Sibnath Deb
Brian A. Gerrard *Editors*

Handbook of Health and Well-Being

Challenges, Strategies and Future Trends

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ISBN 978-981-16-8262-9 ISBN 978-981-16-8263-6 (eBook)
https://doi.org/10.1007/978-981-16-8263-6

This Springer imprint is published by the registered company Springer Nature Singapore Pte Ltd.
The registered company address is: 152 Beach Road, #21-01/04 Gateway East, Singapore 189721, Singapore

The book is dedicated to

• Biological researchers and pharmaceutical companies for producing the COVID-19 vaccine

• Frontline workers like doctors, nurses, and other caregivers, including mental health professionals, for their dedicated services to COVID-19 victims

• Police and local administration for ensuring COVID-19 safety measures

• National and international professional bodies, and academics, as well as researchers for their dissemination of knowledge and information

• Federal and local governments of different countries for taking all possible measures for the safety and welfare of citizens

• Last, but not least, all COVID-19 victims and their family members

Foreword

This new text, *Handbook of Health and Well-Being: Challenges, Strategies and Future Trends*, marks an important turning point in our understanding of health care. It marks a turning from an emphasis on mental illness, disease, and disorder to a more positive emphasis on health and well-being. Mental illness and well-being exist on a continuum. There is no real demarcation between those considered mentally ill and others whose circumstances at a particular moment may be more fortunate. . Disaster could strike in an instant, a tsunami, a cancer, sweeping away all that is familiar and with it, familiar ways of coping. A global pandemic puts the world's entire population on alert, requiring a massive response of not only healthcare professionals, but individuals, families, communities, governments, and international agencies. Climate change poses an existential threat to more complex species, such as human beings, for whom the resources of the planet may not always support life as we have come to know it.

The old nomenclature of diseases, disorders, and diagnostic categories, no longer suffices. The old distinction of mind and body as separate, bifurcated entities no longer makes sense. Health and well-being demand a new nomenclature, new strategies for helping everyone cope better with their environments, which are in themselves not static but ever changing. Individuals, the focus of the illness model, grow up and develop in families, which grow and change; families exist in communities, which form and reform, whose values are reflected in cultures, which are not necessarily bound by geographic boundaries, in a geopolitically changing world, increasingly interdependent, globalized for better or worse. How best to survive? Thrive? These are the issues that *Health and Well-being* takes on. They are concerns for all.

The new nomenclature focuses more on ability than disability, resilience in face of adversity. The new nomenclature should help mitigate the stigma that has long been associated with mental illness across cultures. The new nomenclature bridges mind and body, bio-psychosocial and spiritual aspects of well-being. The World Health Organization has long realized that health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." This famous definition of health in the World Health Organization charter has long been

acknowledged, but rarely realized. The chapters presented in this volume take this reality seriously and should go a long way to help a more integrated understanding of health and well-being.

The old "medical model" sharply delimited illness and wellness. That line required people to cross a threshold into the world of the ill. One was no longer the former self. One had to adopt a new identity; one had to assume the role of patient and place oneself in the care of others, doctors, healthcare providers. One was supposed to regress to a state of dependency.

Susan Sontag famously referred to this threshold as a "metaphor": "Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place" (Sontag, *Illness as Metaphor,* 1977, p3). Sontag was referring to two illnesses in particular, tuberculous and cancer, the social ideas of which transcend the purely medical understanding with lurid prejudices. There was thought to be something wrong, perhaps even blameworthy, with being sick. Later, she wrote about HIV/AIDS (*AIDS and Its Metaphors*). And by extension, we must include diseases called "mental illnesses." One of my patients said something similar about her depression. "Why is it that people have so much difficulty accepting depression as an illness?"

The global mental health movement, as it has emerged in the twenty-first century, recognizes the prevalence of these non-communicable challenges to health and well-being, notably depression. Depression is a leading cause of disability worldwide and is a major contributor to the overall global burden of disease. Some people will need mental health care, but not everyone can see a psychiatrist or mental health professional, and not everyone needs to. There are many community-level strategies, which are evidence-based and proven effective. This book documents many of them, broad in its scope and deep in its specifics. Health and well-being are truly concerns for all.

Health and well-being are complicated, complex, as the chapters of this book illustrate. They involve not only biological and psychosocial factors, but also spiritual factors as well as social and economic determinants of health. In this sense, "global" takes on a broader meaning. Global means not only around the planet, but in the truest sense "comprehensive," accounting for the myriad factors that contribute to health and well-being.

Durham, NC, USA Prof. Allen R. Dyer, MD, Ph.D.

Prof. Allen R. Dyer MD, Ph.D., is Professor of Psychiatry and Behavioral Sciences and Vice-chair for Education at the George Washington University in Washington DC. Previously, he was Senior Health Advisor at the International Medical Corps. He is a graduate of Brown University and received MD and Ph.D. degrees from Duke University. He has designed education programs to help communities heal after a number of disasters and conflicts. He is the recipient of a number of wards including the Bruno Lima Award of the American Psychiatric Association and an Award and Recognition for service to the people of Iraq. He is the author of a number of books including

Ethics and Psychiatry: Toward Professional Definition and is Editor of the forthcoming *Textbook of Global Mental Health: Ethical Principles and Best Practices.*

Preface

A popular saying goes, *"health is wealth,"* which means, if one is physically healthy, he/she can lead a better and active life. Health does not merely refer to physical health alone; it encompasses physical, mental, social, and spiritual health. Therefore, one should fetch high scores in all the parameters of health, and in turn, one may be qualified as a person with good health. For example, if one is having good physical and mental health, it does not necessarily mean he/she will be good at social adjustment. Social adjustment has a significant role in every individual's life in leading a quality life and maintaining good relationship with different social agents in different situations. In turn, good social relationships provide a person with a sense of happiness and satisfaction. Similarly, spiritual health has a certain meaning in our life and it talks about a purpose of life, transcendence and actualization of different dimensions and capacities of human beings. In fact, it strikes a balance between the physical, psychological, and social aspects of human life. Examples of spiritual health are prayers, yoga, meditation, and so on.

At the same time, health and well-being are also interconnected. As health influences overall well-being of a person, similarly well-being also influences both mental health and physical health. Rightly enough, UNDP through its sustainable development goals targets to enhance good health and well-being. According to the World Health Organization (WHO), *"well-being exists in two dimensions, subjective and objective. It comprises an individual's experience of their life as well as a comparison of life circumstances with social norms and values."* Life circumstances of an individual which influence overall quality of life and well-being of an individual include economic and living conditions, level of education, nature of occupation, family relationships and/or emotional bondage with parents and children, safety within the family and in social life, stress in daily life, social support facilities during crisis, social comparison, and so on.

Nevertheless, health and well-being of an individual vary, depending upon the nature of physical and mental health. For example, sufferings of people with chronic physical health problems will be much more than that of people with acute physical health problems. Likewise, if one person of a family suffers from any kind of mental health challenge and remains unattended, it would adversely affect the mental peace

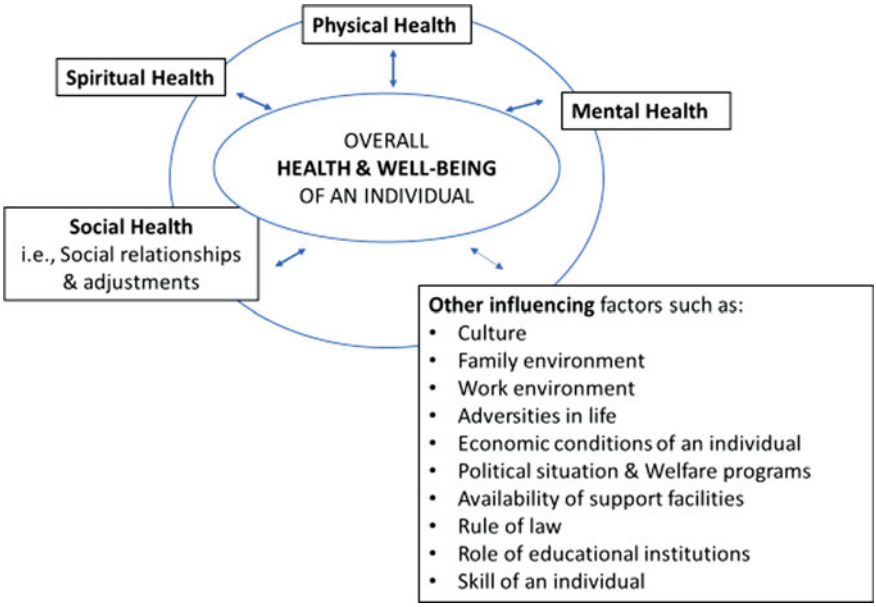

Fig. 1 Health and well-being: A conceptual interaction model

of all the other family members. In addition, availability of support facilities from the family members and health professionals will have a tremendous impact on the overall well-being of all the members.

As long as one survives, life should be meaningful, enjoyable, productive, and beneficial for the larger society. If one remains physically and mentally healthy as well as adjusted with a positive attitude and outlook, one can lead a reasonably happy and healthy life, and in turn, it will contribute to the overall well-being of the person.

Evidence demonstrates that the relationships between health and well-being of human beings are very complex in nature and it is multi-dimensional. The issue requires interdisciplinary research to understand it better from the right perspectives, although it is very challenging. Nevertheless, a conceptual interaction model (Fig. 1) is provided below to give a better understanding of the relationship between health and well-being holistically.

The proposed interactionist model depicts the need for multidisciplinary approach in ensuring the overall health and well-being of an individual. The simple yet pragmatic model highlights the confluence several components like physical, mental, spiritual, and social health along with a few other influencing factors such as culture, family, educational institution, rule of law, personal skills of the individual, and so on, as mentioned, in determining the quality of health and thereby well-being of an individual. The subjective nature of the construct "well-being" makes it difficult to directly estimate its status in an individual or community; however, the established link between health and well-being should be amply utilized to comprehend

the topic and render appropriate interventions. The need for an extended multidisciplinary involvement and expertise is the highpoint of the model. Taking cognizance of this fact, the book takes the unique advantage of having authors from various yet related disciplines of health and well-being such as psychology, law, public health, education, environmental studies, and sociology.

Limited literature exists on the relationships between health and well-being. Moreover, the COVID-19 (corona virus) pandemic caused tremendous challenges for human civilization globally by physically, psychologically, socially, and economically affecting normal life. People of a cross section of the society, irrespective of age, are stressed and becoming more restless due to continuous lockdown, knowing about the necessity of the lock down. Psychological distress is clearly visible in the behavior of common people. A large number of them are becoming paranoid while some are suffering from obsessive compulsive disorder; that is, whatever they buy from the market, they wash it many times, including currency notes and coins. Social distancing as part of the safety measure is a normal phenomenon. The suspected health condition of every individual is an issue of concern. Given this background, the editors thought of coming out with a book titled "*Health and Well-being: A Concern for All*" compiling the rich experiences of academics and researchers from various fields.

Response from academics and researchers from diverse fields related to health and well-being for this edited volume was overwhelming. After careful review of all the chapters, they were classified into eight broad parts for a systematic presentation of the rich knowledge and experiences of the contributors.

The broad objective of this volume is to present the holistic perspective of health and well-being and its importance for leading a quality of life. The volume intends to share the issues and concerns related to health and well-being with the health policymakers, administrators of educational institutions, teachers, researchers, academics, students, parents, and guardians to sensitize them about the role of health in our life. Highly experienced academics, researchers, and professionals from developed and developing countries contributed chapters to this volume on a wide range of issues related to health and well-being.

Part I: Locating Health and Well-Being in Changing Perspectives

There are six chapters (Chaps. 1–6) in this part discussing various issues and concerns related to health and well-being in changing perspectives.

In Chap. 1, Emily L. Winter, Cheryl Maykel, Melissa Bray and Mirand Graves-discuss overall happiness across the lifespan, and in this regard, physical health has a special role to play. Physical health and practices to maintain good health are interrelated, in order to successfully navigate life's challenges. Resources, intimacy, competence, and health are the four factors of the RICH theory of happiness. This

chapter discusses physical health as a foundation for overall well-being through the exploration of the RICH theory. Herdiyan Maulana and Nigar Khawaja discuss the cultural perspective of well-being in Chap. 2.

From time to time, human civilization experienced various health hazards which caused social discrimination and finally affected the quality of life of people who became the victim of a particular health hazard. Leprosy is one such health hazard which affected the overall well-being of their life. Chapter 3 by Subhasis Bhadra emphasizes upon psychological distress of people affected by leprosy. The broad objective of any correction system is to modify the behavior of the convicts. However, in some communities, they are perceived differently by the law enforcement agencies, and as a result, instead of corrective reform approach, they rely more on penal reforms. Chapter 4 by Belinda Hernández Arriaga, Corie Garcia, Amy Argenal, and Alex Chavez highlights the Mexican policy and discusses its lacunae, by giving examples of other countries.

COVID-19 did not affect the global population alone physically; it changed the entire social dynamics and the life of common people. In the context of COVID-19, the physical belongingness of human civilization is under threat. Chapter 5, written by Anjali Gireesan, discusses the evolution of belongingness, referring to past, present, and future. The concept of well-being differs from community to community and even among individuals and different social and cultural groups, based on individual and group values. Play and physical activities are good for health and mental happiness. More precisely, Chap. 6, written by P. Aneesh Kumar, S. Syama, Shalini Sreenivasan, Shinto Thomas, and K. Alphonsa Jose, emphasizes upon the need for play and recreational activities since it has high correlation with holistic development of children and their effective learning. Research highlights that because of urbanization, play and recreational activities are neglected among the current generation, leading to poor physical and mental health outcomes. The chapter further brings together literature on play across the lifespan, highlighting upon how play and recreation impact the health and mental health of adults and older adults.

Part II: Mental Health and Well-Being of Students and Workers in Organizations

This part comprises of seven chapters (Chaps. 7–14). Resilience capacity of the students across the countries varies, and it depends upon the nature of upbringing of the children and parenting styles. Adolescent health and overall well-being have got special attention of the global health policymakers since they constitute more than one-sixth of the global population. In Chap. 7, Nandita Babu and Mehreen Fatima discuss various issues related to adolescent health and well-being, justifying the need for paying special attention to their health. Chapter 8 by Phillip Slee discusses the violence against children and bullying in academic institutions from a human rights perspective in addition to emphasizing on need for prevention of the same.

The challenges of children and students in different geographical location vary. Sometimes, it is because of socioeconomic and political factors of a country, while sometimes, it is because of climate and other reasons. Children living in the conflict zone of Jammu Region, India, are the worst victims of turmoil, which has adverse impacts on their mental health, education, and social relationships. The authors of Chap. 9 (Raveena Kousar and Subhasis Bhadra) discuss the same issues at length based on their first-hand experience. Mental health plays a very important role in every aspect of our social and professional life. It not only contributes to overall productivity of an individual, but also facilitates adjustment capacity and overall happiness of an individual. In Chap. 10, Bishakha Majumdar elaborates upon the need for positive mental health in organizational effectiveness, in addition to discussing the critical nuances of professional mental health concerns, the mental health situation at work in the twenty-first century, and ways to build a healthy and empathetic workplace. In Chap. 11 K. Alphonsa Jose, Shinto Thomas, P. Aneesh Kumar, and S. Syama discuss the psychosocial characteristics of post-millennial, its trends, challenges, and prospects in mental health and propose strategies for delivering effective psychological support services based on the evidence to the youth and student population in general. Chapter 12 by Jace Pillay examines the mental health of university students since they are at the verge of completion of their higher education and worried about their future career. Work place discrimination and its impact on health and well-being have been discussed in Chap. 13 by Tusharika Mukherjee. Chapter 15 offers a conceptual analysis of psychosocial factors in the workplace that impact employees at varying levels of functioning and explores the intra- and extra-organizational conditions that enhance or hinder employee well-being. Performance demands, lack of autonomy and commitment, discrimination and loneliness, and work–life imbalance constitute physical and mental health hazards and impede both individual and organizational growths. Conversely, effective performance is embedded in autonomy (self-determination), positive work experiences, and organizational practices that promote positive organizational behavior and psychological capital.

Part III: COVID-19 and Its Impact

COVID-19 adversely affected the health and overall well-being of people of all sections of the society. It affected the global population with some variations. India is one of the worst-affected countries by COVID-19. Although Indian scientists invented the vaccine for COVID-19 and India extended support to other countries by providing free vaccine, the second wave of COVID-19 sometime in March 2021 onwards caused serious challenge for the Government of India to save the life of people affected by COVID-19 by providing oxygen and other essential medical services. This part pays special attention to this issue. Part III consists of four chapters (Chaps. 14–17) focusing on challenges posed by COVID-19. Chapter 14, written by Subhash Chandra Parija, Sukanto Sarkar, and Sunayana Choudhury, examines

the medical aspects and mental health challenges of people affected by COVID-19 pandemic and discusses the various strategies to overcome the challenges efficiently, while Chap. 15 by Sibnath Deb, Nidup Dorji, Aleena Maria Sunny and Shayana Deb presents the mental health of Indian youth during lockdown phase of mid-2020 and examines its association with their background and stress. In Chap. 16, a group of professionals from NIMHANS, Bengaluru, viz. Swati Ravindran, Roopesh B. N., Manisha Murugesan, Sanjeev K. Manikappa, and Naveen Channaveerachari, discuss their first-hand experience in providing online counseling during the COVID-19 pandemic and its efficacy. Chapter 17, written by Aleena Maria Sunny, is about the plight of floating laborers of India. This chapter examines the health and well-being of the floating laborer community of India, who are involved in some form of development projects, in addition to examining the health hazards and other risk factors involved in their work. Further, the chapter highlights the role of socioeconomic and political correlates in setting the context of migration in the country. The suffering of the migrant laborers during COVID-19 is also examined and discussed.

Part IV: Health and Well-Being of Elderly People

Health and well-being of elderly people are very important since they are valuable resources for the younger generation not only in professional field, but also in social and family life. Part IV of the book highlights the quality of life of elderly people (Chaps. 18 and 19). Chapter 18 by Raman Mishra and T. V. Sekhar discusses happiness among aged and its interrelation with increased physical and mental health, higher longevity, better compatibility with life events, and life satisfaction. At the same time, the chapter also highlights that subjective well-being is a multi-faceted concept which not only refers to the absence of mental illness, but to positive evaluation of psychological functioning and experience. Chapter 18 further examines the effects of social capital and subjective well-being on the happiness among the elderly in India. On the other hand, Chap. 19 by Nidup Dorji focuses on quality of life, psychological well-being, and happiness of older adults, with special reference to the role of spiritualism, social connectedness, and health. The author highlights the vulnerability of the elderly people with increasing age. However, spiritualism and affectionate relationships with family, children and grandchildren, and significant others enhance the quality of life. Finally, the author emphasizes on the need for enhancement of good relationships with family members for promoting the well-being and quality of life of older adults.

Part V: Well-Being of Marginalized Population

The speciality of this part consists in the presentation of issues and perspectives of some categories of marginalized population (Chaps. 20–22). Part V has 3 chapters covering issues of marginalized population, mostly disadvantaged children. Chapter 20, written by Celina Korzeniowski, discusses the ecological model, referring to the role of predictive socio-environmental factors on cognitive development of children, especially in socially vulnerable conditions. Evidence highlights that children growing up in socially disadvantaged conditions are exposed to numerous risk factors that impact their cognitive development.

Globally, a large number of children suffer from different types of disabilities. Intervention program for children with disability is much less as compared to the need. Chapter 21 throws light on the mental health of children with physical disabilities as most of the previous studies focused on their physical health only. In particular, in Chap. 21, Phakula E. T. and Jace Pillay discuss the overall well-being of children with disability and recommend a number of measures for improving their quality of life while Chap. 22, written by Anjali Gireesan and Jeshtha Angrish, discusses the general health and related issues in the context of persons with disabilities, evolution of disability as a concept, the magnitude of disability in Indian context, the ways and procedures adopted in disability assessment (both general and specific procedures), the prevention, identification and management of disability, the role of different parts of different stakeholders in managing disability, the challenges that they may face in imparting effective services to the persons with disability and the legislations that emphasize the significance of health and welfare in this context. In each section of this chapter, an attempt has been made to bring out the importance of centering thoughts and actions on the health and welfare of the children with disability.

