen in other subject areas. It is a step to restructure the critical pedagogy perspective that opens up many such questions as- What can we do to allow for positive experiences which exist in terms poetry or music etc. to transfer into education in general?*

INTRODUCTION

What kind of moral issues can be successfully explored with young children through traditional songs, using the medium of educational music? In what ways do such songs lend themselves to this kind of work and why? How are moral meanings made and interpretive by children through the art form of music?

To answer such question and more, some of the classic poetry of Kabir which is sung by some great Kabir lovers now known as 'musical poetry' is being used in this research. This is an attempt to revive the essence of some of the classic Indian poetic songs in the field of education in India.

Music matters to young people; it matters in profound and existential ways. The main aim of western studies is to emerge with an intentionally accessible art form which may be used as fuel to keep the fires of art education burning in schools. As an example of complementary arts-based research, many studies complements and confirms earlier findings about student attitudes towards their music education and extends these findings into the beginning articulation of the deeply held, affective and philosophical dimensions that music and music education can open up in the lives of young people (Prendergast, M., Gouzouasis, P, Leggo, C & Irwin, L. R. (2009). The literature pertaining to such a significant movement is not available on Indian population.

Review of literature shows that many western studies show similar findings such as the study by Prendergast, M., Gouzouasis, P, Leggo, C & Irwin, L. R. (2009), employed an arts-based approach that offers a complementary perspective that music plays a key role in most students' lives, and that music is generally perceived to be fun, engaging and rewarding as well as demanding and disciplined. Therefore the art forms especially music and poetry was being regarded as successful break-through the hegemony of pedagogy.

Today's generation only listen's and not engages in music experiences during school years that has little to do with the tedious and traumatic life that students live and breathe in with increasing mental health problems in

Correspondonce: Priyanka Gera*, E-mail: priyanka03@hotmail.com*

India. Evidence gathered by *World Health Organisation* predicts that by year 2020, childhood disorders will rise by over 50% internationally, to become one of the five most common causes of morbidity, mortality, and disability among children. I believe that the Kabir's musical poetry captures the depth and intensity of emotions, engagement and transformative affects that adolescents experience and in matters of their lives.

This study is to add to the ever-growing contributions being made in these areas and to focus on the Indian students and demonstrate the potency in the context of studies investigating the music as essential aspect of affective human experience. It focuses on reconnecting pathways back to ancient wisdom via spiritual practices, healing modalities and creative practices. All these can be mediated by the Kabir poetic endeavours sung by Sufi singers.

These pathways are body-centred and earth-centred different from the patriachical religious distinctive hegemony which exists in India. It is an approach to attain balance in one self, of spiritual and psych-emotional intricacies via the holistic approach which does not separate individual. It involves exploration of holistically engaging all human faculties- different aspects of mind, body, spirit, intuition and memory. In its essence the Kabir's musical poetry is the embodiment of LOVE as an active principle, both the mechanism and goal simultaneously. The version of Sufi singing is a music-based spiritual practice.

बाहर क्यों भटके ?
----कबीर

धोरा राम ह्रदय माही
बाहर क्यों भटके ?

ऐसा ऐसा हीरला घट मों कहिये
जोहरी बिना हीरो कोण पारखे?

ऐसा ऐसा धर्त दूध में कहिये
बिना झुगिए माखन कैसे निकले ?

ऐसा ऐसा आग लकड़ी में कहिये
बिना घसीए आग कैसे निकले ?

ऐसा ऐसा कैवाड हिवडे पर जड़ीया
गुरा बिना ताला कोण खोले ?

कहत कबीर सुण भाई साधो
राम भजे थानों कोण हटके ?

The study is based using the principles of grounded theory. It is a method consisting of set of inductive strategies for analysing data. It begins with abstract conceptual categories to synthesize, explain and understand the data and to identify patterned relationship between them. Then involves building theoretical analysis on what we discover is relevant in the actual world that we study within the area of research.

eTherefore it is effective techniques enable us to focus the intensity of the affective aspects of student's experiences through poetic ndeavours.

METHOD

The study involves a purposive sampling or the data collected, a poetry written by Kabir and sung by Sufi singers from the book "In Every Body Kabir", by Divya Jain & Shabhnam Virmani in 2008)

(The English Translation of the poetry by Vidya Rao, in the book "**In Every Body Kabir: Songs of Kabir by 10 artists",** by **Divya Jain & Shabhnam Virmani in 2008)**

Baahar Kyon Bhatke?
(Why go a-wandering?) Kabir

Ram's in your heart,
Why go a-wandering?