Part VI: Role of Family, Teachers and Mental Health Professionals in Well-Being

This part comprises of three chapters (Chaps. 23–25) focusing on the welfare of children through school-based family counseling and role of mental health professionals in extending support services during crisis. Chapter 23, written by Brian A. Gerrard, elaborates upon how School-based Family Counseling (SBFC) may be used by mental health practitioners and educators to promote well-being among children, families, and schools, explaining the eight strengths of SBFC and they include school and family focus, systems orientation, educational focus, parent partnership, multicultural sensitivity, child advocacy, promotion of school transformation, and interdisciplinary focus. The chapter concludes with recommendations for educators and mental health practitioners on how to overcome challenges in implementing SBFC programs so as to maximize the well-being of children, families, and schools. In Chap. 24, Victoria G. Lidchi, Margarita Androvik, Caroline Bradley, Subreena

Z. Charlemagne-Odle, Jessica Elmer, Emma Goodman, and Sara Roberts outline a model of service delivery that has been found to be useful by a London Child and Adolescent Mental Health Service (CAMHS) to provide mental health services to children, young people, and their families who find it difficult to avail the same services, while in Chap. 25, Emily J. Hernandez, Adriana Aceves, and Natalie Peikoff discuss about the mental health of educators to create a supportive environment so that they can deliver more effective services. Online counseling is found to be very beneficial during natural disaster and/or man-made disaster.

Part VII: Psychological Capital

Resilience is the psychological capital of an individual which helps him/her to bounce back from any crisis situation or disaster. It varies from individual to individual. In addition to resilience, this part has chapters on spirituality and sustainable well-being. In all, there are five chapters in this part (Chaps. 26–30). Chapter 26, written by Manjula M. and Apoorva Srivastava, discusses about resilience and its association with happiness and over well-being. In Chap. 27, Subhasis Bhadra and Allen R. Dyer discuss the best practices of mental health and psychosocial support, drawing on lessons learned and applied from a number of disasters. Further, the chapter draws a contour of the survivors of different disasters from the historical perspective, touching upon the different interventions done for strengthening resiliency among the diverse group of survivors through community-based intervention strategies, for enhancing their well-being. Thus, resilience building activities are essential components of psychosocial support with a focus on enhancing well-being.

Different people behave differently during any adversity in life. Chapter 28, written by Shikha Soni and Amrita Deb, examines both the maladaptive and positive behavior of people, who are victims of different adversities in life. Some people display resilience in coping with adversity and eventually establish a state of well-being. This chapter highlights positive case studies of resilient behavior of people who have faced different challenges such as physical health, relationship loss, domestic violence, and child sexual abuse and have bounced back. Chapter 29, written by Nilanjan Sanyal, elaborates upon the practice of physical, emotional, and spiritual cleanliness which helps an individual to foster a state of tranquility leading to the maintenance of well-being among *Homo sapiens*. The chapter further engages into a theoretical critical analysis of the varied means of sanitizing oneself on the whole to foster well-being of the society.

Positive mental health is more important than absence of mental illness; it also includes well-being. Spirituality aims toward transcendence and transformation, thereby contributing to well-being through a meaningful framework in life. India has a long and diverse spiritual tradition, with Yoga being one of the important pathways to ultimate spiritual realization. In Chap. 30, Jyotsna Agarwal discusses about Indian yogic spiritual tradition and its association with well-being.

Part VIII: Future Perspectives

This part contains two chapters (Chaps. 31 and 32) related to legal disputes and its impact on mental health. Chapter 31, written by Lina Mathew, discusses some commonalities of definitions of child sexual abuse (CSA). The chapter also examines the structural barriers to research on CSA in addition to examining the need for the law to safeguards the well-being of child victims of sexual abuse in India. Chapter 32, written by G. Subhalakshmi, specifically examines the impact of prolonged and never-ending legal disputes which affects an individual emotionally, financially as well as their overall well-being. Further, the chapter discusses the factors that cause delay in the justice delivery system and the effect of such delays on the mental health and well-being of individuals.

An effort has been made to publish the volume without any error. However, if any typing error is noticed, the same may be excused.

Sriperumbudur, India — Sibnath Deb
Florida, USA — Brian A. Gerrard

Acknowledgements

Conceptualization of an edited volume requires discussions and deliberations with professionals working in the same field. The idea of bringing out a volume on **Health and Well-Being** was shared by Satvinder Kaur, Senior Editor—Social Sciences and Humanities of Springer sometime in 2018. Thereafter, we had given a serious thought on the issue and identified the broad areas to invite chapters from the experienced academics and professionals and grassroot-level workers. The contributors were identified very carefully from different countries looking at their research experience and contribution in the field of health and well-being, and accordingly, an invitation was extended to them for writing a chapter. We are grateful to all the contributors for their significant contribution in this volume in an important area.

The book proposal underwent both internal and external reviews. We are thankful to all the experts for their valuable feedback about the volume and suggestions. We made the necessary changes in the broad framework of the volume based on the suggestions of the experts.

During COVID-19 lockdown phase, it was very challenging for us to remain focused in our task and follow-up with the contributors and publishers for progress of writing the chapters as well as status of the proposal. We are thankful to our families because their support was immensely helpful to our remaining psychologically strong and able to focus our energies on this book.

Finally, we are thankful to Springer for publishing the volume.

Sibnath Deb
Brian A. Gerrard

Contents

Editors and Contributors

About the Editors

Sibnath Deb Ph.D. and D.Sc., is Director of Rajiv Gandhi National Institute of Youth Development (RGNIYD), Sriperumbudur, Tamil Nadu, India. Prior to joining RGNIYD, he taught at the Department of Applied Psychology, Pondicherry University (A Central University), and at the University of Calcutta. During April 2009 to August 2009, Prof. Deb visited the School of Public Health, Queensland University of Technology (QUT), Brisbane, Australia as Visiting Faculty. Currently, he is also Adjunct Professor of the School of Social Justice, Faculty of Law, QUT, Australia. During 2004–2008, he served the International Society for Prevention of Child Abuse and Neglect (ISPCAN) as Councillor Member. He has 30 years of teaching, research, and administrative experience and has published a large number of research articles in leading national and international journals as well as in edited books. He has written eight books and edited six. Some of his latest books include (i) *Disadvantaged Children in India: Empirical Evidence, Policies and Actions* (Springer, 2020); (ii) *Community Psychology: Theories and Applications* (Sage, 2020); (iii) *Social Psychology in Everyday Life* (Sage, 2019); (iv) *Childhood to Adolescence: Issues and Concerns* (Pearson, 2020); and (v) *Positive Schooling and Child Development: International Perspectives* (Springer, 2018). His research interests include child safety, students' mental health, and adolescent reproductive health. He has got three international and five national awards for his contribution in academics and research. In 2019, he received the "Visitor's Award 2019" from Hon'ble President of India for his contribution in the field of child protection and health psychology.

Brian A. Gerrard has a Ph.D. in Sociology from the University of New South Wales, Sydney, Australia, and a Ph.D. in Counseling Psychology, from the University of Toronto. He holds teaching awards from two universities. He has extensive experience teaching a wide variety of Master's and Doctoral level courses in counselor education. Dr. Gerrard is Emeritus Faculty Member of the University of San Francisco where he developed the masters MFT program and for 14 years served as

MFT Coordinator. His orientation emphasizes an integration of family systems and problem-solving approaches. He is Experienced Administrator and has been Chair of the USF Counseling Psychology Department three times. Currently, he is Member of the Board, University of San Francisco Center for Child and Family Development. The center, co-founded by Dr. Gerrard, has for years managed the largest longest-running School-Based Family Counseling program of its type in the USA. Its mission possible program has served more than 20,000 children and families in over 70 Bay area schools. Dr. Gerrard is also Chair of the Institute for School-Based Family Counseling and Symposium Director for the Oxford Symposium in School-Based Family Counseling. Currently, Dr. Gerrard is Chief Administrative Officer and Core Faculty Member in the Western Institute for Social Research in Berkeley, California. He is Senior Editor of the book *School-Based Family Counseling: An Interdisciplinary Practitioner's Guide* (Routledge, 2019). He has an active research project developing computer content analysis programs for use in School-Based Family Counseling.

Contributors

Adriana Aceves MS, AMFT, is a registered marriage and family therapist in Los Angeles, CA. She holds a Bachelor's Degree in Rehabilitation Services from California State University, Los Angeles, an area which involves providing services for people who have physical, emotional, and intellectual disabilities, and for individuals with economic and social disadvantages. She completed her master's degree in Counseling from the School-Based Family Counseling Program at California State University, Los Angeles. Under the supervision of Emily Hernandez, she conducted research on school-based family counseling and the need for mental health services in the field of education. Her experience includes secondary school counseling, working with at-risk youth with a focus on dropout prevention. Her experience in mental health therapy includes providing services for couples, families, and children experiencing a range of issues such as trauma, immigration, substance abuse, bullying, and mental disorders.

Jyotsna Agrawal is currently Associate Professor in the Department of Clinical Psychology, at National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore, from where she had completed her M.Phil. and Ph.D. degrees. She is a consultant for adult psychiatry, geriatric medicine, positive psychology, and integral medicine, along with being the faculty in-charge of Vedic Indian Psychology Research and Application (VIPRA) division, under which she runs two clinics, Sattva and Swasthya (for enhancing well-being, informed by yogic psychology). She was awarded the prestigious Fogarty International Postdoctoral Fellowship at Washington University, School of Medicine, St. Louis, USA, and another postdoctoral fellowship at S-VYASA Yoga University, Bangalore. Prior to joining NIMHANS, she served as Assistant Professor at the Indian Institute of Technology Patna. She has also worked at various research and management positions at Community Empowerment

Lab, Lucknow, and at Tata Motors Ltd, Jamshedpur. Her research interests include positive psychology, preventive and promotive approaches toward public mental health, psychotherapy, Indian psychology and yoga, and consciousness studies. She is currently working on applications of Indian psychology and positive psychology in the clinical settings. She has several publications in the field and is also supervising M.Phil.- and doctoral-level research in this area.

Margarita Androvik is Clinical Psychologist in Developmental and Clinical Psychology and DESS in Clinical: Child and Adolescent Psychology equivalent to DClinPsych from Institute of Psychology, University of Rene Descartes (2004), registered as Clinical Psychology Practitioner with the HCPC. She has worked in France and the UK, in hospital settings in departments such as neonatology, pediatrics, maternity, and perinatal mental health as well as with Children and Adolescents Mental Health Services. She also has experience working with adults experiencing mental health problems within a primary care setting and with families affected by cancer. Throughout her professional career, she has gained experience of working with a large variety of client groups in terms of cultural, ethnic, linguistic, and socioeconomic backgrounds and has been working with Local Authority CAMHS in Camden for the last 7 years as a senior member of staff, mainly working with children presenting with complex trauma and attachment difficulties. She also holds a master's degree in Management.

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Caroline Bradley is a clinical psychologist who works with the Whole Family Team for the Tavistock and Portman NHS Trust. She specializes in trauma-informed practice with young people and their families who have experienced intergenerational trauma and who are now under the care of local authority services. She has researched and published in the area of the impact of insecure housing and homelessness on child and parental mental health.

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Part I
Locating Health and Well-Being in Changing Perspectives

Chapter 1
Physical Health as a Foundation for Well-Being: Exploring the RICH Theory of Happiness

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Abstract Overall happiness across the lifespan is impacted by feelings of independence, the ability to initiate and maintain relationships, competence in some areas, and physical health. The RICH Theory of Happiness explains these four factors: Resources, Intimacy, Competence, and Health and recognizes these factors as essential to overall well-being. This chapter aims to explain physical health as a foundation for all others through exploration of the RICH Theory. Our overall feeling of wellness and self-efficacy in tackling life's challenges can be impeded by physical illness or disability. Physical health, in terms of proper nutrition, sleep, and exercise are all directly related to mental health and cognitive agility which then impacts our ability to perform tasks at work, to maintain positive relationships with others, and to maintain an overall sense of wellness.

Keywords Physical health · Well-being · RICH · Happiness

Introduction

Happiness, historically, has been approached and conceptualized as "subjective well-being" in both theory, research, and practice (Griffin, 2007; Keyes, 2007; Ryff, 1989). However, this perspective of happiness is limiting, as it fails to recognize the complicated nature of the emotional state of happiness (Delle Fave & Bassi, 2009). In their endeavor to define and describe happiness, as well as attest to the inherent complexities, researchers Delle Fave and Bassi (2009) note that the pursuit of happiness

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_1

encapsulates and depends on a variety of factors such as the related activities one is involved with, the ability to demonstrate growth of skills, the impact on social development, and the contribution to an overall sense of meaning. Happiness, thus, is best conceptualized in research, practice, and theory, as being influenced and affected by a variety of factors that interconnect with each other, which lends itself well in dissecting the main focus of this chapter: the RICH Theory.

The RICH Theory was first proposed in 1986 by Thomas J. Kehle and later expanded and further explained by Kehle and his colleagues to integrate the concepts of psychological well-being and overall happiness (Kehle, 1989, 1999; Kehle & Barclay, 1979; Kehle et al., 1993, 2002). Kehle used factor analyzed data from mothers in a cross-cultural sample distributed by Jesuit priests to further understand these concepts (Kehle, personal communication, January 1, 1997–January 1, 2016; Kehle, 1986a, 1986b, 1989). In fact, Kehle proposed that the two, happiness and psychological well-being, are inexplicably intertwined and further synonymous (Kehle & Bray, 2004). People with poorer mental health have reported less life satisfaction (Lombardo et al., 2018). As per the theory, the acronym RICH stands for four aspects connected to happiness: Resources, Intimacy, Competence, and Health. Prior literature noted the interconnected nature of the four characteristics, which determined that an increase in one of the areas is likely to lead to an improvement in the others (Kehle & Bray, 2004), and decreases in one area are expected to impact functional levels on the other characteristics (McCabe et al., 2011). These processes, however, are dynamic and nonlinear.

Prior reviews of the conceptual model noted its similarity to Russell's original (1931) definition of happiness, suggesting that happiness is not relegated to one factor, rather it encompasses a balance of the four aforementioned characteristics (Begum et al., 2014). Further, the model defines happiness as related to a life without fear or anxieties (Kehle et al., 1993). Proponents of the theory also cited Wilson's (1998) *Consilience: The Unity of Knowledge* as well as Skinner's (1971) *Beyond Freedom and Dignit*y, both as major influencers in the development of the conceptual model (Kehle & Bray, 2004). These foundational academic and theoretical pieces provide a basis for interpreting the well-being of an individual person, instead of a systemic analysis of subjective health (Chafouleas & Bray, 2004).

Overall, as mentioned above, happiness and overall mental health are synonymous as per the RICH Theory (McCabe et al., 2011). Individuals can access all four of the characteristics, despite other personal variables in their lives, such as age (Kehle & Bray, 2004). Further, in 1999, the RICH Theory's clinical utility was described when Kehle used an example of loneliness in an elderly individual, which emphasizes the theory's application to individuals at various stages of their lives.

Further, Bray and Kehle (2011) noted that the concept of RICH embodies what a mother would want for a young child. In the creation of the theory, Kehle asked mothers in 32 countries what they desired for their child and their development. Since this original inquiry, Kehle's 30 years of conversations with students have yielded similar outcomes and answers, all centered around the notion of the four characteristics (Bray & Kehle, 2011). Kehle and Bray (2004) further note "within each component, variable, or concept of the theory there is a dynamic aspect that can

either promote or retard movement toward the four RICH characteristics" (Kehle & Bray, 2004, p. 49), thus suggesting that that there is an opportunity for growth or stagnation as related to the RICH Theory.

The Four Factors

Resources

Kehle and Bray (2004) noted that when resources (i.e., time and money) are distributed and provided appropriately, an individual will experience an increase in independence, self-control, and autonomy over their life and use of time. Kehle believed that if high school students were afforded decision making over the days and times of their classes, they would have increased independence and improved academic functioning (Kehle, personal communication, January 1, 1997–January 1, 2016). In more current research, when people invested in time saving services, they experienced increased life satisfaction and overall happiness, providing further support for a correlation between free time and happiness (Whillans et al., 2017). Whillans and colleagues' work has further been referenced in other academic literature in the field of happiness research, creating a notion that there are "time spending happiness principles" (2017, p. 126).

Mogliner and Nortion (2016) have noted that both time and money are two concepts that, when overseen in an effective manner, can contribute to happiness. They suggest that time may even possess a greater element of contribution toward happiness than money. It is reported that spending both time and money on others also increases happiness (e.g., Aaker et al., 2011; Dunn et al., 2008). In addition, it has been suggested that time and money spent on experiences, rather than on material goods, also leads to greater happiness (Howell & Hill, 2009; Van Boven & Gilovich, 2003). In sum, peer-reviewed literature in the field suggests resources, including time and money, contribute to a person's overall happiness, supporting the RICH Theory.

Intimacy

The second characteristic, intimacy, encompasses interpersonal connectedness and relationships. Intimacy can be conceptualized as the degree to which an individual engages in relationships and experiences pleasurable emotions when in the presence of others. Kehle described love as the "enjoyment of the company of another" (Kehle, personal communication, January 1, 1997–January 1, 2016). Intimacy also encapsulates emotions such as empathy, gratitude, and overall appreciation of connectedness, as well as relationships with people, pets and spiritual entities, among others. Consider the act of giving a cat to residents in a nursing home, as the relationship

can work to increase their functioning in other areas, such as physical health (Kehle, personal communication, January 1, 1997–January 1, 2016). As all four factors are interrelated, intimacy also encompasses friendships, developing competence in some areas, as well as a commitment to practices that improve physical health and its correlates (Kehle & Bray, 2004; McCabe et al., 2011).

Competence

Competence is the third characteristic in the RICH Theory, which incorporates a personal perspective and reality that one is proficient in, experienced with, or adept to engage in some related skill set. Competence is directly related to personal ability, as well as self-efficacy or the belief that one will experience success in their endeavors. While competency may not be achieved across a variety of areas, one must be proficient in at least one area, according to the RICH Theory.

The idea of having meaning or a purpose in one's life may be subsumed by this factor, and in part by intimacy as well, depending on the area of competence or from where the feeling of purpose stems. An individual may feel that they are making a contribution to their field, or more broadly, to the world around them, and believe that they are successfully supporting their family. These contributions likely fulfill the individual's need for purpose. In sum, these examples featured above cause the individual to be considered competent within this theory. As was mentioned previously, it is interrelated with the resources, intimacy, and overall health of the individual.

Health

The final factor is that of health, which relates to participation in, and a deeper commitment to, a lifestyle that encompasses attributes of physical well-being (McCabe et al., 2011). Research across various fields has connected happiness and physical health. A 2016 study of medical students noted that those who had breakfast on a regular basis, who ate consistent meals, and who consumed high servings of fruits and vegetables had higher levels of happiness (Lesani et al., 2016). Further, researchers have also found that increased levels of physical activity also contribute to greater levels of happiness (Richards et al., 2015). Both of these studies highlight how simple acts of basic self-care contribute to overall well-being and happiness.

The health factor also takes both the physical health as well as the mental health of an individual into consideration. Some research supports that individuals who spent more time in nature, in green spaces, and outdoors, were significantly happier and healthier than those in urban areas (MacKerron & Mourato, 2013). In Kehle's interpretation (Kehle, personal communication, January 1, 1997–January 1, 2016),

it is described as an "allegiance" to practices related to wellness, a person who is physically well is also simultaneously independent, competent, and connected with intimate relationships.

Other Considerations

Kehle and researchers have also considered the potential for the addition of other factors into the model; however, despite years of inquiry, the original four remain steadfast. Other proposed factors, such as spirituality, have easily fit under previously existing characteristics, such as intimacy (Kehle & Bray, 2004). Also, the variable of "environmental suitability" (ES) was suggested by Dr. Eunice Hartley (Hartley, personal communication, 1997). Dr. Hartley suggested that RICH could be obtained in some settings perhaps, but not in others. However, Kehle did not agree. Dr. Hartley proposed the acronym be changed to RICHES not RICH, in order to accommodate for environmental suitability. This was, in Bray's opinion, one of the best last factors suggested over the years.

Chance

The RICH Theory included consideration of the notion of chance, stating that chance often leads to change, emphasizing an inherent value. Originally proposed by Bandura (1982) during his tenure at Stanford University, chance encounters may act as a critical role in guiding the path of a person's life. Bandura notes that events, and chains of events, although espousing separate causes, may also be critical in where they intersect. Such intersections of events likely occur by chance rather than that of a conscious plan. Bandura noted that fortuitous chance encounters may have impacts on an individual's life path.