Such rare jewels in your body!
Without a jeweller,
Who will know their worth?

Such pure ghee in the milk!
Without churning,
How will the butter emerge?

Such fire in the heart of the twig!
Without being struck,
How will it ignite?

Such big doors shut over your heart!
Without the guru,
Who will open the locks?

Says kabir, listen seekers:
When you've got Ram,
Who can stop you?

हेली किण संग करा सनेह?
----धरमदास

हेली ,
किण संग करा सनेह?
सांगत भली धर्मी साध री
सांगत कीजे नार्मल साध री

हेली,
बास उगो इन बाग़ में, थरक रही बन राय
आप जले औरा ने जाले, आग्नि घनी आग माय

हेली,
चन्दन उगो इन बाग़ में, हरख करे बन राय
चन्दन पास मै जाऊ , आप चन्दन होई जाये

हेली,
दव लागो इन बाग़ में, पंछी रे बैठो आए
हमरे जलो पांख बहिरो , तक उडी परे को जाए

हेली,
फल खादों रे पान बिरोडिया, रमिया डालो डाल
तुम जलो मै उबरू , जेवनो कीतरीक बार

हेली,
दव बुझायो झाडा मेठिये, दूध बूटा मेह
कहत कबीर धरमदास, नित नित नवलो नेह!

Heli, Kin Sang Karan Sneh? (Whom should I love, my friend?) - Dharamdas

Whom should I love, my friend
True seekers make good company
Seek the kinship of the pure in heart.

A bamboo grew in this grove
And all the forest trembled.
When it burns, it burns all else
There's so much fire in its body.

A sandalwood grow in this grove
And delighted all the forest!
I go near that sandalwood tree,
I became fragrant too!

A fire lit the forest, a bird came to sit.
The wingless tree cry:
We're ablaze, we have to burn
But you, winged one, should fly!

I ate your fruit, soiled your leaves,
Played from branch to branch
Leave you to burn, and fly away?
We live and love but once!

The fire went out,
The clouds, rained milk
Says Kabir to Dharamdas:
Everyday my love is new.

(A folk song by Mahesha Ram of the Meghnal community of Jaisalmer, Rajasthan in Western India, translated by Vidya Rao)

The Procedure used in the research is a qualitative method of inquiry known as Grounded theory to analyze the above data collected. According to Charmaz (1995) it was founded and created by Barney G. Glaser and Anselm L. Strauss in 1967. It is a research tool which provides a structure within which a researcher can approach a mass of unstructured data rich in conflicting meanings. The methodology is consistent with an interpretative view of the research processes as created through interplay between the perspective of the researcher and the data an interactional construction and rendering of the data, which fits with a social constructionist perspective. The steps followed in the analysis were as follows:

i. Collecting the data: in this case, two poetries sung by Sufi singers and written by Kabir: *Baahar Kyon Bhatke? And Heli, Kin Sang Karan Sneh?* Were taken from the book, 'In Everybody Kabir: Songs of Kabir by 10 artists' edited by Divya Jain & Shabnam Virmani, 2008.

ii. Coding the data: It means dividing the material into coherent units and conducting theme analysis which further involves three steps. First the line-by-line coding was done, where the derivation of meaningful units took place, next was focused coding, where the data was divided into meaningful elements and inductive categories were developed. And in the last axial coding was done where the inductive categories became tentative themes.

iii. Memo-writing: where as a result categories were explained breaking them into their components. Further the comparison of the theme with the purpose of the study took place.

RESULT

The theme emerged after conducting the analysis of two of the poetic songs written by Kabir and sung by the Sufi singers in different parts of India today enfolds important lesson for all that is **"ESSENCE OF TEACHING IS TO ENCOURAGE SELF JOURNEY"** which is important in awakening of student. Each song involves six categories according to each poetic stanza and further divided into many units within it.

First song is:

"Baahar Kyon Bhatke?"

(Why go a-wandering?) Kabir

The first stanza is focusing on the category of Materialistic lives leading to increase in problems, tensions, low performance, aggression, hyperactivity and irritability among the youth. The stanza is as follows:

Ram's in your heart,

Why go a-wandering?

Here, 'Ram' signifies happiness and 'Heart' signifies soul. Also 'wandering' is signifying the happiness we try to find in the materialistic things such as money or brands or possession of external goods or high score etc. These act as primary gains which is resolution of the conflict between a wish or/and secondary gains which is establishing disturbing behaviour enabling the person to get attention and temporary care which was being neglected (referring to the Freudian concepts providing an interpretation and deeper understanding to the pathology). These are strong defences which act an obstacle to achieve the real rasa of life that is happiness. Thus the author wants to convey that the happiness lies in the soul of the person thus it resides inside and not external to the body and unless we evolve from within, we will not be able to achieve this ultimate goal of life.

The second stanza focuses on the role of teacher to enhance 'Self Worth' or 'Self-concept' which is essential in showing the path towards achievement of the ultimate goal of life. The stanza is as follows:

Such rare jewels in your body!

Without a jeweller,

Who will know their worth?

Here the 'Jewels' signifies the inherent talent and 'Jeweller' signifies the teacher (traditional concept of a guider known as guru). The author emphasises the role of the 'teacher' or 'guider' to motivate, inspire and become role-models in the life of the student so as to enlighten him/her with their inherent uniqueness which resides in each of us. Also to help them acknowledge his/her purpose of existence; by bringing out the inherent quality within the individual. This will lead to a coherent self-concept (according to Rogers Self theory, it's essential for the development of a fully functional person) to value oneself and enhance self-esteem which in turn makes one active, successful and optimistic.

The third stanza indicates the importance of the hard-work or struggle in the life of the student to taste success and happiness. The stanza is as follows:

Such pure ghee in the milk!

Without churning,

How will the butter emerge?

Here the 'pure ghee' signifies the talent or quality, 'milk' signifies the soul or self and 'churning' signifies hard work. Thus the author wants to say that hard work or efforts are needed for the inherent talent to emerge as

'butter'. The butter has qualities of being pure, white, serene, shining, has strength. Thus for such qualities to emerge and for development of a holistic personality hard-work or struggle is essential. Also recently many psychology thinkers have evolved with a new term know as 'Hardiness', it is a personality disposition that is marked by commitment, challenge, and control. It is associated with strong stress resistance and it is found that people high on hardiness are less prone to illness. Thus hardiness or hard-work leads to development of a healthy personality.

The fourth stanza focuses on the relevance of the skill or practice needed to master the inherent talent and gain triumph. The stanza is as follows:

Such fire in the heart of the twig!
Without being struck,
How will it ignite?

Here the 'fire' signifies the passion, 'twig' signifies the body, 'struck' relates to being able to use it skilfully and 'ignite' relates to mastery. Thus the author says that for the inherent talent to emerge another essential ingredient is the mastery of the skill to achieve success or fame in life. Therefore the skill is required to deliver the required service of the individual and fulfil his/her purpose of life. This skill can only emerge with unswerving and resolute practice. To be an effective in any profession for example, to be an effective psychologist, one needs communication, interviewing skills etc similarly to be an effective person and be able to make an impact on others, one need to have mastery over the skills.

The fifth stanza indicates that knowledge is essential to resolve ignorance and leads to attainment of personal growth or state of self-actualisation. The stanza is as follows:

Such big doors shut over your heart!
Without the guru,
Who will open the locks?

Here, 'big doors' signifies ego boundaries, 'heart' signifies the soul and 'guru' is the knowledge. Thus the author says that these ego boundaries consisting of locks in terms of jealousy, comparison, rage etc are residing in the soul of an individual. Knowledge is needed to shed all these and walk on the path of wisdom. When there is breaking of these ego boundaries with help of a guru, the person can touch parts of self and leads to self actualization (Maslow's) where the feelings of richness and bliss is found. This a person can achieve through evolving the humane qualities in oneself such as love, empathy etc essential for holistic growth.

The last stanza focuses on the Self- identification or recognition of the soul (Atman) is essential for the learner to complete teaching. The stanza is as follows:

Says kabir, listen seekers:
When you've got Ram,
Who can stop you?