When determining the impact of chance encounters, Bandura proposed a few factors such as personal and social determinants. Personal factors related to the proposed impact of the encounter include: (1) entry skills, such as personal skills to remain involved in conversation and connection, (2) emotional ties, or the interpersonal relationships that fuel lasting connection, and (3) having similar value standards to the person with whom one had an interaction. The social determinants may encompass: (1) affiliative inducements, incentive systems, or social rewards, (2) entrance in a symbolic environment, such as promotion through media, (3) involvement in a milieu that is close and involved, and (4) psychological closedness (adhering to beliefs and values). This phenomenon, however, is nonlinear by nature. Change, therefore, helps individuals grow and develop, and are likely to lead toward attaining RICH characteristics, improving an individual's life, and increasing happiness. This is done via maximizing attempts assistive for change while minimizing those not effective or useful for change (Kehle & Bray, 2004).

Withdrawal

The RICH Theory also addresses withdrawal, on both psychological and physical levels, as well as by voluntary and involuntary means. The concept of withdrawal is about taking away contingencies connected to daily living, or as Kehle and Bray define it, "removal from one's rut" (2004, p. 47). When taking away those contingencies of daily life, emotions increase and there is a heightened desire for stimulation from the individual's environment, with simultaneous susceptibility to such an environment (Kehle & Bray, 2004). With this, a person is better equipped to learn new material, be creative, as they tend to have a developed understanding of the connection between the self and the environment. This type of cognitive activity may then lead to a change in "ruts or value systems" (Kehle & Bray, 2004, p. 47).

Creativity

Another consideration often cited as related to withdrawal in the RICH Theory is creativity. Creativity can be conceptualized as "the origination of new knowledge that is brought about through the comprehension of novel relationships between or among previously acquired knowledge" (Kehle & Bray, 2004, p. 47). With this, new knowledge is connected to the attainment of the characteristics inherent to the theory. Kehle and Bray further note that knowledge may be needed in this creative process in order to recognize the relevance of new and creative information or perspectives, which is essential in sharing ideas and information that are significant and noteworthy.

Researchers in the fields of intelligence and creativity note the inherent creativity has on individuals and society, explicitly tying in the ways in which creativity can curate and create a more effective and happier world (Kaufman, 2018). Creativity is slightly correlated with higher performance in work and school, espousing higher relations with a multitude of other measures such as having stronger physical health (Stuckey & Nobel, 2010), being perceived as sexually attractive and preferable (Kaufman et al., 2016), as well as being likely to have higher levels of satisfaction with work and career (Seibert et al., 2001). Research suggests that people who engage in creative processes are more likely to experience personal growth, which therein leads to living a more productive life and potentially contributing overall to a better world (Heine et al., 2006).

Kaufman (2018) further connects the idea of happiness with creativity, noting additional prosocial outcomes arising from happy people, such as engaging in philanthropic activities (Priller & Schupp, 2011; Thoits & Hewitt, 2001), actively promoting environmental sustainability (Sulemana, 2016), experiencing increased productivity at work (Barsade & Gibson, 2007), and being less likely to participate in illegal activities (Buunk et al., 2016). On a systemic level, some researchers have argued that assessing the happiness of the country may be an important approach to consider, beyond conventional standards such as gross domestic product (Maccagnan et al.,

2019). In sum, there is a substantial literature base supporting the inherent connection between creativity and happiness, and further, how this inspires meaning in life. Kaufman (2018) notes that with time, those who are increasingly happy, are connected in life, and work alongside diverse groups of people, may in turn be those who problem solve and brainstorm the creative solutions to society's difficult questions.

Diversity

Kehle and Bray also cite diversity in a philosophical stance, rather than as related to a particular racial or ethnic group, as important in developing a person's "axiological, ontological, and epistemological beliefs," (2004, p. 47) and thus increasing a person's chance for survival. Kehle and Bray (2004) connected the notions of organizational behavior to Darwin's historical theory related to natural selection, noting that survival in a world that is constantly changing is reliant on diversity. Thus, adaptability, creativity, and diversity will help an individual problem solve and make choices, which is especially important when working in groups. Likewise, when an individual or group works to be creative, problem solve in innovative ways, and attain success, these tasks are likely aided by diversity. At first glance, they note, it may seem that in order to achieve aspects of RICH, individuals may be likely to seek out those who are similar to themselves. However, this is a misconception, as diversity improves the likelihood of chance and both "similarity and diversity within human organizations, and within the individual, are prerequisites for enhancing survival and movement toward the RICH characteristics" (Kehle & Bray, 2004, p. 48).

Physical Health as a Foundation for Overall Well-Being

Previous research has suggested that physical health may be identified as the foundation for overall well-being (Zaidi, 2020), as physical health connects to overall well-being via reduced stress levels and a healthy, functioning body. Therefore, it may be recognized that in order to achieve greater well-being, one should strive to live a physically healthy lifestyle. Common sense would indicate this path would be most likely to result in more positive feelings, physically, as related to less pain, discomfort, and fewer limitations. Additionally, it may lead to greater ability and more success as one attempts life's daily tasks and various leisure activities alike, as well as living with fewer medical concerns, medications and doctor's visits. Such assumptions are backed by research, as indicated below. This attention to health and well-being may tie in psychological attempts to improve overall functioning, a concept known as mind–body health.

Introduction to Mind–Body Health

Recent literature suggests that the connection between physical and emotional health is uniquely intertwined. This connection is coined by the term "mind–body health," known as a perspective recognizing the role of the mind (i.e., thoughts, feelings, and emotions) and the role the mind plays in the physical health of the body (Goleman & Gurin, 1993). Certainly, physical health also impacts mental well-being. This field may also be known in the science communities as psychoneuroimmunology or connecting behavioral components to physical well-being (Pelletier, 1992). Interest in researching connections between the psyche and the body has continued to increase with time, especially as individuals continue to live increasingly stressful lives (Pelletier, 1992). Mind–body health interventions for a variety of physical health conditions have been, and continue to be, researched in order to evidence complementary and alternative medicine practices (Finger & Arnold, 2002). The current state of the literature as related to mind–body health has examined the role of a variety of interventions related to a myriad of health concerns and medical populations (Finger & Arnold, 2002). In sum, it is clear that factors related to physical health (e.g., nutrition, sleep quality and quantity, exercise, presence of disease), therefore, influence perceptions and feelings of overall well-being and therefore are likely to be influenced by psychological and behavioral interventions.

Nutrition

Research has considered ways by which the brain is influenced by environmental factors, such as nutrition. Overall nutritional health has been connected to mental health and effective psychological functioning, such as in the amount or type of food one consumes. For example, in an experiment with rats, Gomez-Pinilla (2008) found that a lack of nutrition in a diet saturated in "junk food" impacted a rat's learning and memory, which later influenced the animal's quality of life and mental health. In addition, rodents with abnormal caloric intakes (i.e., fasting or restricting calories) had an increased chance of developing diseases such as Alzheimer's or Parkinson's disease, impacting physical health and well-being (Gomez-Pinilla, 2008).

Personal longevity can also be increased via proper nutrition, as malnutrition affects cognitive function which, in turn, influences various psychiatric disorders. For example, glucose metabolism is associated with a variety of psychiatric conditions, and proper nutrition can create a normal glucose level and help boost overall mental health (Gomez-Pinilla, 2008). Research has also suggested an association between diabetes and some psychological disorders such as schizophrenia and manic depression (Gomez-Pinilla, 2008). Glucose metabolism is an important factor in these disorders with proper nutrition being crucial (Gomez-Pinilla, 2008).

Overall health is essential for proper cognitive function including problem solving, higher order thinking, and decision making. Nutrition plays an important role in

cognitive functioning. Fernando Gomez-Pinilla (2008) examined the role of nutrition on mental health and cognitive function, and reported that quality energy supplies are necessary for proper cognitive functioning (Gomez-Pinilla, 2008). In sum, what people consume and fuel their bodies with has the potential to influence a variety of domains related to happiness in conjunction with the RICH Theory.

Sleep

Sleep is also an important foundation as it relates to a variety of life outcomes. When examining nonmedical interventions for sleep disturbances, researchers have found that mind–body health interventions are effective in improving overall well-being, thus connecting physical health entities (i.e., sleep) and overall well-being on a variety of levels (Neuendorf et al., 2015). Research indicates an association between sleep and the risk of psychiatric disorders, as well as other diseases related to cognitive function. A recent meta-analysis conducted in 2015 examined 1,300 sleep interventions related to the effect of meditation on a variety of sleep outcome measures (e.g., quality, latency, duration). About one-third of the meditation studies showed positive outcomes. Further, half of the studies on the sustained impact of meditation were shown to be effective. The findings suggest that sleep is improved with more consistent meditation over time, suggesting that meditation across a longer lifespan may have a stronger effect on sleep patterns. Results were varied, depending on a slew of factors (i.e., stress, mental health) related to the participant. More specifically, mixed results were found in patients, who had preexisting mental health concerns such as depression or anxiety, as well as heightened experiences of stress. Specifically, the mindfulness-based stress reduction (MBSR) approach conveyed no benefits to sleep, unless the intervention was routinely used over a long stretch of time. In sum, although there are some positive findings related to continued and consistent use of meditation as an intervention for sleep, limited research in the effectiveness of meditation on sleep necessitates future studies to be completed (Neuendorf et al., 2015).

Studies have also considered the impact of movement on sleep (Neuendorf et al., 2015). Over half of studies examining movement, primarily yoga, have indicated positive effect on sleep. Others indicated some discrepancy to whether physical activity, the mind–body factor, or a combination of the two creates a positive effect on sleep (Neuendorf et al., 2015). It is also wise to consider the variety of dimensions related to a "good night's sleep" (e.g., duration, quality, comfort).

Better sleep quality has also been associated directly with increased overall happiness. Shin and Kim (2018) demonstrated that individuals who sleep better tend to have increased life satisfaction. Frange and colleagues interpret sleep duration as "a predictor of an individual's health status" (2014, p. 107). Limited sleep is related to a variety of health concerns, such as heart issues and obesity. Frange and colleagues (2014) identified that those who sleep too much or too little have a higher chance of mortality. Sleeping duration has also been connected to self-rated health, with less

than seven hours of sleep tending to result in a lower overall health rating (Frange et al., 2014). In sum, the role of sleep is not to be overlooked when considering overall well-being, potentially contributing to factors related to happiness.

Exercise

Exercise has a positive relationship as related to life outcomes. Exercising an appropriate and healthy amount has been shown to improve mental health and overall happiness (Rasmussen & Laumann, 2014), as well as reduce symptoms related to depression (Cooney et al., 2014). Additionally, researchers have demonstrated the reward that exercise has on cognitive function (Gomez-Pinilla, 2008). Through the improvement of learning and memory, overall life satisfaction also improves and slows the cognitive decline over time (Gomez-Pinilla, 2008).

Fernando Gomez-Pinilla (2008) has suggested that when pregnant women exercise, the fetus receives benefits. For example, children tend to have improved learning and memory abilities, as their brain is influenced by exercise (Gomez-Pinilla, 2008). Thus, as the areas of learning and memory of the brain are affected by exercise, overall quality of life and mental health is influenced as a result, further highlighting and emphasizing the association between exercise and overall health.

Among children, researchers have examined how physical activity may impact a student's academic achievement. Various factors have been considered in this relationship including chronic activity (i.e., overall amount of time engaged in exercising), acute activity (i.e., length of each exercise session), intensity (e.g., mild, moderate, vigorous) and type of activity (e.g., walking, running, physical activity in class lessons). When comparing fitness and other activity, differences in functioning on specific cognitive tasks have been noted, such as executive functioning abilities and ability to stay on task (Maykel et al., 2018). Further, it is believed that physical activity influences cognitive function, which can lead to improved academic performance (Donnelly et al., 2016). Further, studies have indicated that children who are physically fit have high cognitive functioning abilities (Donnelly et al., 2016).

Among the elderly, a meta-analysis examining the effects of mind–body exercise on life outcomes suggested a reduced cognitive decline (Zhang et al., 2018). Yoga, pilates, and Tai Chi are found to be effective. These exercises combine movement with a relaxative state. Results of aging demonstrate a decline in verbal functioning and visual spatial awareness, and mind–body exercises can have a positive effect on both of these areas specifically. Thus, quality of life may be improved. Cognitive improvements may occur through the involvement of the frontal lobe, as movements in these types of activities require both planning and memory. These findings may also be due to the increased use of the hippocampal regions and other areas of the brain that impact cognitive functioning (Zhang et al., 2018).

Relationships

Physical activity is also associated with social skills and social networks among adolescents (Marks et al., 2015). Social cognition involves higher level thinking, which influences social interactions and the ability to form relationships. Marks and colleagues (2015) suggested that students who spend more time doing physical activity outside of school tend to be increasingly social, have more friends and more social interactions. This peer influence is found to be stronger for boys than girls. Friendship and networking characteristics are often better developed in students who are more active, thus more physically healthy. Physically healthy peers have an influence on increased physical activity of those who surround them (Marks et al., 2015). On the other hand, a lack of physical activity is associated with increased sedentary time (e.g., screen time), obesity, as well as other health conditions and problems.

Further literature has also suggested a connection between physical health and overall general life satisfaction. One study examined the influence of physical health on marital and work satisfaction (Yucel, 2017). Findings indicated an association between poor physical health and marital and job dissatisfaction, highlighting that stress and dissatisfaction can cause a worsened physical health state (Yucel, 2017). When considering the impact of relationships on overall well-being, there are a variety of outcomes related to health, happiness, and overall life functioning, that need to be addressed and considered.

Finances

Research examining the relationship between financial status and well-being suggested a significant relationship between financial debt and overall well-being (Sweet et al., 2013). Sweet and colleagues (2013) noted that increased financial debt often led to worsened an individual's health status, as finances can be a large stressor on a person's life. Sweet and researchers (2013) also mentioned that health outcomes may be affected by the amount of debt an individual has accrued. Outcomes of long term financial stress may include cardiovascular diseases and mental health concerns, as well as other metabolic problems. These side effects of financial stress illustrate the connection between stress, diet, and physical activity, further highlighting that financial stress can also influence physical health (Sweet et al., 2013).

Sweet and researchers (2013) also suggested that the weight of financial debt may also impact physical functioning. A self-report measure was used to analyze general health and a blood pressure monitor to determine stress levels. Lifestyle choices were noted which included: smoking, issues with normal physical functioning, nutritional choices, physical activity, and mood (Sweet et al., 2013). An association between financial debt and obesity was noted, which is supplemented by other evidence that the majority of members in a credit card counseling group were overweight (Munster

et al., 2009). Although there may be underlying hardships that are associated with financial problems, researchers still believe that health and finances are directly related.

Mental Health

Various physical health conditions influence mental health functioning. There is an increased burden associated with living with numerous physical health problems, which can have an impact on mental health. A 2017 study examined suicide risk among patients with major physical health conditions (Ahmedani et al., 2017) and found that patients with multiple physical health conditions had a greater risk. Ahmedani and colleagues (2017) suggested that more than half of individuals in the study, who died by suicide had a preexisting health condition. Study results indicated 17 physical health conditions that were associated with suicide, including brain diseases and HIV/AIDS. Consider the relationship between diabetes and mental health functioning. Diabetes distress is related to the burden of living with diabetes (Robinson et al., 2018). The risk of hypoglycemia can lead to extreme worry and anxiety. Mental health diagnoses, more specifically mood disorders such as major depressive disorder, bipolar disorder, and schizophrenia, may often be comorbid with diabetes (Robinson et al., 2018). Statistics reveal that approximately one-third of people with diabetes have symptoms of depression and roughly half of those with bipolar disorder have worsened glucose metabolism (Robinson et al., 2018).

Further studies assessing specific areas as determinants of overall life satisfaction have examined the relationship between mental health and social roles. Symptoms associated with mood disorders may impact one's ability to function in everyday circumstances. Social relationships are affected by an individual's inability to function. Ge and colleagues (2017) examined the relation between isolation, loneliness, and depression symptoms in adults aged 21 and older. The results demonstrated a strong association between isolation and depressive symptoms (Ge et al., 2017). Social isolation was also further determined by marital status, interactions with friends and families, and present living arrangement (Ge et al., 2017). Individuals with more depressive symptoms tended to interact less with those close to them, suggesting the impact of social support on depressive symptomatology. Social isolation can accompany symptoms of depression, which can impact social relationships (Ge et al., 2017). The results highlighted how symptoms of depression may present as an example of the impacts of mental health on social roles, as related to the intimacy pillar of the RICH Theory.

Symptoms of anxiety and depression can also affect work engagement. Work engagement is a life function that assesses one's ability to concentrate and perform well in a work environment physically and mentally (Innstrand et al., 2011). Results of a study conducted by Innstrand et al. (2011), a connection between self-worth and work engagement. Further, the study considered conservation of resources, which relates to motivation and response to stress in the workplace, as a measure of work

performance (Innstrand et al., 2011). Innstrand and colleagues (2011) research used self-assessment procedures to examine physical symptomatology that may be related to poor mental health such as sleep problems, loss of appetite, or feelings of loneliness. Researchers concluded that increased self-reported symptoms of anxiety and depression related to less work engagement (Innstrand et al., 2011). Such findings extend to the relationship between mind, body, and heath, and how it is relevant to the domains of RICH.

Well-Being and RICH

Direct use of the RICH Theory has been applied to various sectors of psychological and medical health fields as related to the concept of well-being. For example, a 2008 review conducted by Bray and colleagues examined psychologically oriented procedures for children with chronic asthmatic disorders and sought to apply mind–body health related interventions in the school setting to increase student success. School treatments, non-pharmacologically based in nature, considered the role of the psyche and cognitive approaches to help students succeed. Interventions such as written emotional expression and relaxation and guided imagery called upon Kelhe and Bray's (2004) explanation of RICH Theory, in order to encompass personal independence, interpersonal connectedness, as well as increased competence. The RICH Theory has also been cited in relation to interventions targeting psychologically oriented mental health concerns, such as depression (Kehle et al., 2004).

The RICH Theory has also been cited as a helpful link to consider when implementing interventions for children with obesity (Crothers et al., 2009). The authors note that orienting interventions to be psychologically minded may be beneficial in order to integrate psychological wellness and happiness into interventions for weight loss. This may be done via self-modeling or use of virtual reality in order to help children see themselves engage in successful behaviors related to competence, social interactions, and overall autonomy.

When working to support children in school, the RICH Theory can be applied to increase student happiness. In 2011, McCabe and colleagues examined student happiness and life satisfaction and further connected positive well-being as something that is both physical and mental in nature. They cited the important role of educators in increasing student happiness and that this concept should be considered as a primary goal for those supporting students in the school setting. The theory has also been mentioned by researchers seeking to uncover the interaction of home and school in relation to happiness (Badri et al., 2018).

Researchers have also noted that the RICH Theory goes above typical definitions of intelligence, noting that intelligence not only addresses a student's ability to handle complexities, but understanding oneself and their environment, as related to increasing the four characteristics (Kehle et al., 1993). In this perspective, intelligence is not as "resistant to intervention than traditionally defined intelligence, and therefore less elitist" (Kehle et al., 1993). School-based practitioners have used this

theory as a foundational positive psychology perspective when working with children with aggression and when considering assessment as an accurate portrayal of student ability (Springer, 2018).

When reflecting specifically on school-based practice, Kehle and Bray (2005) have suggested implementing the RICH Theory to bridge the research and actual clinical practice gap. In other words, Kehle suggests that the RICH Theory should be the ultimate end goal of a child's education. The authors note the power of explicitly and subtly addressing components of the RICH Theory in the educative process, citing the importance of addressing resources, intimacy, competence, and health, in order for a child to be successful and flourish in the system. In sum, the authors reference the immense power that the RICH Theory can have if used effectively in transforming and improving the lives of students via their educational experience. The RICH Theory, at its core, emphasizes equal opportunity, as all students are able to make gains across the four characteristics and have the potential to achieve happiness. In sum, Kehle and Bray suggest that the relationships and efforts of school-based mental health providers, such as school psychologists, as well as the efforts of the classroom teacher, may persuade great influence on children when using the RICH Theory as a framework in practice. These practitioners can target student well-being and happiness as the ultimate goals through the use and application of the theory. These goals of education are often evident and reflective of the desires of parents for their children to be happy, independent, connected with peers, competent, and well (Kehle & Bray, 2005).