Here, 'Kabir' refers to the author; 'seeker' is the learner and 'ram' refers to happiness. Thus the author wants to say that once the person as identified the happiness within its soul then no one can stop him/her in attainment of his/her goals or to fulfil his/her dreams. The Indian thinkers believe that Atman represents independent, non-material realisation of a real self. This self-realization induces one with confidence and brings one closer to the 'ideal self' which involves two Indian notions that is *jitendriya* (a person who has control over his receptors and effectors) and *aparigrah* (keeping limited things that can satisfy the minimum needs). Hence the 'pure happiness 'is achieved through the attainment of 'soul' or 'Atman".

The second song is:
Heli, Kin Sang Karan Sneh?
(Whom should I love, my friend?) -
Dharamdas

The first stanza is focussing on the most important and core aspect of life that is Love is within oneself and not to be found outside of one's soul (Atman). The stanza is as follows:

Whom should I love, my friend
True seekers make good company
Seek the kinship of the pure in heart.

Here 'love' refers to eternal love or lasting forever or existing forever happiness, 'my friend' refers to Kabir or guru, 'true seekers' refers to pure souls and 'good company' refers to friend or lover or companion. Thus the author asks his guru 'Kabir' that who is one that can lead to eternal love or happiness in life. The true souls or human beings generally make good company in terms of positive acceptance or feelings when with the 'other' which is a friend, lover or companion but are unable achieve the real rasa of life that is 'true happiness'. This resides not outside or in 'other' but in the origin of the self, which refers to the heart, soul or ATMAN. We can

never find fulfilment anywhere except in the inner self, yet we do absorb qualities from one another through emulation. Without human friendship might never get a hint of god's infinitely greater friendship. Moreover, human love is the 'greatest delusion' without it we might never feel inspired to seek its true fulfilment that is, union with happiness.

The second stanza indicates that Physicality's of Life leads to destruction. The stanza is as follows:

A bamboo grew in this grove
And all the forest trembled.
When it burns, it burns all else
There's so much fire in its body.

Here, 'bamboo' refers to the child with type-A personality, 'grove' refers to the small community, 'forest' refers to the human race and 'fire' symbolizes the achievement, competition, desires etc. Thus the author says that, the children who are born in community with the type-A personality or characteristics such as hard, achievement oriented, strictly disciplined without humility, when grows all the human race is shocked in excitement or the accomplishments of such people. If they burn, which symbolizes failure such as failed in exams etc, their aspirations or dreams in life shatter. They then burn the entire human race with an attempt to suicide, anxiety-prone, disturb mental health etc. Thus the physical body hold only 'fire' which means it is the outer body filled with 'food' that is 'wants' or 'materialistic gains'. Thus the author wants to show that the physical body is only a container for its animating spirit, to which one's feelings truly belongs.

The third Stanza indicates that the 'Pure aura spreads true happiness'. The stanza is as follows:

A sandalwood grow in this grove
And delighted all the forest!
I go near that sandalwood tree,
I became fragrant too!

Here, 'sandalwood' refers to child with type-B personality, 'grove' refers to the small community, 'forest' refers to entire human race and 'fragrant' refers to happiness. Thus the author wants to say that the child with qualities of sandalwood tree such as radiant, humility, acceptance, forgive etc and closer to type-b personality traits such as relaxed and calm. Such people not only help their community to grow but spread happiness among the entire human race. Hence the author says that if anyone goes near to them, they are like aromatic air that fills the other with happiness and bliss. Each senses in the pure other has a quality that satisfies a deep need. Yearning, they reach out as if to absorb a fulfilment long and passionately awaited.

The fourth stanza indicates that the Realization can set one free. The stanza is as follows:

A fire lit the forest, a bird came to sit.
The wingless tree cry:
We're ablaze, we have to burn
But you, winged one, should fly!

Here, 'fire' refers to companionship, ambition, achievement etc, 'forest' refers to the community or society, 'bird' refers to the seeker or child, 'wingless tree' refers to parent, 'ablaze' refers to destiny and burn symbolizes end. Thus the author says that the physicality's or the materialistic cravings had leaded the forest that is the community or society to be destroyed. Among this a bird which is symbolized as a new child or baby is born and is pure with his/her wings. Here wings means search, thus baby has capacity and ability to fruitfully utilize his/her life and search for its essence. The wingless tress or the parents have come to their realization of wasting their life and hence cry to their misery. They believe that they were destined to destruction and had to burn to start new. They plea to the baby to realize his/her power of the wings, which here symbolizes hope to find real essence of like-happiness. Therefore baby must fly, hence must seek his journey of growth.

The fifth stanza indicates that, Happiness is the purpose of existence. The stanza is as follows:

I ate your fruit, soiled your leaves,
Played from branch to branch
Leave you to burn, and fly away?
We live and love but once!

Here, 'I' is the baby or child who is born, 'fruit' symbolizes mother, 'leaves' symbolizes father, 'burn' symbolizes calamity and 'live' refers to happiness. Thus the author says that that the baby pleads to his/her parents that I have taken my existence from my mother and formulated my personality from my father. They have given me a caring and nurturing environment to grow and flourish. Now, when they are struck with

calamity, they are asking me to fly or set myself free. Here the parents realization takes the form of purpose in view and wants the child to understand that the real purpose of existence is to live that is seek happiness. And to love that is to attain eternal love. For both the child needs to set himself/herself free from all bounds and fly towards attainment of purity in life. Therefore author coveys that the child, each with its own interests and self-created destiny has the purpose to embrace love.

The sixth stanza indicates that, Let's be coloured by true love. The stanza is as follows:

The fire went out,
The clouds, rained milk
Says Kabir to Dharamdas:
Everyday my love is new.

Here, 'fire' means desires, ambitions etc, 'cloud' symbolizes motherly heaven, 'milk' refers to being pure and 'Dharamdas' is the author and 'Kabir' is the guru or teacher. Thus it means that all the materialistic gains in terms of desires, wants' or wishes are finished and washed away as the fire is stopped spreading. This was only possible through the rain of purity or strength sent from the clouds which symbolizes motherly heaven. Thus the guider or guru says to the author that now I have felt it radiance and I am coloured with its true shades of love. These shades are many in terms of joys of excitement, which is attained when reached such pure state of being. Hence every human desires, ambitions and aspirations are destined for ultimate disappointment, unless it transcends its human limitations with the essential colour of eternal love.

DISCUSSION

The qualitative analysis of the Kabir's musical poetry, "Bahar Kyon Bhatke?" and *"Heli, Kin Sang Karan Sneh?"* shows that the "***Essence of the Teaching is to Encourage Self Journey.***"

This fruitful journey can be mediated through the first song at lower level of child development. Then the second song symbolizes further deeper indulgence which is achieved at higher level of child development along with exploring intricacies of ones life.

According to the first song, 'Bahar Kyon Bhatke?,' focus that the self journey begins by not indulging oneself into materialistic gains and chained by problems. Rather to seek happiness within self. The role of the teacher is to enlighten seeker with the path towards success. But the journey doesn't end here; one also needs to struggle and work hard. The attainment of the mastery in the skill is also an essential ingredient in this process. Also there is the need to show significance of knowledge that ignites the path with wisdom and bliss. Hence realization of self or soul is the ultimate purpose of existence and helps one in achievement of the goal that is 'pure happiness'.

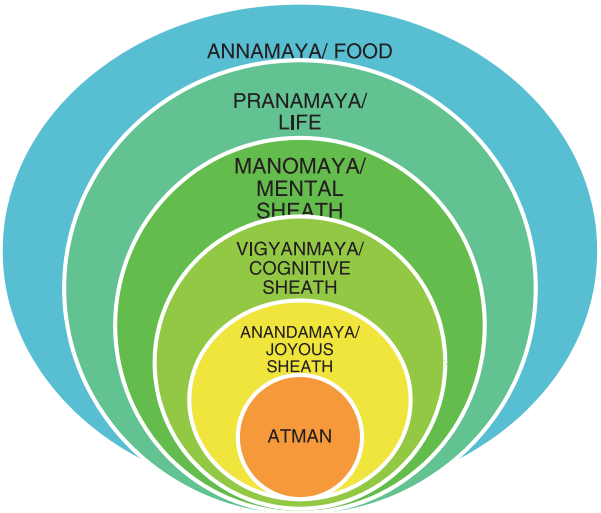
Also according to the second song 'Heli, Kin Sang Karan Sneh?,' this takes into account further development of the self journey which touches on deeper issues of enrichment. It starts by indicating that love is within oneself therefore the soul is the destination. It focuses on the physicality's of life that leads to destruction. It gives importance to the pure aura that spreads true happiness such as in terms of fragrant or true people in our life can show us the strength of existence. Once we realize this then we are set free in terms of our wings and can fly to seek happiness that is the purpose of existence. Therefore the author pleads to let oneself be coloured by true love.