Issues and Concerns

The RICH Theory has practical applications and as such is currently in the process of index development and validation by Bray and colleagues (Kehle, personal communication, June 15, 2020). The world's current mental health needs are amenable to RICH; a RICH index could help people of all ages with setting life goals and aid in informing knowing where and how to develop a remedial plan along the four RICH factors. However, issues and concerns may arise when exploring the use of the theory such as the negative impact that one characteristic may have on the other areas. The model encompasses reinforcers, which "promote[s] movement toward any of the four characteristics" (Kehle et al., 2009, p. 691). Kehle and Bray describe the "dynamic contradictory element" (2004, p. 48), which suggests that any predictors or reinforcers of the RICH characteristics may hold the ability to enhance or inhibit progress toward the characteristics. An example of this is while one may drink wine as a form of withdrawal, to promote creative thinking and to move toward the four characteristics, overuse would likely result in a regression away from attainment of RICH (Kehle & Bray, 2004). It is possible to misuse a reinforcer, which can impact the other characteristics, thus resulting in inhibited progress. Further, improvement or decline in any of the characteristics could lead to similar impacts on the other three. As an example, a disruption to a child's level of independence or increased adult

control might lead to diminishment in the other three areas (Kehle et al., 2009). If these disruptions persist, it may be difficult to fulfill and maintain all characteristics.

Building a secure parent–child attachment is imperative in increasing future independence, friendship, academic ability, and physical health. Attachment style provides a high correlation with the ability to initiate and build friendships, which is a product of the intimacy attribute. However, it is also interrelated with the other three RICH characteristics. It is suggested that "…the best definition of psychological health or happiness is what primary caregivers want for their children…" (Kehle et al., 2009, p. 689). While caregivers across cultures consistently describe their desires for their children to attain the RICH characteristics, it is necessary to understand the limitations of assessment and evaluation strategies that provide this information.

The application of the RICH Theory, specific to attachment, has been studied cross-culturally. Cultural assessment norms may affect our analysis of the characteristics. For instance, a formal observational assessment and a structured interview regarding attachment styles were conducted with mothers from South Africa (Kehle et al., 2009). Results demonstrated that agreement between the two evaluation methods was only 29% for securely attached children, when culture was not taken into account. This suggested that mothers in South Africa may describe their attachment to their children differently than European mothers (Kehle et al., 2009). While data was not collected pertaining to the incorporation of culture in evaluating securely attached children, results indicate the necessity of this consideration. When understanding the RICH Theory, as it applies to attachment, it is essential to understand cultural biases and influence for interpreting results. Further, it has been reported that despite parent's desires for their child to attain the four characteristics, it is assumed that they must have high income, marital status, educational achievement, and commitment to religion (Kehle & Bray, 2005). These areas may be difficult to attain for various groups of people therefore, there may be challenges in understanding the information gained from parents and caregivers regarding attachment and informing the use of the RICH Theory.

Cultural differences may also appear across definitions of happiness and should be noted when understanding the RICH Theory. For instance, an analysis was conducted on the definitions of happiness in multiple countries (Oishi et al., 2013). Researcher's interpretations of the findings suggested that luck and fortune was present in 80% of nations' definitions of happiness but was absent from the USA, Spain, Argentina, Ecuador, India, and Kenya. It was also found that people experienced more happiness in nations where luck and fortune was not part of the definition of happiness (Oishi et al., 2013). The cultural variation may hinder the application of the RICH Theory, as an analysis of well-being may not align with obtaining the four characteristics. Definitions of happiness that do not include luck and fortune are more ambiguous and may warrant further research to better understand the RICH Theory. It has also been noted that the definition of happiness may vary both across and within cultures (Ford et al., 2015). Understanding how an individual or cultural group conceptualizes happiness and well-being offers a foundation for using the RICH theory in practice. Additionally, other studies revealed that collectivist cultures view happiness from a

socially engaged perspective (Ford et al., 2015). Those cultures that do not align with a collectivist view may be more individualized, which may impact the perspective of the four characteristics, specifically intimacy. A firm understanding of the social nature of these cultures is necessary, as perspectives on progress toward the four characteristics may vary.

Another consideration for the use of the model is when it is applied to individuals with emotional and behavioral disorders. "Depression is also related to less than optimal academic achievement, poor social relations, and atypical and inappropriate behaviors" (Kehle et al., 2004, p. 862). Those with behavioral or mental health concerns may have difficulty in fulfilling the four characteristics without appropriate interventions or supports in place. For instance, previous studies have suggested a link between physical health and mental health problems (Combs-Orme et al., 2002; Hysing et al., 2007), as well as impacts on employment status (Zimmerman et al., 2010), and intimacy and/or relationships with others (Whisman & Baucom, 2012). The RICH Theory suggests that those with mental health and behavioral disorders may have difficulties in establishing well-being, as progress toward the four characteristics is impacted. The implementation of mind–body health interventions may increase happiness, as well as progress toward the four characteristics.

When considering the use of the RICH Theory in practice, careful considerations need to be made in order to address the appropriate function. For example, Kehle and Bray (2005) considered the concept of rewards and reinforcers. When used effectively, rewards may increase a person's sense of independence, which thereby influences their sense of intrinsic motivation in order to pursue tasks or learning. However, if rewards are seen from a manipulative or controlling perspective, people are likely to have a decreased sense of autonomy. This can, in turn, impact their view of competence, and progress toward overall well-being, while also decreasing intrinsic motivation to continue beyond the period of intervention. This example highlights the importance of interventions using the RICH Theory to be carefully crafted and considered so that they are applied in the correct fashion in order to support growth and well-being.

Recommendations for Addressing the Issues Raised

Knowing this information, what can individuals do to improve their overall well-being as related to happiness and physical health? Below are recommendations and interventions related to applying elements of the RICH Theory, including research-based practice for well-being, happiness, and overall mind–body health. Such interventions may be considered for use in a variation of environments, across age groups, with little training, and at low or no cost, aside from time and space to practice.

Mind–Body Health Interventions

Relaxation and Guided Imagery

Relaxation and Guided Imagery (RGI) is an evidence-based intervention that guides individuals through visualization of images to increase relaxation for mind and body. This process, which helps to moderate the communication between perception, emotion, and physiologic change, has been effective in reducing stress, anxiety, and depression (Howland et al., 2017). "An RGI exercise begins with a relaxation procedure that is believed to be effective in minimizing motor reactions, thoughts and external stimuli" (Kapoor et al., 2010, p. 312). RGI practices involve increasing relaxation by reducing uncomfortable emotional states and directing attention toward the visualization of specific images (deLeyer-Tiarks et al., 2020).

As it relates to the health component of the RICH Theory, RGI can assist in increasing physical well-being. Peck and colleagues (2003) implemented RGI in a small group of school-aged children with asthma to determine the impact on physical and mental health functioning. Measures of pulmonary functioning, anxiety, quality of life and asthma were collected during baseline and follow-up to determine the effects of the RGI intervention. Overall, results demonstrated an improvement in lung functioning, as indicated by pulmonary functioning and deceased levels of anxiety across all four participants (Peck et al., 2003). Further, RGI can help to increase competency and happiness. Results from Scrimin and colleagues (2014) indicated that when students were exposed to a negative mood inducing video clip, they experienced a change in mood and performance on an academic task. However, when students viewed the video and engaged in an RGI intervention immediately following, they did not experience a significant change in mood or performance on academic assessments. Evidence has also shown that RGI can build intimacy by increasing positive relationships with others (Howland et al., 2017). In a study completed by Howland and researchers (2017), RGI was implemented with mothers of preterm infants currently hospitalized in the NICU. The intervention involved engaging with a 20-min recording once daily for eight weeks, which included developing a relaxed state, working with difficult feelings and developing a friendlier feeling toward themselves (Howland et al., 2017). Results showed that average mental distress and cortisol levels decreased over time, as well as increased maternal–infant responsiveness.

RGI interventions may be adapted to each individual based on the need including timing (e.g., ranging from 5 to 50 min), visualization (e.g., may select a relaxing scene that is suitable for the individual), and delivery (e.g., individual session or group). Visualization scripts and exercises may be found through prior research conducted by Peck and colleagues (2003).

Progressive Muscle Relaxation

Progressive muscle relaxation (PMR) is an intervention in which individuals focus their attention on muscle groups throughout the body by tensing and releasing muscles, in order to eventually eliminate all muscle contractions (Lopata, 2003). PMR is a noninvasive, mind–body health intervention that may result in reduction of stress and anxiety, relief of muscle tension, sleep benefits and decreasing sensitivity to pain (Noruzi Zamenjani et al., 2019). Evidence additionally suggests that PMR can provide numerous benefits such as decreased blood pressure, anxiety, pain, cortisol levels, and heart rate (Lopata, 2003). School-based studies have revealed PMR is effective in reducing physiological symptoms of anxiety and reducing test anxiety in elementary and middle school students (O'Donnell & Dunlap, 2019).

Evidence supports the use of PMR toward the RICH characteristic of competency by increasing the ability for individuals to cope with stress inducing situations (Ozgundondu & Metin, 2019), as well as increasing cognitive performance (Tyndall et al., 2016). Further, self-efficacy has been reported to increase following implementation of PMR practices in patients with significant health issues. Evidence reveals that self-efficacy improves when individuals perceive their ability to cope has increased, which can affect the physiological functioning (Noruzi Zamenjani et al., 2019). Thus, as it relates to the RICH Theory, when the competency characteristic increases as a result of PMR, health may improve as a result. Previous studies have noted improvement in blood pressure and heart rate in women with bronchial asthma, as well as decreased back pain for women who were pregnant (Sadeghi et al., 2015).

PMR may be easily incorporated into an individual's environment. Teachers have reported acceptability of the intervention for use in classrooms with students (O'Donnell & Dunlap, 2019) and studies have shown effectiveness when PMR is implemented in a hospital or clinic setting (Noruzi Zamenjani et al., 2019). Many written scripts are available to deliver a PMR intervention, as well as audio and video recordings (University of Michigan Counseling & Psychological Services, 2011; https://caps.umich.edu/article/progressive-muscle-relaxation-meditation-video).

Mindfulness Meditation

Mindfulness, the act of paying attention to the present moment without judgment, has intimate ties with happiness both in internally experienced happiness (Davidson et al., 2003) as well as how other people interpret personal disposition and relate it to happiness (Choi et al., 2012). Davidson and colleagues (2003) explored the physiological impacts of an eight-week training meditation program, and noted improvements in brain functioning as well as increased immune functioning. On a cognitive level, mindfulness meditation practices have been shown to improve self-regulation via one's ability to regulate emotions and enhance self-awareness (Tang et al., 2015). Such changes have been associated with alterations in brain composition and brain matter, such as in the anterior cingulate with attention enhancement, fronto-limbic

with emotion regulation and handling stress, and midline prefrontal cortex and posterior cingulate cortex as related to present-level awareness and self-awareness (Tang et al., 2015).

In relation to the RICH Theory, regarding resources, competency, and the overarching sense of autonomy, researchers have suggested that mindfulness meditation may be linked to increased self-awareness and self-confidence. Researchers at Brigham and Women's Hospital suggest that the practice of mindfulness intertwines the complex higher order thinking process of meta-awareness, which related to self-awareness, the ability to monitor and control personal behavior (self-regulation), as well as focus on the needs of others as well as engage in effective interpersonal interactions (self-transcendence) (Vago & David, 2012). Further, related to intimacy and interpersonal relationships, research has shown that engaging in mindfulness exercises may increase social skills for those students with learning disabilities (Beauchemin et al., 2008). A branch of mindfulness, interpersonal mindfulness, suggests that use of mindful practices is a predictor of friendship quality (Pratscher et al., 2018). Regarding health, mindfulness meditation practices have been linked in prior literature to help individuals cope with clinical and subclinical health and personal concerns (Grossman et al., 2004). Additionally, mindfulness meditation has been linked to cognitive improvements such as sustained attention and higher order thinking (executive functioning) (Zeidan et al., 2010). Regarding specific health improvements, in research, mindfulness meditation is related to improved psychological, physical, and stress reduction for oncology patients (Ott et al., 2006), heart disease (Parswani et al., 2013), asthma (Kraemer et al., 2015), and obesity (Dalen et al., 2010), to name a few. Additionally, improved symptoms for patients with psychiatric diagnoses such as ADHD (Zylowska et al., 2008), eating disorders (Wanden-Berghe et al., 2010), and bipolar disorder (Perich et al., 2013), among others.

Concerning mindfulness exercises, a variety of exercises are available online for no or low cost through a variety of web streaming platforms and phone applications.

Yoga

The physical act of yoga has multiple effects on both psychological and psychological well-being. Yoga incorporates using physical postures as well as breathing methods and meditation (Büssing et al., 2012). In sum, yoga intertwines various elements of well-being: physical, mental, emotional, and spiritual (Chu et al., 2016). Although there are a variety of distinct yoga schools of thought and practice, all stemming from distinct backgrounds, overwhelmingly, the general goal of yoga seeks to grapple with the notion of consciousness, which presents as a universal theme (Feuerstein, 2012).

Further related to the RICH Theory, practicing yoga has been associated with benefits related to intimacy and interpersonal effectiveness. Prior research has suggested that the mere practice of yoga espouses the potential for personal transformation, as well as often leads to more opportunities for social interaction and affords healthy

coping mechanisms to use when dealing with relationship concerns (Ross et al., 2014). Interpersonal impact of yoga has also been extended to special populations in the research, such as women who are pregnant (Rakhshani et al., 2010), as well as for high school students, who reported various social benefits after participating in a yoga intervention (Conboy et al., 2013). Related to health, physiologically, prior research on yoga has suggested that engagement in yoga practices decreases self-reported anxiety and depression. In one intervention using pre and post-measures after a three-month yoga meditation retreat, improved well-being on a biophysiological level as evidenced by increased level so antiinflammatory cytokine Interleukin-10 coupled with decreased levels of proinflammatory cytokine Interleukin-12. Additionally, increased levels of brain derived neurotrophic factors (related to neuron health and productive functioning) were found (Cahn et al., 2017). Yoga interventions have been successfully implemented for prevention of heart disease (Jayasinghe, 2004), asthma (Manocha et al., 2002), and eating disorders (Carei et al., 2010), among other aspects of physical health and well-being. Concerning competency, yoga interventions have been linked to increased self-esteem and self-regulation (White, 2012).

Regarding free interventions for use of yoga, a variety of low and no cost yoga interventions can be located online. For example, research by Peck and colleagues have used Yoga videos for Gaiam Yoga in their research on yoga interventions related to ADHD (Peck et al., 2005) as well as asthma (Bray et al., 2012). Specific interventions for children and yoga are also widely available through organizations such as Sesame Street (n.d., See https://sesamestreetincommunities.org/activities/yoga/).

Gratitude

The notion of gratitude considers what is the inherent value of gratefulness as well as how to foster a personal life perspective rooted in thankfulness (Emmons & Shelton, 2002). The concept of gratitude, historically, has been referenced in countless spiritual and religious texts, highlighting a common denominator of expressing thankfulness for received good fortunes in one's life (Emmons & Shelton, 2002). Gratitude has further been extended into various psychological theories, such as Maslow's Hierarchy of Needs, where the ultimate achievement of self-actualization is rooted in appreciation for oneself, one's life, and a person's good fortunes, which results in overall feelings of pleasure and joy (Maslow, 1970). Scholars in the fields of positive psychology have suggested that gratitude is imperative for well-being, physically and emotionally (Lomas et al., 2014). These benefits related to various facets of health and well-being have been evidenced in a variety of age groups (Emmons & McCullough, 2003; McCullough et al., 2001). For example, prior research suggests that children as young as ages six to eight are able to experience gratitude (Froh et al., 2007). In school-based settings, gratitude interventions have been met with success across a variety of capacities: subjective well-being, social support, and interpersonal skills, as well as school-specific benefits such as academic motivation (Froh et al.,

2007). Further on that note, similar benefits related to increased well-being with gratitude interventions have also been replicated in populations working with older adults (Killen & Macaskill, 2015).

When examining prior literature, incorporating gratitude into daily life may result in a variety of benefits related to the RICH Theory. Related to physical health and well-being, research has suggested that dispositional gratitude correlates with higher levels of physical health on self-reported measures, mediated by factors such as psychological well-being, engaging in healthy activities, as well as one's willingness to reach out for assistance related to health-related issues (Hill et al., 2013). Engaging in a gratitude intervention may also increase healthy eating behaviors in teens and young adults (Fritz et al., 2019). Related to intimacy and interpersonal relationships, felt gratitude may increase partner satisfaction in romantic relationships (Gordon et al., 2011), adult parental–child relationships (McConnell, 2017), as well as among adult friends and siblings (Rotkirch et al., 2014). Further, expressing gratitude to a partner increased behaviors related to relational maintenance (Lambert & Fincham, 2011). Related to competency, expressing gratitude from a manager to an employee was likely to result in increased pro social behaviors via route of social value (Grant & Gino, 2010). Concerning the facet of resources in the theory, adolescents engaging in gratitude interventions may experience decreases in materialism and are increasingly likely to donate substantial amounts to charities (Chaplin et al., 2019). Below please find some examples of interventions related to gratitude with an evidence base.

Counting Blessings

One intervention related to gratitude is known as counting blessings. Froh and colleagues (2008) asked middle school students to respond to the following prompt:

> There are many things in our lives, both large and small, that we might be grateful about. Think back over the past day and write down on the lines below up to five things in your life that you are grateful or thankful for. (Froh et al., 2008, p. 220).

The researchers contrasted the gratitude condition to a hassles condition, where they asked students to provide a list of irritants they encountered in their daily lives. Overall, this low-cost and low-time commitment intervention suggested that counting blessings increased gratitude, optimism, life satisfaction, as well as decreased negative affect as measured by self-report measures. These findings extended on a three week follow-up assessment, suggesting the potential for long lasting effects of engaging in gratitude practices.

Gratitude Letters

Letter writing, incorporating elements of gratitude, presents as an overlap between journaling and gratitude. In one study, researchers asked participants to engage in a reflective expressive writing process to author a positive letter, while avoiding a mere thank you note for a material good (Toepfer et al., 2012). After being examined by the research team, the letters were mailed to recipients. Research findings noted that simply authoring letters increased the subject's well-being on measures of happiness and life satisfaction, at the same time also decreasing levels of depression (Toepfer et al., 2012). Similar interventions using gratitude letters have extended similar effects in youth populations (Froh et al., 2009).

Cultural Competency and RICH Applications

When using the RICH Theory to evaluate well-being, it is necessary to understand the cultural discrepancies that may be apparent. By increasing knowledge and education regarding cultural differences specific to assessment and evaluation of attachment, the application of the RICH Theory may be better understood. As outlined by the National Association of School Psychologists (Miranda, 2002), there are three aspects related to cross-cultural competence which include awareness, knowledge, and skills; however, awareness and knowledge are most applicable in this context. While this model is specific to clinical practice, it may be appropriate to address cultural gaps specific to the RICH Theory.

Awareness

In order to better understand cross-cultural influences and differences specific to well-being, it is essential to understand one's own cultural perspectives through awareness of personal biases and prejudices, as well as recognition of cultural standards, different beliefs and attitudes (Miranda, 2002). In the context of the RICH Theory, the first step of applying cultural competence would be to identify that different perceptions of happiness or understand that cultures may emphasize the four characteristics differently. Although this stage perhaps is the most challenging to achieve, it is of utmost importance. Once awareness is achieved, it is important to begin education related to cultural variety.

Knowledge

Increased knowledge and education of cultural definitions of happiness and well-being, as well as values, may assist in applying the RICH Theory. While differences may exist between cultural groups, there are often differences within groups (Miranda, 2002). Additionally, the cultural interpretation of resources, intimacy, competence, and health may vary and education of these differences across groups can help further assist with the application of the theory. One may engage with a cultural mediator, a person from a specific cultural group, to learn additional information. Further, a distinction between deep culture and surface culture should be considered. Surface culture refers to food, traditions, and celebrations, whereas deep culture identifies specific thoughts, feelings, and values (Miranda, 2002). An understanding of deep culture may be more valuable in promoting the RICH characteristics.

Discussion

People often say that if you don't have your health, nothing else matters. This is the foundation for everything else because prioritizing your health allows you to work toward everything that you want out of your life. Likewise, people who do not have their basic physical needs met are generally not thinking past these issues to other aspects of developing the self. Instead, they are focused on survival. The RICH Theory aligns well with the well-known humanistic psychologist Maslow and his hierarchy of needs, which is often depicted as a pyramid. The foundational tier of this pyramid includes the physiological needs of food, water, shelter and so forth. This tier is akin to the "H" of the RICH Theory, and it promotes an understanding of physical health as foundational to overall wellness. The second tier is safety and security which is related to the "R" of the RICH Theory. These needs are related to resources that we can only acquire in good health. At Maslow's next tier are the need for belonging and love, which clearly aligns with the "I" or intimacy of the RICH Theory and emphasizes the importance of strong positive relationships to overall well-being. The next tier includes the esteem needs such as feelings of accomplishment, confidence and respect which aligns with the "C" of the RICH Theory and which agrees with the importance of feeling competent and as though one is able to contribute positively to the world around them. Lastly, at the very top tier of the pyramid is self-actualization which can be considered the point at which one is reaching their full potential and in light of the RICH Theory can perhaps be akin to achieving happiness and fulfillment in life.

Practical Application

In our study of mind–body health, we are consistently reminded that everything is connected. In clinical work, we are constantly striving to take a whole person approach or to view the individual as one who exists within several ecological systems, who has lived particular experiences, who has a particular genetic make-up, a unique personality, and their own ideas about what happiness means and how achievable that vision is for them. We believe that it is possible to help people at any point of their lives to work toward achieving happiness through the four RICH characteristics. Setting up our youth for success early in life by teaching the importance of happiness as the ultimate goal in life and by challenging each student to determine what that really means can help to set them on a path to true fulfillment.

Future Directions

In order for an individual to take advantage of the wisdom that the RICH Theory has to offer, they really need to understand and assess each aspect of their lives so that they can determine in which areas they require intervention or change. Such a measure is currently in development (Bray, Maykel, Sassu, & Theodore). It seeks to inform an individualized approach to counseling individuals that will help them to move toward attainment of all four RICH characteristics and achieve happiness. This includes wellness in all areas of life including, social emotional, physical, and academic areas.

Conclusion

The RICH Theory is influenced by Darwin's theory of mutation, with the belief that the individual is significantly impacted by chance in their environment. The concept of the RICH Theory grasps that chance allows for change, which can promote progress toward the four characteristics. This is not to say that the individual does not have free will or the ability to make decisions and alter the course of their own life, but rather that we must identify how to take advantage of resources we have access to, including those within us, in order to have success. Urie Bronfenbrenner is a well-known developmental psychologist who proposed the ecological systems theory, which later evolved into the bioecological systems theory. He emphasized the importance of recognizing the many layers of environmental influences on the developing child, but he also recognized that the child has the ability to impact their environment as well.

The story of our lives has not yet been determined, and therefore, we have the power to alter our life course if we can recognize that and if we are willing to do the

work to get ourselves out of our ruts. We have the ability to put ourselves into new situations that will allow for more chance encounters such as through immersing ourselves within diverse environments, traveling, and simply trying new places and new activities. We can withdraw ourselves through meditation, exercise, art, music, education, technology breaks, and vacations. We can choose to live differently, to start new habits and to work on ridding ourselves of those that no longer serve us as we strive for happiness. By considering the four aspects of the RICH Theory and what they really mean, we can evaluate our progress toward attainment in these areas and we can choose to make changes; we can choose to be happier.

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Chapter 2
A Cultural Perspective of Well-Being

Herdiyan Maulana and Nigar G. Khawaja

Abstract Well-being is extensively researched worldwide. The majority of the inquiries have taken place in Western countries (e.g., Australia, European North America countries). Literature based on the West indicates well-being as a multidimensional concept, which comprises self-growth, personal-oriented life satisfaction, and positive emotional responses. However, these conventional theoretical approaches and literature on well-being determinants may not fully explain the experiences of those living in the non-Western cultures. Recently, the focus of well-being studies has shifted toward the non-Western cultures. Cross-cultural approach on well-being provides a better understanding of well-being by considering how social–cultural variables shape the way people feel about their quality of life. These emerging approaches explain the variance of well-being in the non-Western developing countries. The Western society is typically influenced by individualistic culture. People living in these cultures are likely to prioritize their own personal interest instead of those of others, while the non-Western society tends to be more collectivistic and emphasize others. In these cultures, individual relationships with other group members play an important role in one's identity and life. Members of collectivistic societies focus on group membership and the others over their own personal needs. Some well-being features of Western society are universal. However, using the Western models to explain well-being in the non-Western society may need to be taken cautiously. This distinction is crucial as in non-Western countries, the profound cultural values, such as spirituality and strong social cohesion, may influence the way people perceive well-being. Theories and indicators that explain the well-being of people in individualistic societies may not be adequate for non-Western societies. Indonesia is one of the largest countries in the world. It is a massive archipelago and a vast heterogeneous society of 300 different ethnicities who speak 700 languages and dialects. Studies conducted by the authors indicated that Indonesians endorse

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_2

well-being as a multi-dimensional concept comprising basic needs fulfillment, positive social interactions, self-acceptance, and spirituality. This chapter establishes a fresh outlook and perspective of how well-being is articulated in different cultural contexts using Indonesia as an example.

Keywords Well-being · Culture · Perspective · Indonesia

Introduction

Over the last three decades, well-being has been one of the most investigated psychological concepts (Diener et al., 1999, 2018). Most of the research on well-being has been conducted in the West (Australia, Europe and North America). This research has highlighted well-being as a multidimensional construct (e.g., Cummins et al., 2003; Huppert & So, 2013; Seligman, 2011). This body of research indicates important factors and models of well-being. Some factors pertain to be universal and commonly applied across countries, while other factors are culturally unique to particular societies. Some research on well-being is starting to emerge in the non-West countries (e.g., Kadariya, Gautam & Aro, 2019; Lee & Kim, 2018; Rich et al., 2020). Incorporating the non-Western perspectives and cultures, these works throw light on the definition of well-being, contributing factors, and how this construct can be measured. Considering the population, Indonesia is the fourth largest nation in the world. Indonesian people have a strong collectivistic culture and religious values (Jetten et al., 2002). Despite the emerging research on well-being in the country, most Indonesian researchers have preferred to use the Western indicators and theories of well-being, rather than relying on their own cultural framework and measure of well-being (e.g., Abubakar et al., 2014; Ferdiana et al, 2018). It is important to present the outcome of recent well-being research in Indonesia as an example of how well-being could be interpreted diversely in different social–cultural contexts. The conventional, West-oriented frameworks of well-being are challenged in order to promote an understanding of the concept, centered on the respective social and cultural context.

History and Definition of Well-Being

The progress in well-being research has been remarkable. Initially, researchers conceptualized it as a unidimensional construct, which focused on an individual's ability to conquer daily adversity (Bradburn, 1969) so that life is evaluated positively (Diener, 1984). The unidimensional concept evolved into a multi-dimensional model, which describes well-being as an ability to accept life with a positive outlook, and to be aware of the fact that personal experiences of happiness originate from a wide array of life, such as social–cultural and financial conditions (Huppert & So, 2013;

Keyes, 2002). Past historical developments throw light on how these transformations in the field of well-being occurred.

Philosophers, across cultures, were the first to examine and conceptualize well-being as a unidimensional concept (e.g., Aristotle, Al-Ghazali). The study of well-being/happiness was also found in ancient Indonesian's teachings of wisdom, such as in the Javanese and Sumatran folktales and proverbs. The philosophers originally introduced the concept of well-being as a part of ethical and moral theories (Polansky, 2014). The Greek philosophers referred to two major paradigms: the Eudaimonia and the Hedonistic approaches (Waterman, 1993). In Greek traditions, the term Eudaimonia refers to "happiness or welfare" and refers to a fully functional life with an absence of physical illness or mental anguish (Ryff, 1989). The initial unidimensional concept of well-being evolved into a multidimensional model of well-being known as psychological well-being (PWB). The multidimensional concept of well-being is also reflected by the Hedonistic approach, which portrayed well-being as an effort to achieve objectives or valued goals in varying settings (Diener, 1984). Diener (1984) introduced the subjective well-being (SWB) concept as an ability to line one's life with a sense of happiness and positive emotions. He indicated that SWB has two primary markers: cognitive and affective. Cognitive well-being (CWB) refers to the dimension-specific or global appraisal of one's personal life satisfaction in various areas such as one's job and/or marriage. The affective well-being (AWB) relates to the magnitude and strength of one's positive and negative feelings that emerge in everyday life activities. To date, most research about well-being has focused on the multi-dimensional nature of well-being.

The multidimensional conceptualization of well-being changes the way researchers and people understand this concept. Subsequently, current studies of well-being emphasize this multi-dimensionality conceptualization (Cummins et al., 2003; Huppert & So, 2013; Seligman, 2011). The findings of these studies show that well-being is made up of a multiple factors, such as demographics, including age, gender, education and financial aspects, and subjective determinants related to cognitive and emotional reactions to everyday life events (Delle Fave & Bassi, 2009; Huppert & So, 2013).

Researchers have introduced several well-being models and frameworks. One of the popular theoretical models proposed by Ryan and Deci (2001) is referred to as the self-determination theory (SDT). The SDT suggests that an individual's experience of well-being is associated with their ability to fulfill numbers of primary psychological needs such as autonomy, competence, and relatedness. These components are important indicators for well-being measures. While another theory suggested by Keyes (2002) promotes "flourishing" as a substantial process to achieve happiness and well-being. Flourishing is described as a state where people feel positive emotion toward themselves while maintaining good social relations with their environment. Hence, the idea of "authentic happiness" which is primarily a consequence of one's positive feeling, commitment, and meaningful life experiences was introduced by Seligman in 2004. Seligman has transformed this idea into a PERMA model of well-being which is the acronym for five key measures of well-being: positive emotion, engagement, relationship, meaning, and accomplishment (Seligman,

2011). According to him, well-being is best understood as the aggregation of these psychological experiences, which emerge across multiple areas of life.

Further, Cummins' (2010) proposed that happiness is impacted by a person's ability to keep a balanced state of psychological resources in one's lives. This paradigm is known as the homeostasis defense range, which refers to one's capacity to maintain affect and cognitive resources in equilibrium states while facing daily life conditions. He suggests that each individual has their own set point of psychological threshold, where they would feel fine if they can still remain within this range of position (Cummins, 2010). Dodge et al. (2012) further resonated Cummins' idea by highlighting the importance of cognitive and affective resources to achieve optimum well-being level. This idea helps people get well and overcome their everyday problems by means of their emotional, social and physical capitals (Dodge et al., 2012).

Similarly, Huppert and So (2013) introduced another multidimensional model of well-being, inspired by Diener's concept of flourishing. They suggested that the well-being experience is strongly associated with an individual ability to maintain their physical health, emotional stability, life meaning, optimism, and self-esteem. Huppert and So (2013) argued that well-being is the opposite state of being ill, which means it is unlikely that those who have achieved well-being have any mental/emotional disorder. One way to categorize indicators on well-being is to distinguish between the universal and cultural-relative aspects (Lomas, 2015). The universal dimensions are directly measured using the objective aspects such as standard of living, access to infrastructure, and physical health. These aspects are results of social and economic development. While the relative factors have been difficult to measure, they deal with psychological and social perceptions, views, and feelings associated with cultural context. In the light of the above definitions, there is a consensus that well-being is an umbrella term used to explain one's positive capacity to attain satisfaction within social and psychological dimensions. Nevertheless, due to differences between socio-cultural contexts, well-being is interpreted variously in Western and non-Western cultures.

Western and Non-Western Cultures: An International Divide

A bulk of research on well-being conducted in the Western, developed, and industrialized countries has used the Western values to explain well-being. Individualistic culture is the hallmark of these Western civilizations. Individualism ensures that the individual freedom, autonomy, and preferences are prioritized. Individualism exalts the moral worth of freedom, personal initiative, privacy, and freedom. Another value that is most often associated with the Western civilization is secularism, which plays an important role in the Western modern society. The separation of religion and state is an example of the practice of secularism in Western society.

These values, such as individualism and secularism, have influenced the theorists, who have formulated well-being theories and frameworks. Social structure of the Western society is built upon individualism-oriented values. As a member of

the society, a person is competitive and driven by the self-interest for individual benefit/profit. Such value is highly emphasized on personal achievement and satisfaction. Self-concept in this society is strongly linked by the common belief that people have both the capacity and the right to choose things they want based on their own interests.

In general, the Western society puts spirituality and religion in a private setting. The Western nations have embraced secularism in the institutional- and social-level systems. The secularism principle is intended to preserve the individual freedoms by separating faith from the public–state institutions. This is to ensure religious values do not mix with the public–state affairs and vice versa (Modood, 2016). The value of secularism and individualism is interconnected creating an independence oriented society. As secularism expands, people are getting more secluded from religious values and traditions. As a result, religion is perceived less important and no longer relevant to personal life which in turn may affect how they meant what is important in life. Limited religious affiliation has affected how the Western society thinks about their goals in life, their interaction with others, including how they interpret happiness.

From the economic and financial point of view, the Western countries are generally wealthier compared to the non-Western countries. Based on the World Bank data (2019), the North American countries, Australia, and most of the European nations have better economic indicators compared to the non-Western countries (Asia, Africa, and Latin America). Despite a decrease in global poverty in the last decade, there is a huge gap in the wealth distribution around countries in the world. North America (USA and Canada), Australia, and European Union share about 40% of the world's gross domestic product (GDP). Nevertheless, South Asia despite comprising 30% of the world population only accounts for less than 4% global GDP. People living in the wealthier countries enjoy the highest standards of living and have higher chances to access social facilities and infrastructures. The productive economic sector, stable political conditions, and efficient social service programs contribute to the high quality of life in the Western countries.

People living in the non-Western countries are part of a collectivistic culture. Countries in Asia, South America, and Africa are considered as collectivistic societies in nature. Collectivistic cultures prioritized the goals and needs of the community over the individual interest (Hofstede, 1991). A person is expected to build a mutual, social relationship with other members of the society. Common characteristics of collectivistic society are families and communities playing an important role in shaping one's identity. Further, social norms focus on promoting common needs over personal pursuit, and each individual is encouraged to do what is considered best for their family and society. In these cultures, people would be perceived as "ideal" if they are attentive to the needs of others. According to Markus and Kitayama (2001), people in these societies are interdependent and benefit from the strong social solidarity and relations. This view is in strong contrast with the individualistic cultures which often place a pursuit of personal achievement as a standard of ideal success. Moreover, people in collectivistic societies view religion as a social matter, and individuals are generally affiliated with the religious group. As such, this perspective is

distinct to the individualistic Western societies that recognized religion as a personal matter. Moreover, in the collectivistic societies, identity is built upon group affiliation. These cultural differences are prevalent and may affect how societies function.

Ferrer-i-Carbonell (2005) indicated that well-being incorporates personal evaluation of one's actual circumstances and living conditions. This inquiry is often focused on quantitative socioeconomic dimensions like wages, employment status, and schooling. Extant literature suggested that an association between these indicators and well-being varied when the nation's socioeconomic context was taken into account (Ferrer-i-Carbonell, 2005; Kenny, 2005). Compared to the industrialized-developed countries, poverty, unemployment, and social–economic disparity are often becoming an economical and financial concern in the non-Western regions (e.g., South-East Asia, Africa, and South America). Most of the countries in these regions are economic-developing countries, categorized by a low to middle level of income. Most Asian nations, except Japan, Korea, and Singapore, are categorized as developing countries. Veenhoven and Ehrhardt (1995) indicated that financial circumstances would strongly predict well-being only if basic/material needs are becoming society's main concern. These researchers' (Veenhoven & Ehrhardt, 1995) model suggested that the relationship between financial and economic aspects to happiness across nations relies upon society's social–economic status. Based on this theory, people living in a wealthier country may experience a higher level of happiness compared to those who live in an underprivileged country. The sociocultural and economical variation may generate distinct understanding about what factors contribute to an ideal standard of life. While there is substantial information about well-being in the Western developed countries, it cannot be generalized to populations in non-Western developing countries. A careful approach is warranted to study the experiences of people living in non-Western developing countries.

Western Perspective of Well-Being

As explained above, the Western countries often focus on individualistic-oriented dimensions of well-being. These dimensions involve an array of economic, social, and psychological indicators to capture what is essential for a good life. Using these dimensions, a number of Western countries developed an index/standard used to measure well-being. For example, Canada developed the multidimensional Canadian Index of Well-being (CIW) (Langlois, 2015) that comprises eight key dimensions relevant to what constitutes well-being for household financial capacity, time allocation, education, and environmental quality. These dimensions include physical health, democratic engagement, leisure, objective, and subjective aspects of well-being. The objective aspect includes self-reported health and economic dimensions evaluated through household expenditures and income, while the subjective aspects include how they perceived democracy, leisure times and life expectancy. These subjective dimensions are measured through individual mental and social function. The measure of well-being in Canada emphasizes one's ability to thrive in pursuit

of individual well-being, while the social functions are measured through one's civil participation and freedom of expression.

Another example is Australia, which is considered a Western nation although geographically close to Asia. Australia uses the European political and legal institutional system, and their language and literature are derived from Britain. In 2001, a consortium of university, federal government, and private companies developed an index to monitor the well-being of the Australian. It resulted in an Australian Unity Well-being Index (AUWI). The AUWI evaluates well-being as the average level of one's satisfaction across seven key dimensions of life: standard of living, health, life achievement, personal relationship, community connectedness, safety, and security. These dimensions are based on the homeostatic well-being theory (Cummins et al., 2003). The theory emphasized on how humans attempt to attain a state of balance to achieve well-being. The Australians need to maintain their personal resources to overcome life challenges. Personal resources refer to one's psychological, economical, and social capital. People with a high level of well-being are those who are physically healthy, financially stable, and socially open.

One leading aspect of the socioeconomic dimension, mentioned in the examples above, is personal income. Ferrer-i-Carbonell (2005) suggests that people with higher levels of earnings are considered to have a better chance to obtain well-being. However, the literature on well-being in developing countries (e.g., South Asia or Latin America) indicated that in terms of personal well-being, income and financial achievement shared a minimal effect on happiness (Kenny, 2005). While in well-developed countries (North America and European nations), income has consistently shown a positive relationship to well-being (Frey & Stutzer, 2000). Overall, most of the theoretical frameworks used in the Western countries are mostly centered on the individual interest. One's identity and goal are mostly determined by the individualistic pursuit and not derived from the interests of the society or other group members.

Non-western Perspective of Well-Being

Compared to the West, research about well-being in the non-Western developing country is still at an early stage. Nevertheless, some well-being studies conducted in Asian countries have yielded interesting results. Suh et al. (1998) found well-being to be associated strongly with a diverse sociocultural background. Research indicated that cultural values expressed in the social system, such as strong social cohesion (Jaafar et al., 2012), family importance (Sun et al., 2014), and religious experiences (Eryilmaz, 2015), have all been found to be related with happiness in non-Western populations. Furthermore, Davey et al. (2009) reported important findings about how socioeconomic status was not associated with the perception of quality of life in traditional Chinese villages. Similar results, about Beijing urban workers, were also found by Nielsen et al. (2010). A study conducted on the Indian population by Agrawal et al. (2011) indicated that the perception of happiness varied and depended

on socio-demographic factors in India. This study revealed variations on well-being dimensions due to gender, income, marital status, and education. Parnami et al. (2013) indicated that apart from the gender, religion played an important role in promoting the happiness of Indian people. Specifically, in the Indian society, differences of faith were associated with varying social identities, which led to happiness (Kumar et al., 2013).

Most of the well-being research in Asia has been conducted either in the Southern part (e.g., Pakistan and India) or the Eastern part (e.g., China, Hong Kong, Korea, and Japan) of the region. Well-being research in Indonesia is limited as to other Asian countries. Although Indonesia's values and customs are related with other Asian countries, Indonesian cultural heritage remains exceptional for its distinct social–cultural characteristics. Indonesian culture is deeply motivated by the religious beliefs and customs practiced in almost all areas of life (Hofstede, 1991). In Indonesia, Islamic values and teaching are intimately connected to so many social customs and local practices. Islamic values which are also widely adopted in the South-East Asian society (Bangladesh, Brunei Darussalam, Indonesia, Malaysia, and Pakistan) have a distinct view of well-being that may not be fully represented by well-being theories and measures developed in the West. Tiliouine (2013) indicated an Islamic view of happiness as a desire to strike a balance between the earthly life and the hereafter. This balance is expressed in a full submission to God's will, such as accepting life and contentment. Lu and Gilmour (2004) suggest that mainstream approaches of well-being (e.g., hedonistic and eudaimonia) may have overlooked these cultural aspects of well-being as both concepts are developed and mainly tested in the Western developed countries (USA and European nations).