Hence both these songs refer to the six layers of our existence that is body, breath, mind, intellect, memory and self. These are subject to change except the self which is the core and the destination for all. Such as the physical body changes over time. The mind oscillates between past and future, likes and dislikes. The intellect is caught between agreement and disagreement. Memory experiences loss and gain. This concept relates to some indigenous ideas about self-thought (Mishra et al, 2003). The self is the multilayered hierarchy; also in Taittiriyopanishad it states that the Jiva is a multilayered identity. There are five layer of Jiva consisting of five Kosos or sheaths. It is like the concentric sheaths of an onion.

The physical body is the transformation of food, it has an *Annamaya Kosa* (food sheath). The vital airs form another sheath, the *Pranamaya*. It weighs between good and bad, right and wrong in the sheath of mind, or *Manomaya Kosa*. When it fixes upon a step, with a purpose in view, it is the function of the *Vijnanamaya Kosa*. When the joy of achievement is tasted, it is the *Anandamaya Kosa* that functions.

Thus the categories found in the research through the poetic endeavours of Kabir are related to the Indian perspective of this Panchkosa.

- In the first song, the gross physical body is said to be the product of food (*Annamaya kosa*) which is similar to the first category, emphasizing the outer materialistic gains. Thus food is signified in terms of external to the body. Within it is the self that consists of life (*Pranmaya kosa*), which is related to second category of 'guru' that



shows the path and ignites. It is a guru which gives birth to self and hence generates life. The next level involves breathing and other metabolic processes that activates the organs and keep them functioning, mental sheath (*Manomaya kosa*). It is similar to the third, as it emphasises on the struggle and hard-work needed to maintain functioning. It is through this that one seeks the object of desire. The next layer is that of cognitive sheath (*Vigyanamaya kosa*). It involves ideas, constructs etc. that are employed in knowing the world. It is similar to the fourth category indicating the significance of the skill in growth. The innermost layer is called joyous sheath (*Anandamaya kosa*) as it reflects the bliss which is the basic characteristic of the true self. This is similar to the fifth category of relevance of knowledge as the basic characteristic in attainment of happiness. Last is the core, the '*Atman'* which again signifies according to the sixth category with self-realization and reaching the goal or purpose of existence that is "soul".

In the second song, the gross physical body is said to be the product of food (*Annamaya kosa*) which is similar to the second category, emphasizing the physicalities of life and the destruction that it causes if one remains at this stage. Within it is the self that consists of life (*Pranmaya kosa*), which is related to third category of 'pure' aura that spreads happiness. Thus it symbolizes in terms of pure breath needed for meaningful existence. The next level involves weighting between good and bad and right and wrong, mental sheath (*Manomaya kosa*). It is similar to the fourth category, as it emphasis on the importance of realization to set oneself free from all internal as well as external bondages. The next layer is that of cognitive sheath (*Vigyanamaya kosa*) that fixes upon a step with a purpose in view. It is similar to the fifth category that emphasises that the real purpose of existence is to search happiness and eternal love. The innermost layer is called joyous sheath (*Anandamaya kosa*) as it reflects the bliss when joy of achievement is tasted. This is similar to the sixth category of achieving this blissful stage by being coloured totally in pure or true love. Last is the core, the '*Atman'* which again signifies according to the first category which places emphasis on the true love as within oneself and not in the 'other' that is the companion or friend. Hence reaching the "soul" is the essence of the journey of existence

No doubt secular education is needed most for our existence and well being. The scientists in a way are Raja Yogis. They have great power of concentration. They have created a new world within a short time. In this they have acted as assistants of the creator, Brahma. They have produced marvels in the field of science and technology. We enjoy great comforts and conveniences on account of their genius and inventions. Secular education is necessary to earn our daily bread and enjoy comforts and conveniences. For this knowledge of technology, engineering, medicine and other sciences is essential (Spiritual Education of Upanishads, n.d.).

Dr C. Rajagopalachari, popularly known as Rajaji once said that: "the greatest of our inventions cannot reach the border line of metaphysics". There is something greater than material knowledge. Side by side with other activities, we should study the science of Absolute Reality, for man does not live by bread alone. Our goal is not to die like a worm after a brief illness, willful action, accident or old age here on this earth. Our goal is to attain Self-realization. Immortality is not attained by proficiency in modern learning, nor by actions, nor by progeny, nor by wealth, but by Self- realization, Nishkaama Karma(duty to society without any expectation of reward) and Renunciation (Spiritual Education of Upanishads, n.d.).

Spiritual education enables to control the mind, egoism, cultivate divine virtues and attain the knowledge of the Self. It helps the student to develop a strong, healthy body and mind, self confidence, courage, ethical perfection, initiative in all worthy undertakings and a good character. It implants in him the ideals of simplicity, service and devotion (Spiritual Education of Upanishads, n.d.).

This shows that Indian music, poetry and the creative arts in general, are integral to our wellbeing, yet we still often relegate the arts to the periphery or search for

'instrumental' reasons to defend their existence in public schools. The study of arts may provide a space in schools for students to express their identities in a freer and more creative way than is generally seen in other subject areas.

This study aims to restructure the critical pedagogy perspective that opens up questions such as: How can we offer an education to young people that give them the happiness, passion, challenge and satisfaction? What can we do to allow for positive experiences which exist in terms poetry etc. to transfer into education in general? How can music making become a life-long endeavour and its relevance in education?

Weakness in the present study involves researcher's bias as only single interpretation is taken and it is not based on inter-subject judgement. Also it involves subjectivity which reduces its reliability and validity but the 'value' remains intact. Small sample size is another limitation of the current research.

It is an explorative study in this area of inducing the meaningful higher education beyond the colonised educational setup which we are following in our inheritance of the legacy. There is immense need for eyes to open towards the real and pure wealth of knowledge existing in our Indian culture and find ways to spread its colour to the youth of the nation.

In addition future researcher would focus on the uses of practitioner poetry as a tool for facilitating an understanding of the lived experiences of persons suffering from mental illness and providing an evolved meaning to their symptomatology or state which is buried under the heavy labels or diagnosis.

REFERENCES

Charmaz, K. (1995). Grounded Theory. In Smith, A. J., Harre, R. & Langenhove, V. L. (Ed.). *Rethinking Methods in Psychology.* Sage Publications.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* New York: Aldine.

Jain, D. & Virmani, S. (2008). *In everybody Kabir: Songs of Kabir by 10 artists.* The Kabir project.

Mishra, G et al. (2003). *Introduction to psychology: PART-II A textbook for class XII.* New Delhi: NCERT.

Prendergast, M., Gouzouasis, P, Leggo, C & Irwin, L. R. (2009). Ahaiku suite: the importance of music making in the lives of secondary school students. *Music Educational research,* Vol. 11, No. 3, 303-317.

Peck, S. M. (1990). *The Roadless Travelled: A New Psychology of Love, Traditional Values & Spiritual Growth.* London: Arrow Books.

Spiritual Education of Upanishads and Code Of Practice to follow Spiritual Path: Spiritual education of Upanishads and our present day needs. (n.d.). Retrieved February 20, 2010, fromhttp://www.ganeshatemple.orgSpiritual%20education%20of%20Upanishds%20and%20Code%20of%20P.html [Fictional Entry.]

World Health Organisation (2005). *Child and Adolescent Mental Health: Global Concerns and Implications for future.* Geneva: WHO.

A path-breaking crusade for promotion of School Health in India..!!!

INDIAN JOURNAL OF SCHOOL HEALTH AND WELLBEING

(IJSHW)

| Health Services & Safety | Mental Health & Education | School Counseling | Life Skills

"A Journal Of /For School Health Promotion, Policy, Planning & Programming in India."

Published by

'Expressions India'

The Life Skills Education & Comprehensive School Health Program

(LSE – CSHP)

38, Pocket-1, Jasola Vihar, New Delhi

Indian Journal of School Health and Wellbeing

(IJSHW)

38, Pocket-1, Jasola Vihar, New Delhi

SUBSCRIPTION INFORMATION

Name **:**

Designation **:**

School **:**

Company/Hospital **:**

Organization **:**

Address **:**

E-mail **:**

Phone No. **:**

Purpose **:**

Areas of Interest **:**