Well-Being in Indonesia

Indonesia is the world's fourth largest nation with 260 million inhabitants (Indonesian Statistic Bureau, 2016). It has 300 different ethnic groups living on more than 17,000 islands. Although "Bahasa" serves as an official language and is widely spoken and understood, the country also has more than 700 distinct indigenous languages and dialects. The nation is one of the world's most diverse cultures (Indonesia, 2016). Indonesia initially consisted of diverse indigenous kingdoms until the Dutch arrived in the early sixteenth century and gradually managed to conquer some of these kingdoms for more than three centuries. All these diverse cultures united to establish a political power against the Dutch colonial system, later taking the form of Indonesian nationalist groups. This political power encouraged the freedom movement, leading to the independence of Indonesia in 1945.

Indonesian is one of the largest democratic countries in the world. Between 1997 and 1998 Indonesia underwent a prolonged economic crisis following the reformation movement forcing the existing regime to step down. In early 2000, Indonesia entered a new democratic transition phase. Open and transparent general elections were established, promising better economic and financial growth. The economic sector of

the country has increased rapidly following the crisis and reformation era. Indonesia has become one of the emerging economy powers in Asia. The government has successfully reduced poverty by 50% during the last two decades (World Bank, 2019).

Country's demographics indicate that most of the Indonesians are young. The median age of the population is 29, and around 60% of the population is under 40 years of age (World Bank, 2019). Two largest ethnics groups in Indonesia are the Javanese (41%) and Sundanese (15%). Both ethnic groups originate from the Java Island, the most populous island in Indonesia. Indonesia's rich cultural diversity is expressed in their national motto "*Bhinneka Tunggal Ika*" means unity in diversity. More than 85% of the population follow the Islamic faith (Indonesia, 2016), making Indonesia as the largest Muslim majority country in the world.

Islam came to Indonesia in fifteenth century through Indian and Arabic traders and since that time has become the dominant faith in the country. Indonesia incorporates religious ideals into nearly every area of life. The Ministry of Religious Affairs was established to ensure that religious values and principles are followed properly. Islamic ideals and laws are accepted as part of the Indonesian legal system and are broadly integrated in the development of public policies and regulations in Indonesia. The ministry oversees the administration of *halal* food, the arrangement of pilgrimages to Saudi Arabia, managing Islamic banking and finance, as well as the regulation of marriage. Religious principles and rules are used as a primary social reference in everyday social experiences. As a consequence, such solid and interconnected religious traditions are likely to have an effect on the people's psychological well-being.

The interplay between tradition and belief is hard to separate from the Indonesian society. Indonesian cultural values and customs promote the absolute obligation to respect the parents and elders and courteous day-to-day interaction between men and women and a sense of subtle expression of emotion as a form of respect to religious norms and values (Landiyanto et al., 2011; MacDonald et al., 2012; Trommsdorff & Schwarz, 2007). These characteristics are understood as being consistent with indigenous values and traditions in Indonesia and thus are consistently kept in daily social life.

As mentioned earlier, the Indonesian society is predominantly influenced by collectivistic culture (Hofstede et al., 1991). Therefore, group harmony and participation are more important than individual concerns. Group membership is essential as it assists individuals in constructing their social identities. Everyone is invited to support multiple groups in the society, such as their extended family, neighborhood, community, place of employment, and religious group. The Indonesian social structure is hierarchical, as power and roles are distributed according to gender orientation and age (Jetten et al., 2002). Males are viewed as the breadwinner and are expected to provide protection for their families, whereas females are typically responsible for taking care of family members and performing household chores. In Indonesian society, the family bond and kinship serve as social references, and parents and other family members exert a strong influence over individuals' personal lives. All of these characteristics are consistent with indigenous values and traditions in Indonesia and

are maintained in daily social life (Jetten et al., 2002). These ideals tend to differ from traditional values of Western culture. Therefore, in terms of the uniqueness of specific Indonesian's sociocultural settings, it is possible that these characteristics will affect their experience of well-being in different ways.

Well-Being Factors in Indonesia

Although previous research in non-Western countries has indicated that psychosocial and cultural factors are significantly related to well-being, little is known about the role of these factors in the well-being of Indonesians. So far only a few well-being studies, conducted in Indonesia, have been published. According to these studies, psychosocial and cultural aspects that appeared important to well-being are religiosity (Amawidyati & Utami, 2007; Hadjam & Nasiruddin, 2003; Harpan, 2015) and family (Abubakar et al., 2015; Alawiyah & Held, 2015; Herbyanti, 2009; Puspitawati et al., 2012). Amawidyati and Utami (2007) found that spiritual activities, such as praying and going to mosque, were correlated with the Indonesian sense of well-being. Similarly, Primasari and Yuniarti (2012) found that Javanese youth regarded their family and relation to God as the important factors associated with their happiness, good social relations, and self-fulfillment. Further, these researchers identified spiritual aspects as the main source of Indonesian teenager's happiness.

Nevertheless, a number of the studies investigating well-being in Indonesia identified systematic weaknesses, such as weak research design, lack of culture and language appropriate measures, poor sampling, and participants limited to a specific section of the population, such as women, students, or Muslims. Further, these previous studies did not clearly explain how Indonesians define well-being. Some studies used a single question to evaluate the well-being (e.g., used in the Indonesian Family Life Survey), disregarding the good grasp of well-being, varied sociocultural perspectives and were impacted by the validity and reliability issues (Alawiyah & Held, 2015; Sohn, 2013; Sujarwoto & Tampubolon, 2015). As a result, there is very limited published and valid research regarding the specific mechanisms of well-being in this cultural context.

Recent study by Maulana, et al. (2021) highlighted that universal and cultural-related factors were associated with the well-being of Indonesians. The universal factors including social–demographic characteristics (age, gender, education, employment, marital status, health, and personality) and the cultural-related factors referred to variables that closely associated with the Indonesian's norms and values, such as trust, sense of community, and interdependent self-identity. The study was based on Lomas's (2015) universal-relativism model of well-being. Factors such as income, marital status, health, and traits of personality, such as extraversion, which were regarded as universal in nature emerged as important predictors of well-being. Interestingly, the effect of these universal factors decreases when the cultural-related factors were taken into an account. A sense of community, interdependent life, and trusting relationships appeared to be the culture-related factors, which contributed

to the well-being of the Indonesians. Overall, the study indicated that the well-being of Indonesian is best explained by both universal and social–cultural dimensions.

Meaning of Well-Being

Maulana et al. (2018) study indicated that Indonesian's perception of well-being was strongly associated with the collectivistic culture. Their study aimed at understanding well-being using a social–cultural approach and presented an initial model of well-being for the Indonesians society. The findings indicated that there are a number of themes regarding how the Indonesians define well-being (Maulana et al., 2018). Indonesians described well-being by a number of factors, such as their expectations associated with their ability to meet basic needs, their willingness to accept healthy social relationships, and their positive worldviews.

The ability to fulfill their basic-material needs included food, shelter, transportation, basic education, and health. Interestingly, instead of prioritizing their own needs, Indonesians emphasize the needs of family and friends. A good social relationship, which included emotional and instrumental support received from family, others and community (e.g., financial and facilities support provided by parents to their children). This social connectedness is important to them as it is reflecting the collectivistic way of life. These findings are particularly applied to people living in non-Western countries (Camfield et al., 2010; Yip et al., 2007). Personal qualities are also regarded as important for one's well-being. Gratefulness and self-acceptance matter in achieving a good quality life. They viewed these characters as an act of wisdom and ways to confront the unfavorable challenges in daily life. Recognition of the self and life were considered as a modest way to achieve a long-term inner peace that is profoundly internalized in the classical Indonesian teachings, as the old Javanese proverb "Nrimo '' translates into a genuine, self-acceptable mind-set. This finding is compatible with Lu and Gilmour's (2004) research on the relevance of achieving social acceptance for the non-Western cultures. Individuals mirror their own needs in other people (family, others, and community) to sustain a social equilibrium (Lu, 2005; Lu & Gilmour, 2004).

Measures of Well-Being

The measurement of well-being components is present in several ways and forms. Linton et al. (2016) indicating nearly 100 well-being instruments exist covering six major dimensions of well-being appeared in the latest studies (mental well-being, educational, physical, spiritual, and operational and personal circumstances), which unfortunately no cultural-based dimensions emerged or discussed in the paper.

A review of the literature indicated that research conducted in Indonesia primarily investigated factors associated with well-being. However, these studies used the most

popular and readily available tools developed in the West. A number of researchers noted that Western definitions of well-being may not accurately capture how this concept is understood and experienced in different social–cultural contexts (Tov & Diener, 2009). There is a need to develop well-being instruments which are sensitive to respective cultural context (Lu & Gilmour, 2004).

Based on the earlier finding, Maulana et al. (2019) developed The Indonesian Well-being Scale (IWS) which consists of 20 items that reflect four key dimensions of well-being (basic needs, social relations, self-acceptance, and spirituality). These factors represented a unique perspective of Indonesian's sense of well-being. The scale acknowledges the multidimensional approach of well-being (Diener et al., 2015; Lomas, 2015). Four key dimensions of the IWS highlight what Indonesians consider important when evaluating happiness. The scale does not only focus on widely accepted aspects of well-being such as individual interest, but it also emphasizes on the cultural nuanced component of well-being of Indonesians, such as social relations and spirituality.

Gaps in the Literature and Direction for Future Studies

Available theories and literature on well-being are mostly originating from the West. These theories imply that individual factors such as autonomy, financial capacity, sense of freedom, and personal achievement are associated with well-being. Nevertheless, the majority of the well-being studies in the Eastern countries have practiced these theoretical frameworks without critically evaluating their cultural relevance and appropriateness. As a result, we need to be very cautious when applying such concepts and factors in different cultural contexts. This chapter highlights the multidimensional nature of Indonesian's perspective of well-being as well as a newly developed tool to measure well-being covering psychological, cultural, spiritual, and social aspects. Indonesians incorporate universal and cultural factors with their experiences of well-being. This multidimensional model and tool can be useful for the stakeholders (researchers, government, and health clinicians) and can be used to develop policies, interventions, and future studies on well-being in Indonesia. However, further research and publications are warranted to continue adding to the body of knowledge.

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Chapter 3
Leprosy a Life Changing Experience to Live Ostracized: Psychological Issues and Well-Being

Subhasis Bhadra

Abstract Leprosy is an ancient disease, public health issue even today. The disease caused by bacteria typically has a slow onset. It impacts the peripheral nervous system leading to visible deformities of limbs, facial muscles. With high disabilities, it imposes serious functional restrictions. Leprosy is absolutely curable, and the National Leprosy Eradication Program started in 1983, yet the infection is increasing in India. The social stigma attached to it imposes serious restriction that limits their developmental opportunities and force to a dehumanized living condition. India has eliminated leprosy in 2005, yet there are more than 1000 leprosy colonies, where people are living being excluded, ostracized with deprivation and poverty, dependent on begging or meager livelihood activities. The detection of the disease itself becomes an existential crisis that impacts the overall well-being as the subsequent life course becomes highly stressful and emotionally exhaustive with combinations of negative life events. Leprosy affected persons require medical attention and treatment for lifelong. The leprosy colonies in India at present have a history of origin linked to the leprosy hospitals where the patients were admitted for treatment and deserted by families. After discharge, they started living in and around without much rehabilitation planning and support from any authority. While begging becomes a survival strategy many of them entered family life and their offspring continue to live with similar realities. An international organization working in the colonies across India was visited by the author and the chapter reflected the realities from the ground through various narratives and case stories. The dehumanizing experiences, marginalization, and the diseased identity caused a lot of mental health issues that require constant multidimensional support. There are complex psychosocial issues among leprosy affected persons that require focused, systematic planning and long-term intervention for sustainable development, empowerment, human rights fulfillment, and enhancing capability to facilitate well-being.

Keywords Leprosy · Life · Experience · Ostracization · Psychological · Well-being

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_3

Introduction

Leprosy is a disease from the past that still continues to be a public health problem in many underdeveloped and developing countries. India has effectively achieved the target for elimination of the disease by bringing down the rate of prevalence to less than 1/10,000 population and further in 2016 it was reported 0.66/10,000 population (Central Leprosy Division, 2017). Thus, officially India has eliminated leprosy in the year 2005, though still it is increasing and new cases are detected making the disease a public health concern. But, the fact is quite worrisome as the disease started resurfacing and India counts the highest number of the new cases detected every year. Even after all the epidemiological data, it is well-established that the biological aspect of the disease is one side of the coin that can be quite manageable with the scientific treatment and chemotherapy. The other side of the coin is the main concern that imposes social and psychological barriers in the life of the leprosy affected persons and their family members, as leprosy is one of the highly stigmatized diseases of the world. Leprosy is treatable and curable with medical intervention, but the bigger issue is not biological, rather the social, cultural, religious beliefs and practices that reinforce the ostracization of the persons and gravely impact self-esteem, identity, and well-being. It is not just the person with the disease; rather the whole family gets the blow of social rejections that often make them believe and act in a manner that is quite strange. It is seen if anyone in the family gets affected by leprosy the family members tend to disassociate themselves and mostly desert the patient at the hospital meant for the treatment of leprosy. This practice continues for decades together becoming a practice and custom that lead to the development of ghettoized colonies of the leprosy affected people. The blow to the life of the leprosy affected persons changes the whole life course that explains their living in a most dehumanized condition being marginalized and deprived. Though the work of Saint Mother Teresa, Father of the Nation Mahatma Gandhi, and further Baba Amte has established a humanitarian milestone for caring for leprosy affected persons still the people living in colonies are at the bottom of socio-economic strata living with diseased identity and the daily struggle for survival. The poor capability and low fulfillment of human rights often extended the problem to the generation next and they continue to face hardship.

Concept of Public Health and Leprosy as Public Health Issue

The triple burden of disease is quite evident in India that includes the communicable, non-communicable, and reemerging infectious diseases. As a whole the disease burden is increasing quickly with demographic changes, epidemiological transitions, continuing environmental degradation and progression of infectious diseases (Narain, 2016). In this scenario the reemergence of leprosy is a real concern from a public health perspective. In “Global Leprosy Update 2017: Reducing the Disease Burden due to Leprosy,” WHO () mentioned in the year 2017, South-East Asian

Region accounted for 73% of the global leprosy burden, where India and Indonesia contributed 67.4% of the new cases. WHO has recognized leprosy as neglected tropical disease that is closely connected with multiple social issues, like, poverty, social rejection, leading to living in isolated areas (WHO, 2015). With its rising spree still leprosy is a public health problem in the world of the twenty-first century.

In this context working through public health perspective to deal with leprosy is a crucial consideration. Public health is a combination of scientific and social approach to improve the community health and well-being of the target population through organized effort (Novick & Morrow, 2008). Thus, it is about improving the health of the community by engaging the community people for prevention, early detection, treatment, and rehabilitation. As a public health prevention strategy, the leprosy prevention work also targets the population rather than individuals. The social, environmental, and biological factors interact to determine the impact of disease and health outcome. Therefore, reducing the disease and improving the health and well-being is the key focus for working with leprosy affected persons. An elaborative definition of public health that was provided by the New York County chapter of American Red Cross in 1920 is quoted here. "Public health is the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infection, the education of the individual in principles of personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease and the development of social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health." For the care, treatment, and rehabilitation of the leprosy affected persons and communities, various public health activities are undertaken by the humanitarian organizations and government. The focus of the public health work for leprosy comprised of different actions, like, providing awareness in the community, early identification of the cases, providing preventive medicines, hospitalization, treatment of the cases, reduction of the disabilities, enhancing functionality through various rehabilitation measures, facilitating long-term care, and providing other support (like, microfinance, livelihood, housing, water sanitation, provision of food items, or other materials, etc.) for enhancing the community living and well-being. Low education, poverty, living in secluded locations, severe social stigma attached to the disease made the life of the leprosy affected people quite devoid of basic standards, associated with denial of social justice, human rights, and low entitlement status. Often the required support services are not provided in a holistic manner and further lack of coordinated efforts, funds, and low priority toward this neglected disease are hindering ensuring well-being for the persons with leprosy, their family members and communities.

Sustainable Development Goals which is an extension of Millennium Development Goals as global commitments for improving human lives and environmental protection has many essential important focuses on ensuring well-being of the most marginalized and vulnerable sections of the society. The global commitments for reducing poverty, hunger, enriching health and well-being are directly associated with improving the condition of the leprosy affected persons and communities as

their living is marked by denial of opportunities for development and fulfillment of basic needs to ensure a dignified human living. While WHO launched a new "global strategy seeking accelerated efforts to end leprosy" in 2016, it specifically mentioned that the equity and universal health coverage will contribute toward achieving the SGD goals.

Prevalence of Leprosy World-Wide and in India

The mention of leprosy is found in the ancient text of Egypt before 4300 years of Christ and detected in India about 4000 years ago. Thus, it is called one of the most ancient diseases, yet causing multiple issues in the life of the leprosy affected persons. The epidemiological data that included data from 102 countries, published by the World Health Organization (WHO, 2014), showed that Southeast Asia and Americas remains the most affected areas by Leprosy. The prevalence rate varied from 8.38 and 3.78 per 10,000 populations, respectively. Southeast Asia with prevalence of 8.38 cases per 10,000 inhabitants is quite worrying as a public health problem, though 1991 WHO sets its goal to eliminate leprosy as a public health problem by lowering the rate of prevalence lower than 1, per 10,000 inhabitants. The new case detection rate in India was 126 913, highest in the world. India, Brazil, and Indonesia are most endemic and account for approximately 81% of new cases worldwide. The medical operational guidelines strictly focus on the disability assessment at the early diagnosis and reducing the disability or incapacity of the patient. Disability and limitations in the daily activities is one of the main problems while it impacts the economically active age group. The disabilities within the peripheral nervous system can occur before, during, or even after treatment, based on the onset and the treatment received by the patient. The degree of disability imposes the functional restriction as well as future prospect of rehabilitation or developing independent livelihood activities. The degree of disability medically is ranged between 0 and II for leprosy. While assessing the disability, the condition of eyes, hands, and feet must be determined. Grade-0 disability denotes no-disability, Grade-I means, loss of sensation in hand and/or feet, and Grade-II indicates the presence of visible damage or disability (Noriega et al., 2016).

Further, an update by WHO in the year 2019 reported 183,238 cases of leprosy patients were recorded as "on treatment" globally, that correspond to the prevalence rate of 0.24 per 10,000 populations. In the year 2018 the new case detection rate was 2.74 per 100,000 population, and in total 208,619 new leprosy cases were detected globally. "The numbers of new cases reported annually in the past 10 years, between 2009 and 2018, by WHO region. The trend shows a slow decrease in the detection of new cases, from 244,796 in 2009 to 208,641 in 2018" (WHO,). Case detection among children is a bigger concern from a public health perspective, as it shows the community transmission of the disease. In 2018, it was reported that the Southeast Asia Region reported 74% of the new pediatric cases globally. Detection of 96% of new pediatric cases was from the 23 priority countries. The priority countries are

Angola, Bangladesh, Brazil, Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Egypt, Ethiopia, Micronesia (Federated States), India, Indonesia, Kiribati, Madagascar, Mozambique, Myanmar, Nepal, Nigeria, Philippines, South Sudan, Sri Lanka, Somalia, Sudan, and United Republic of Tanzania (WHO, 2019a, 2019b).

India has made major success in reducing the number of leprosy through the National Leprosy Eradication Program (NLEP) initiated in the year 1983, after revamping the national leprosy control program that was initiated in 1955 (NIHFW, 2014). The rate of prevalence was 57.8/10,000 population in the year 1983 and it was reduced to less than 1/10,000 by the end of 2005 when India declared to have reached the World Health Organization (WHO) target of elimination as a public health problem. The prevalence rate was further down to 0.66/10,000 population in the year 2016. Further elimination at the subnational level was also important, as some states of India had higher rates of prevalence, like Orissa, Chhattisgarh, Bihar, and Madhya Pradesh. In March 2011–2012, out of 36 states/UTs, 34 states/UTs succeeded in achieving elimination at the state level. Chhattisgarh and the UT of Dadra and Nagar Haveli were yet to achieve elimination at that time. "By the end of March 2016, 551 districts (82.36%), out of the total 669 in districts, in India had a prevalence of <1/10,000 population which is the target of elimination as a public health problem. The number of districts with prevalence between 1 and 2/10,000 were 76, number of districts with prevalence between >2 and 5/10,000 were 39, and those between 5 and 10 were 2 districts" (Rao & Suneetha, 2018).

History of Leprosy

As documented in different literature, possibly the origin of leprosy was in Eastern Africa about hundred thousand years ago and further transmitted with the flow of migration to India, subsequently in Europe, Middle East, and Americas. In two ancient Indian texts, *Sushruta Samhita* and *Charak Samhita* (dating back 600 BC and 300 BC) the mention of the disease can be found. But, the genome Mycobacterium Leprae was mapped by the scientist in 1993 (Sasakawa Health Foundation, 2016). A Norwegian scientist, Dr. Gerhard-Henrik Armauer Hansen, was a medical graduate who discovered *Mycobacterium leprae* as the causative organism for leprosy in 1873. He also disapproved the hereditary affliction theory of the disease and identified the disease as an infectious one (Ghosh & Chaudhuri, 2015). Therefore, leprosy is also known as Hansen disease, after his name. M Leprae has a long incubation period of approximately 5 years, and it multiplies very slowly and affects the skin and peripheral nerve, causing visible deformities. The untreated leprosy causes severe disabilities and it progresses gradually. The disability severely impacts the quality of life of the people, daily activities, psychological status, and further added social prejudices (Noriega et al., 2016). People just do not suffer from the disease; rather suffer due to the disease, as rejection, expulsion from family, community, punitive confinement, forceful detention, and imprisonment of the leprosy affected persons are also common all over the world.

The evolution of effective treatment with MDT (Multi-Drug Therapy) for leprosy is an outcome of a long scientific journey in different countries. Dr. Daniel Cornelius Danielssen, the supervisor of Dr. Hansen, was committed to treat and find-out solution for the disease and his effort was crucial to make Bergen the city of Norway as an epicenter of leprosy research. In 1921 U.S. Public Health Service established the Gillis W. Long Hansen's Disease Center in Carville, Louisiana, for research on leprosy. Till 1940 the doctors treated leprosy by injecting oil from the chaulmoogra nut, that was quite painful and the long-term outcome was questionable. Further Promin was used, but had many limitations. In 1950 Dapsone pills were found to be effective in treatment, but soon the bacteria developed resistance. During 1970s, in the island of Malta the first successful multi-drug treatment (MDT) regimen for leprosy was developed through multiple drug trials with the patients. Further WHO recognized the treatment and recommended MDT for the treatment and cure of the leprosy. MDT is found to be most effective for preventing nerve damage, deformity, disability, and further transmission (Stanford, 2018). Presently, development of leprosy vaccine is under research and some important achievement has been made in this regard (Coppola, et al., 2018).

Major Program to Control Leprosy

The control of the disasters focused on early detection, specific treatment with multi-drug therapy and awareness generation of the mass to promote voluntary treatment and reduction of prejudices, myths, and social stigma around the diseases. Case detection method of leprosy is classified as passive and active detection. The primary requirement for leprosy control is strengthening passive detection that includes spontaneous demand for treatment by the population to health units or referral of the suspected cases by the doctors, health workers to tertiary healthcare facilities to confirm diagnosis. Therefore, awareness among the mass about the sign and symptoms of the leprosy is most crucial for detection and prevention. Active detection denotes search of potential cases through epidemiological surveillance, evaluation of the high risk groups, identification of the case source, specifically while a child under 15 years old is diagnosed with leprosy that reflects an early and intense exposure with higher threat of contamination and spread of disease. For, active detection training of the healthcare personnel, small-scale campaign, taking care of the social issues, regular monitoring of the confirmed cases, are very important (WHO, 2009). Considering the continuation of the spread of the disease and new case detection in endemic countries, WHO in 2016 launched the "Global Leprosy Strategy 2016–2020: Accelerating toward a Leprosy Free World" (WHO, 2016). This is a program aimed at stopping the new infection specifically among children. Further reinvigorate efforts to control leprosy and avert disabilities. Creating medical infrastructure for detection, treatment, specific research, capacity building of staff, reducing stigma, community participation, political commitments, and close monitoring were highlighted.

India is still one of the endemic countries for leprosy. The organized leprosy work started in India in 1925 through the establishment of Indian council of British Empire Leprosy Relief Associate. This was renamed Hind Kushtha Nivaran Sangh in 1947. The National Leprosy Control program was started in 1955. In 1983 for the purpose of eradication of Leprosy India adopted NLEP (National Leprosy Eradication Program). Use of MDT (Multi-Drug Therapy) through Primary Health Care (PHC) system was the main treatment focus that gave a major success in reducing the burden of leprosy. In the National Health Policy 2002, the target was set to eliminate the leprosy as a public health problem and the same was achieved in the year 2005 (DGHS, 2017). Further, the annual new case detection rate of 9.71 cases per 10,000 population in the year 2015–16 showed the need for further serious focus on the issue. Therefore, a new approach of door-to-door Leprosy Case Detection Campaign was started in 2016 in 149 districts of 19 states. Further it gained a political commitment and from 2017, it is back on the agenda of the Ministry of Health and Family Welfare (Tiwari et al., 2019).

Leprosy and Social Stigma

The social stigma and marginalization cause discrimination that contributes to disability within the environment. "Stigma develops out of an initial, universally held motivation to avoid danger, followed by an (often exaggerated) perception of characteristics that promote threat, accompanied by a social sharing of these perceptions with others. Moreover, stigmas exist primarily in the minds of stigmatized and stigmatized individuals as cultural social constructions**…**" (Stangor & Crandall, 2000). Stigma is the origin of a typically social process, experienced, or anticipated by the stigmatized individuals or communities, characterized by exclusion, rejection, often blame, or devaluation; those results from experience, perception, or reasonable anticipation of an adverse social judgment, and lack of scientific understanding about leprosy. Stigma is a formation of several issues rather a single phenomenon in case of leprosy that is entwined with religious and cultural negative belief and practices. "Stigma affects not only patients, but families, groups and communities and even nations" (Weiss, 2008). Different stigmatized conditions are associated with various features like, physical appearance, exaggerated perception about the disease, moral condemnation, blame, and intensely held negative belief. Such perceptions about stigma are strongly related with experiences, understanding, behavior associated with leprosy among both the leprosy affected persons, communities, and unaffected persons living in the nearby communities who have ideas about the leprosy thus may stigmatize the affected persons and communities. It consists of several components like, self-stigma is related to shame and lowering self-esteem, losing self-worth and learned helplessness. Public stigma is associated with belief system and general public prejudices hold by the people causing social participation restriction and discrimination for leprosy and other tropical diseases (Weiss, 2008).

A model of stigma in case of leprosy is presented in the bulletin Medicus Mundi Schweiz (2015). Stigma forms the perspective of people who are stigmatized and stigmatizer. The leprosy affected people anticipate, internalize, and experience the stigma and further consequences. On the other hand, they stigmatize, perceive, symbolize, develop fear, and enact on the same. In both the situation the ultimate suffers is the leprosy affected persons and communities who are forced to live in segregation leading to poor quality of life and extreme marginalization.

The persons affected by leprosy anticipate that they will be rejected by their families and communities as part of the community belief and practice once someone's disease status is known to others in the community and neighborhood. This anticipation causes fear, depression, and self-blames that lead to hiding of information, delay in diagnosis, treatment accompanied with restricted social contacts. The stigma continues to the next generation and often the children of the leprosy affected parents become equal victims of the social stigma. The children and family members who live in the colonies of leprosy affected persons experience humiliation and exclusion. Here two cases are presented to understand the context of leprosy and stigmatization in India.

Case Study 1: A man of 53 years old was diagnosed with leprosy at his 23 years of age, immediately wanted to commit suicide as he had seen the plight of the leprosy affected communities living at the periphery of his small town in Purulia district of West Bengal. He had seen that one of his relatives was not allowed to come back home after developing leprosy. At the time of his diagnosis he had a small electricity shop and used to visit different houses, thus he immediately suspected that he would not be allowed to enter others' house and needed to quit with dignity instead of entering in a life of rejection. Further, without informing anyone he left home and reached Mumbai being depressed and aimless. On the railway station of Mumbai while he was sitting for more than two days, the beggars of the railway platform took care of him and he joined them and started staying in the slum. Further, he took treatment in some hospitals and moved to different places with menial jobs. Presently he lives in Adarsh Nagar Colony, Kurnool Andhrapradesh.

Case Study 2: Another girl (18 years old, educated till 5th Std) in her age of 15 diagnosed with leprosy was severely upset as she was admitted in a hospital and with deformities and

ulcer. Her family actively rejected her return and forced her to live in the colony of leprosy affected persons. She also expressed that her parents did not tell her the truth before taking her to a hospital and was not initially taken to any doctors as she felt loss of skin sensation on her back and neck. Initially she was asked to keep covering the affected portion and taken to local doctors who could not give any relief. She expressed that her parents used to curse her and often blame her for every other problem in the family and gradually she also became very aggressive. She was shocked as her parents rejected her to come back home. Presently, she is learning vocational courses and often expressed feelings of depression though disease progression has been restricted.

Both these cases showed how stigma was internalized by them leading to self-blame and experiences of discrimination or rejection. The cases also denoted how stigma causes fear among others (due to ignorance), and family members, immediate neighbors act upon the same. Thus, impose restrictions, rejections that absolutely harm their moral and self-esteem.

Psychological Issues Among the Leprosy Affected Persons

Psychiatric comorbidity among the leprosy affected patients is quite higher (Bhatia et al., 2006). Behera (1981) reported that the suicidal thoughts and tendency are higher among the leprosy affected person that he observed with the patients of "Kashi Kusth Swasth Shala and Punarvas Mandir." This study also reported that psychological symptomatology was less reported by those whose duration of illness was longer and more symptoms were reported by those whose illness was of shorter duration (Behera, 1981). This denotes, at the initial stage of the disease the level of stress is very high as the people had a lot of difficulty after the diagnosis and the subsequent requirements of readjustment in life become very challenging. After a few years as the acceptance develops about the disease and adjustment is achieved with the new situation the feeling of stress reduces. A study conducted in Salvador, Bahia, Brazil, showed 71.7% of the patient diagnosed with leprosy is having at least one diagnosable psychiatric problem. Out of them 50.1% of the patients had two or more psychiatric disorders (Rocha-Leite et al., 2014). This study also highlighted that the mental health issues are often hidden as the leprosy affected persons do not get or seek treatment for psychiatric issues, due to added stigma to the mental health problems. There is a fear of being further discriminated against. Somatic complaints are considerably high among the leprosy affected persons. In north-western Nigeria, it was reported that the leprosy affected persons have higher levels of anxiety and depression than the normal population. The psychiatric problem among the leprosy affected persons is closely associated with undesirable changes in lifestyle and various living conditions, that includes, unemployment, rejection by known people and family members, change of residence, breakup of marriage, and loss of stability. Further, disfiguration, disability, and perceived social stigma lead to higher depression and anxiety. In patriarchal society the women face higher risk of discrimination, rejection causing depression (Bakare et al., 2015).

There are a number of studies from all over the world that clearly showed the mental health issues and psychiatric problems among the leprosy affected persons. It is also noticed that often there is no specific effort to assess and treat psychiatric issues that increases the risk of mental health problems. Integrated healthcare strategy is still not in place to ensure a holistic care for the patient with leprosy. The long-term impact of critical mental health issues leads to multiple psychological complications among the leprosy affected persons and also among their family members. The typical psychological complications that are quite evident are low self-esteem, low self-confidence, poor motivation, and an identity crisis.

Self-esteem is the most important component of well-being. It is related to an individual's ideas, values, and worth about himself or herself. It can be a favorable or unfavorable attitude toward self. Low self-esteem leads to negative self-image, negative thoughts that lead to poor well-being. There are different factors that influence self-esteem, like the life experiences, social circumstances, and reactions of others and thoughts. The leprosy affected persons and their family members often have low self-esteem that pushes them to lead a life with poor social status. As self-esteem is not fixed and could be improved, it is also essential to design interventions to enhance self-esteem of the leprosy affected persons and their family members. Self-confidence is about trusting self, own judgments, and abilities. Being confident, it contributes toward a higher level of happiness and paves the way for attaining better success. Self-confidence gives more control over life and abilities to adjust and influence social circumstance to derive favorable outcomes. This also facilitates establishing realistic goals, assertiveness, and abilities to handle critical circumstances and criticisms. Low self-confidence causes doubts about self, feeling of inferiority, and being dependent on others for leading a life. Depression, anxiety, and other psychiatric conditions contribute toward low levels of confidence among the leprosy affected persons. Enhancing skills, functionalities, and opportunities are crucial for boosting self-confidence. A systematic intervention to enhance functionality is essential to enhance self-confidence, as the long experiences of living ostracize result in low self-confidence in the long run.

Low motivation engages the people to fend only for the fulfillment of basic needs of living. Low motivation typically crushes the interest for growth and prevents an individual to do his/her best for their own development. Motivation is related with goal directed behavior. There are cognitive, social, biological forces that activate the behavior or motivate the person to do or not to do something. Behind action oriented behaviors there is a driving force. Higher action oriented behavior that gives both intrinsic and extrinsic satisfaction motivates a person to be more active and work for further betterment. For a leprosy affected person the motivation to do better is usually very low as the depriving experiences crush their interest and abilities. The three components of motivation are activation, persistence, and intensity. Activation is about initiating an activity or behavior like joining in a livelihood intervention program, attending a vocational training for self-improvement, etc. The continued effort toward the goal attainment is persistence, and intensity is about the vigor of doing the work. For leprosy affected persons or the family members, enhancing

motivation through intervention is very crucial to deal with marginalization and to facilitate the process of mainstreaming.

Identity crisis is an outcome of many emotional, social, and psychological aspects in long term, while many issues are unresolved within the psychic process and the person fails to accept his/her own status. The formation of identity starts from childhood and progress through the developmental stages. The different ways of looking toward self-causes identity crises. It is also an outcome of dissatisfaction with self. There is usually a gap between the social perception and subjective interpretation about self. Different life events and social status play an important role in formation of identity. Occupational engagements give an identity like, carpenter, farmer, milk-man, teacher, etc. Similarly, educational attainment, marriage, and financial condition formulate the identities of an individual. Similarly, there are stigmatized identities based on diseased status due to leprosy and deformities thereby. Detection of the disease leprosy and subsequent rejection, discrimination destroys the hope, self-esteem, and confidence of the individual. These events lead to a situation of identity crisis and poor mental health outcome.

The disease status causes a serious mental health problem among the patients with leprosy. Their children also carry the brunt of the stigma and often are being discriminated against in schools while their parents' diseased status is known or their address reflects the domicile in the leprosy colonies (Mahajan et al., 2007). Therefore, poverty and illiteracy among the children of leprosy affected parents are quite common. Often these leprosy colonies are located in very remote corners, or inside the urban slums, where facilities of education are limited. Thus the attainments of the children of leprosy affected parents are often quite poor and they also become victims of the disease. The offspring of leprosy affected parents often continue to live with poor quality of community life. Hence, intervention for well-being of the leprosy affected person's needs to be equally extended for the families and their children to facilitate well-being and to ensure positive mental health outcomes.

Social Issues in Life Course Due to Leprosy

Well-being varies with individual, family, group, and community factors that are closely associated with the life course. Life-course perspective investigates how the experiences in life from the beginning of life facilitate development or restrict the opportunities for growth thus makes a deep impact on well-being. There are a number of risk and protective factors that are interdependent, cumulative, and influence at the different stages of life has profound impact on health issues and well-being. There are chains of risk in life that lead to chronic disease and ill-health in the long term; similarly, protective chains are also available that promote well-being. Both these types of outcome are essential to explore the diseased status of the leprosy affected persons and the well-being achieved through interventions by government and civil society organizations for the development. Life-course approaches have been used in various health researches and to study the perspective of well-being (Wethington,

2005). It is a useful approach to study the long-term diseases and the health outcome. It studies different physical, social exposures, changes from the gestation to till late adulthood and the risk of disease in the continuum (Hutchison, 2015). Within the life-course perspective there are five related concepts that explain the life changing experiences, living, and social condition of the persons affected by leprosy and their family members: (1) group experience, (2) trajectories, (3) transitions, (4) life events, and (5) turning points.

Group experience: In life course, a lot of influences of group experiences are evident in shaping the life of an individual. The leprosy affected persons and their family members live in remote colonies and in such a situation group living and the experiences are almost similar for them. In such living situations subjugation, social stigma, deprivation with denial of human rights and justice are common for them. Such cohorts of leprosy affected persons have similar group living experiences, and identity that impact their disease pattern, behavior, and well-ness. The disease often spreads among the people living in the colony if there is any lacuna in the preventive measures and treatment of the affected persons. At the same time, effective interventions to change the socio-economic status, through livelihood, educational, housing, water sanitation, and medical interventions can bring positive group experiences that can reverse the situation and ensure progressive changes toward well-being by reducing the disability and prevalence of disease. Specific intervention strategies as per the age group, considering the population pyramid, are also crucial for change. The population pyramid will help to categories the intervention, like educational facilities for young children, vocational training for the youths, or livelihood support for the leprosy affected middle-aged individuals for reducing their dependency on charity. Developmental intervention helps in nurturing social connections and can facilitate the process of mainstreaming and social inclusion.

Transactions: This denoted the significant change in social roles and responsibilities, such as change in job, livelihood pattern, and social engagements. Such major changes lead to change in the trajectories in life course. The diseased status, social stigma associated with the diagnosis of leprosy itself is a transaction that alters their social role, responsibilities, and status within the family, neighborhood, and community, pushing them into marginalized living. Within the life course of an individual such transactions due to chronic disease make very long-lasting, strong negative changes that obviously become very difficult to revitalize. These transitions are very stressful, unexpected, and often exceed the coping capacity of the individual. This also led to changes in the habit, behavior, and negatively impacts the mental health status. Therefore, depression and anxiety are quite common among leprosy affected persons. Similarly, transactions can also be positive while someone gets a job or any other developmental opportunities. Therefore, planned interventions within the colony of leprosy affected persons are found to be helpful in facilitating positive transactions to break the barrier of poverty, enhance well-being, and encourage social reintegration.

Trajectory: The term trajectory in health research across life course explained the pattern of health behavior, or the state of health acquired and persisted over a

long time that becomes a chronic disease like leprosy. There are different trajectories, like health, social, economic, and networks that are interrelated and connected, thus influence each other. In case of leprosy affected person the diagnosis of the disease and subsequent rejection by the family members push the individuals toward diseased identity and chronic leprosy affected health trajectory. Subsequently, other socio-economic trajectories are affected. Therefore, a change in health trajectory (through health related interventions) may not be long-lasting if other trajectories do not change adequately. Trajectory also involves multiple transactions over a long period of time. These transactions make a complex whole, in the life of the individuals affected by leprosy and their family members. From the onset of the disease and subsequent progression, developing disability, late treatment makes a health trajectory that negatively impacts their overall well-being. Subsequently, the education trajectory, family life trajectory, and work trajectory all are impacted leading to an exclusion of the leprosy affected persons from mainstream society. Thus, successful multidimensional interventions are important to break the cycle of diseased identity and alter the trajectories among the leprosy affected persons and communities. The socially held beliefs and culture influence the life of an individual and community life too. Thus, with the positive changes, it is possible to alter the prejudices about the leprosy and possibilities of mainstreaming become easier.

Life events: These are specific events in life that have some profound impact in the life of an individual. These are broadly related with family, social, work, financial matters, and health related aspects. Each of these life events demands a specific coping of an individual to deal effectively. The life event scale by Holmes and Rahe (1967) listed 52 such events. The different dimensions of life events depicted that events can be entry or exit oriented, positive or negative, expected or unexpected for an individual. Usually, the entry oriented, positive, expected events produce less stress and even cause eustress that promote motivation to work and develop abilities to work further in a positive direction. For an individual affected by leprosy, deserted by family members, losing home and hope are all negative and unexpected that have severe negative impact on their social status, role, and health behavior. Thus, interventions are crucial for promoting positive life events like, joining in educational activities, joining in social events, learning vocational skills for job opportunities, adopting healthy practices, etc. Facilitating such events help the person with leprosy and their family members to gain income, purchase new assets, and develop new social contacts, and to be engaged in socio-political life. These engagements help in developing confidence, self-esteem and dignity.

Turning point: These points impact the life course in the long term and alter the position, role status of an individual. In life, there are few major turning points for an individual affected by leprosy. Turning points can be both positive and negative. The negative turning points are diagnosis of the disease; subsequent rejection by family members, experiencing deprivation, rejection, and denial from many opportunities for growth that otherwise would have been available to him/her. These negative turning points cause ill-health, disease pattern, and related behavior often leading to negative coping. There can be many positive turns also with the receipt of medical attention, vocational training, and successful livelihood engagements that helped

them to regain their identity, confidence, and self-worth. These turning points are combined with a number of other positive events like, ability to assess education, gain mobility, develop wider social contacts, develop skills in business, etc. that help to gain well-being. The socialization process has a major role in the life of the next generation to adopt a healthy behavior or not. It is important to stimulate positive healthy habits in the process of socialization, as the positive turning points facilitate well-being.

Life-course perspective can help in understanding the epidemiological and demographic aspect of leprosy and the communities. This would help in understanding the different stages of development of the disease and related behavior thus, adequate social policy measures become crucial to empower the communities. The temporal and social perspective emphasized by life course looks across an individual's or a group's life experiences, even across generations for analyzing the current pattern of health and disease prevalence, in the backdrop of both past and present experiences that are shaped by social, political, economic, and cultural context. Thus, it helps to understand the critical stages, difficult turning points, and stressful events in the developmental stages that require specific intervention to augment well-being of the leprosy affected persons and their family members. Such life-course approach to health is highlighted in different documents of World Health Organizations (2018a, 2018b, 2018c; WHO, 2000).

Charity and Leprosy

In the context of understanding the ostracized situation and the approaches to well-being, it is also essential to explore the aspect of charity associated with the disease that often induced learned helplessness among the leprosy affected persons and even to their offspring. Religious belief associated with leprosy is the major reason for practicing charity toward leprosy affected persons. In various religious texts, leprosy is considered as the curse of God due to a sinful activity of an individual. Thus, social distancing, exclusion, and ostracization of the leprosy affected persons are recommended in religious text as normal practice. The stigma toward leprosy as a public perception has come from the Old Testament that identified the disease as a visible manifestation of transgression against God. Thus, a leprosy affected person is sent by him (God) to suffer as punishment. It prescribes the person to have loose clothing, mouth covered with a cloth, and cry out loud to express that he/she is defiled and unclean (Vongsathorn, 2012). In Hinduism leprosy is seen as a curse of God. Though suicide is considered as sin according to Hindu belief, but for leprosy it is not. One of the earlier texts of Hindu religion The Atharva Veda (approximately 2000 BC) and the Law of Manu (1500 BC) explained various skin diseases that resemble Leprosy. Those texts prescribed prohibiting contacts with the person affected by leprosy and marrying them. These texts have "effectively ostracized those with the disease for their past sin" (Jacob & Franco-Paredes, 2008). Reference to stigma can be found in the religious scripture of the major religions, namely Christian, Hindu,

and Muslim faiths that contributed to the socially held notion of stigma toward the disease and systematically contributed marginalization (Scollard & Gillis, 2018).

The religious belief and practice of charity toward the leprosy affected persons is closely connected as the socially held notion of earning "punya" (good deed). Therefore, charity toward the leprosy affected person is a common practice. Similarly, the people affected by leprosy also developed the tendency of accepting charity as a means of earning as job and livelihood options are quite limited for them. Begging is dehumanizing and against the human rights consideration that upholds the commitment of living with dignity. Begging cannot be considered as a livelihood, as it does not produce any consumable goods and services, neither creates any security for the person. But many a time poor socio-demographic profile, including lack of education, skill training, disabilities, and social stigma force them to choose begging as an income opportunity. Gradually, the practice of begging became a formal source of income and at times changing the behavior became more challenging as begging is an easy income without investment and found to be always profitable. During the religious festivals, the income is also reported to be manifold, thus the people affected by leprosy often justified begging as an appropriate means of earning. But systemic intervention has established a number of models of successful intervention in providing alternative livelihood for the person with leprosy and family members that helped in facilitating self-confidence and well-being.

The charity-based organizations for humanitarian cause become an important dimension in social welfare services and practices after the introduction of The Elizabethan Poor Laws in 1601 in Britain and subsequent many changes that focused on developing a comprehensive system for public welfare service. Victorian England witnessed a number of growths in charitable services and organizations. Humanitarian concern and support for the leprosy affected persons and their family members were taken up by a number of Christian missionaries in the British colonial era during 1870–1940 to eradicate leprosy in the colonial world. There were religious charities, missionary societies, and secular health organizations to promote a number of charitable supports for the health care and well-being of the leprosy affected persons and their families. These organizations started working in different parts of the world, specifically, in African countries, Hawaii, Brazil, and India. The earliest leprosy and charity was focused in India in 1870, as India was the focus of earlier leprosy research and charity. From charity to welfare and further civil society engagements in leprosy care, welfare, and rehabilitation is an important major factor for enhancing well-being.

Civil Society Organizations in Leprosy Care

The humanitarian organizations' philanthropic attitude and concern toward suffering of the people with leprosy and their family members are the important milestone in the treatment, care and rehabilitation, shedding away the prejudices and negative religious belief. While missionaries took the initial effort toward care and support of

the leprosy affected persons, gradually the civil society organizations took a much bigger role in facilitating the care. Gradually, empowering and organizing the people with leprosy for gaining adequate rights and justice become more prominent in different parts of the world. On different occasions WHO has pointed out that the NGOs or civil society organization is an important stakeholder in scaling up the action against the leprosy and to facilitate the care and support provisions. Civil society organizations with its strong hold in the community always can play an important role in promoting the socio-economic activities to enhance their status, and further in reducing stigma, discrimination, and facilitate mainstreaming (Singh, 2017). For the empowerment of ostracized, vulnerable and marginalized sections, civil society organizations always played a crucial role to advocate the rights, ensure appropriate policy decisions, and program that strengthen the entitlement and endowment status of the people.

There are some prominent humanitarian organizations that are continuously working with the leprosy affected persons and their families. The International Federation of Anti-Leprosy Association (ILEP) was established in 1966, and it is actively engaged in various leprosy cares, research, documentation, and advocacy to ensure the rights of the leprosy affected person in different countries of the world. There are 14 international organizations who are members of this federation (WHO, 2018a, 2018b, 2018c). The federation works closely with the government in different countries and with WHO. These organizations are ILEP-UK, AIFO (Associazione Italiana Amici di Raoul Follereau) Italy, ALM American Leprosy Mission (USA), ALRA (Australian Leprosy Relief Association), DAHW (Deutsche Lepra-und Tuberkulosehilfe) Germany, DFB (Damien Foundation) Belgium, DFB (Damien Foundation), FAIRMED (Health for the poorest), Fontilles (Salud + desarollo), FRF (Foundation Raoul Follereau), LEPRA (British Leprosy Relief Association) UK, MUPD (Assoçiãcao Portuguesa de Solidariedade), NLR (Netherlands Leprosy Relief), SLC (Leprosy Relief Canada), SMHF (Sasakawa Memorial Health Fund), and TLMI (The Leprosy Mission International). One other important consortium for eradication of leprosy is Global Partnership for Zero Leprosy (2019). This is a coalition of the organizations who are committed to ensure welfare and development of the leprosy affected person and their family members. There are a number of scientific communities, academicians, and research organizations are also part of this coalition. In India there are a number of organizations which are partnering with these international organizations for ensuring benefit, support, and rehabilitation of the leprosy affected persons and their family members. In India the oldest organization "The Mission to Lepers" for the care of the leprosy affected person was established in Ambala, in 1874 by Mr. Wellesley Cosby Bailey from Ireland. From the inception the organization focused on medical care, community participation, empowerment, and residential care by establishing hospitals. In 1973 it was renamed as The Leprosy Mission Trust India (TLMTI). Sasakawa India Leprosy Foundation (SILF),[1] part of Sasakawa Memorial Health Fund, funded by the Nippon Foundation, Japan started working for removing the social barrier and the stigma in the leprosy colonies across

[1] https://silf.in/

India from 2005. The author visited 26 colonies in different states of India and presented the typical issues and stories of the communities and the individuals that reflected the critical issues that still require a lot of planned intervention. Subsequently, it also presented the ray of hope and the success stories achieved through different interventions with the leprosy affected persons and their family members in the colonies that facilitated mainstreaming and attainment of well-being.

In India formation of APAL (Association for people affected by leprosy)[2] in the year 2006 to introduce the self-governing system among the leprosy affected persons was an important milestone to institutionalize the voice of this community at various political, social, and economic forums. APAL created a platform for the people affected by leprosy to discuss their issues and raise their concern to different authorities. The national body of APAL also developed their state chapters to promote the voice and raise the demands to remove the deprivations. APAL through its membership has identified more than 800 self-settled leprosy colonies, where they are focusing to bring the support for development and welfare schemes (SILF, 2011).

Features and Issues of Leprosy Colonies Across India

There are many settlement colonies where the residents do not have the legal rights over their land and house, and are deprived of basic facilities like, electricity, adequate water supplies, toilets, drainage and sanitation, or proper roads and communication. The following three case stories of the community situation reflected the plight of the leprosy affected persons even in twenty-first-century India, when facilitating justice, human rights fulfillment, ensuring equality, and protection are the core values for sustainable development.

Community-1 (Kushth Colony, Darbhanga, Bihar): The community is situated in the backyard of the Department of TB (tuberculosis), Darbhanga Medical College. This housing colony with 36 small family blocks is a two storied building that was built by the Government of Bihar in 2004 as these families were staying in different corners of the hospital compound for years together. The building looks quite dilapidated without any maintenance and also the construction quality seems to be substandard. In December 2015 while visited, there were about 150 people and 43 of them were having leprosy. The whole building is overcrowded. Subsequently few more destitute families came to the colony and constructed thatched-roof rooms around the building as their dwelling unit. The colony has only two toilets and a water connection point from the Hospital. Both sides of the colony were absolutely dirty with open drainage flowing out from the hospital compound. The families living in the colony do not have any legal document about ownership of the land or house. Regarding the same, the colony leaders had a meeting with the local officials, but did not get any solution, except receiving verbal assurance that they will not be forced to evacuate their home. The common livelihood is rickshaw pulling, selling various utility items, fruits on pulling

[2] http://www.apalindia.in/

carts and begging. Though children are enrolled in Government schools but not at all motivated for continuing studies as there is lack of awareness and no systematic monitoring to push the welfare and development agenda through community engagement.

Community-2 (Rajendra Nagar Kushth Colony, Bakhtiyarpur): The colony is located on a railway land close to the platform and railway track. The residents do not have any land rights, and there is always fear of eviction. But, no immediate threat can be perceived as railways do not have any plan of expansion. The people are living in this colony for the last 40 years and more individuals affected by leprosy joined subsequently. There are 42 households and 153 members in the colony. About 13 people are living alone. The people have made their own makeshift dwelling units with mud, bricks, tile, plastics, wood and bamboo. The thatched huts are on one side of the path and there is a big ditch (pond) behind the row of huts. There is no running water supply in the colony. The residents use the unclean water from the pond for regular household courses and collect drinking water from the railway platform. There is no toilet facility and everyone uses the back portion of their hut for defecation. Thus the situation of the colony is quite unhygienic. In every rainy season the whole area becomes full of mud. There is no direct road connectivity with the colony. Either someone has to cross the railway tracks or come through the platform. Every house has an illegal electricity connection from the railway transformer. As the residents of this colony do not have any residential proof, often they face a lot of issues to get government services. Some of them use the address of a local NGO for formal official requirements. Children of the colony are mostly unschooled and the enrolled students do not attend the school regularly. Poor condition, lack of understanding and awareness is quite prevalent in the community. For livelihood people are engaged in various menial jobs like, daily labour, coolie (porter) in railway platforms, or as hawker.

Community-3 (Nirmal Kushth Ashram, Bokaro, Jharkhand): The colony is located in the railway land and all the sides are closed by railway track. As all sides are closed, there is no direct road connectivity with the colony. Total 180 households and 443 people were living in this colony. There are about 43 individuals with leprosy and there is no new case of infection from the last 10 years. The residents are not having any legal document and neither under any panchayat or municipality. This is causing a major problem in getting the electricity connection in the area. The railway refuses to give NOC (no objection certificate) for electricity connection and thus, the community has to still depend on traditional kerosene lamps at night. There is no toilet facility and sanitation system, causing higher risk for infection and maintaining good health. There is bore-well for water supply. Missionaries and Charity- Brothers house mainly supported this colony from long ago. There is a Nirmala leprosy hospital near to the colony providing leprosy care and other healthy support to the people. As this place is a railway land, the residents do not have address proof and mostly use the address of the Leprosy hospital for documentation purpose to receive the government facilities or to obtain the personal documents like, driving license, bank pass book etc. the children of the school are all enrolled in school and many of the youths have received vocational training in different trade. The Brothers from Missionaries and Charity continuously provided awareness, motivation and support to promote the value of education and also encouraged the community people to develop a cohesive, caring pattern of functioning. Many of the youths of this community are appointed in industry in different cities of India. The people are engaged in different kinds of skilled and semi-skilled jobs. Some of the families also cultivate the empty railway land and get annual come from the same.

The above three case stories showed that none of them had any legal rights over the land and had no possession of the dwelling unit they were living in. This often caused a lot of insecurity and became a source of stress. Particularly, living on an unauthorized land caused various typical problems like, notifying the address for

different purposes and to go for opening a bank account or to get an identity card, join in formal school, or to receive a driving license. Though 20 communities out of 26 communities had their land rights, yet, some highly marginalized communities are having this issue. The older generations have accepted their fate and have no hope to alter the situation, whereas the younger age groups are more concerned about their future and for their children to have a better quality of life. The issue of land right is also connected with electricity connection and receiving other government welfare schemes and benefits. Often children have to attend ICDS centers and schools in other displace places as these localities are not having such facilities. Safe and secure house is a basic right to have other facilities, like water connection, safe toilet, for maintaining adequate health, hygiene, and well-being.

It is not that every colony is in bad shape. The following three case stories explained the colonies that have emerged from the ashes and now maintaining quite well. The active community participation helped them to overcome many limitations and started challenging the social stigma attached to leprosy.

Community-4 (Devarapalli Leprosy Society is in the Nizamabad district of Telangana): The colony is located between the national highway and state highways with an approx. distance of 10 km from district headquarter. The colony developed from 1965 onwards as people treated for leprosy in Victoria Christian Hospital started living in this area after getting discharged. The colony has a good road and drainage system, electricity supply and water supply. The people in the colony are having different sources of income, like working as drivers, working in Telangana University as outsources contract employees, cattle keeping, sealing milk, agricultural engagements, few people have business, government and private jobs. As a whole, in this area leprosy was highly stigmatized and still other local communities avoid marital relationship with this community. All the families in the colony have land rights and legal documents of ownership of the house, and agricultural land. In this colony there are about 120 families and 600 individuals living. Around 30 members from the community are regularly engaged in begging. From the government hospital the leprosy affected people are provided medical care. In 2006, with the help of APAL leaders, the local community leaders registered 'Devarapalli Leprosy Society' and subsequently got various government help. While the colony was visited in 2016, it was reported that every family with a leprosy affected person gets 35 kg of rice every month from PDS (Public Distribution System). There are about 120 aged people affected by leprosy living in this colony and there are no cases of leprosy among the younger generation. All the leprosy affected people receive Government pension of Rs. 1500/- per month. Most of the women are part of SHG (Self-Help Group) under government schemes or facilitated by some NGOs.

Community-5 (Vandrikal Leprosy Colony, Kamareddy District, Telangana): The community was established in this location in the year 1980, as the Director and Nurse of Victoria Leprosy hospital, Dichpalli (run by Foreign missionaries) got the land approved and encouraged the leprosy cured families to come and stay here independently. Though this area was far from the main city and at that time there was poor road connectivity. The missionaries helped the families to build houses and each of the family had received three acre of land. Gradually, they cleaned and developed the land for agriculture and started farming. The missionaries were continuously providing help to improve the lives of the community people. Another non-profit organization named "Jeevadan hospital" constructed 16 houses for the families in this village. Further, the community leaders advocated with the local administration and politicians to get the roads and build bridges to reach to their village. Presently, there are 33 families and 110 members. In the community 23 Leprosy affected persons are living and all of them receive 1500/- as monthly pension. There is a community hall, and common utensils

used for meetings, celebration and marriage by all the members of the community. From the government hospital the health worker and nurse visits and provide regular services to the leprosy affected patients as needed. The children are attending the primary school situated about two kilometers away. Further, youths go to the district town for higher studies and college education. Almost all the women are part of the Self-Help-Groups under the Government scheme. For different purposes the people had received government loans and still loan facilities are availed by them. The women of the community are equally active and supportive and work at par with the men in the agricultural field. All the families have regular income from farming, dairy, and some of them are employed outside too in private jobs.

Community-6 (Sri Sai Ramavtar Katha Colony, Indore, MP): Community-6 (Sri Sai Ramavtar Katha Colony, Indore, MP): The colony evolved from 1960 onwards as there was a Leprosy hospital and the patients started living in this area following their treatment. All these settlers were deserted by their family members. The colony is well connected with the main road and situated in a premier location of Indore city. The community has a good drainage system, water supply, electricity supply and concrete lanes. Each of the families has individual water points and toilet facilities. The lanes are daily cleaned by the sweeper appointed by the city municipality corporation. Though the lanes are narrow and people have small houses, yet the cleanliness and hygiene is maintained well. This is an authorized colony and each of the family is having legal papers of their landholding. About 72 families with 260 members are living here. In the community they have constructed a temple with a community hall that serves the purpose of any community meeting, gathering or family functions. Every year they celebrate bhajan Sandhya (prayer meeting) for two days and have community fest, when they invite neighbouring communities to come have community lunch in their area. From this colony still about 40 members are engaged in begging on a regular basis. About fifty older adults of the community are affected by leprosy. A girl from the same community provides nursing services to the people after receiving nursing training from a government hospital. All the Leprosy affected people are having disability certificates and get pension, Rs. 300/- per month from the Government. All the children are going to nearby schools and some of the youths are enrolled in higher education too. Most the families have settled livelihood engagements as driver, shopkeeper, and small business or working in different jobs. The community leaders have registered a society named "Sri Sai Ram Awater Kustha Seva Samithi" to manage their community common account and affairs.

The above three case stories showed that there are communities of the leprosy affected persons that are well served by the welfare and development program. In these colonies, people have their basic facilities to maintain a minimum standard of well-being. The strong leadership, community engagements helped them to gain control over the discriminatory situations and raise their voice to get the services. In such communities health services toward the leprosy affected person is better and the younger generations have more confidence to overcome the challenges due to stigma. The people here have better job opportunities and also have taken up different livelihood options that can give more income and livelihood security.

Though there is both extreme of good and bad situation while looking into the condition of the leprosy colonies, it is pertinent to elaborate on the key features that still require specific attention to deal with the socially disabling factors and strengthen the effort of mainstreaming by enhancing the capability of the leprosy affected persons and their families.

- Almost all the colonies and their residents have a past experience of deprivation, suffering, and humiliation that has imposed various psychological barriers to revolt from all the odds to achieve the desired changes. Therefore, still the people are largely engaged with unskilled and semi-skilled livelihood options with poor educational attainment. Wider sense of deprivation, low self-esteem, and poor achievement motivation are prevalent even among the next generation of the leprosy affected persons.
- The locations of the colonies are grossly away from cities or villages or inside the overcrowded urban slum. Most of the colonies are physically separated from other villages and still the stigma is quite visible in various culture and practices of the communities. The excluded location inside the jungle or at far flung destinations often imposed restrictions and limitations in communication and opportunities for job, business, or accessing the educational or health facilities. Geographical marginalizations of these communities are deep rooted in the psyche and social system.
- Except for a few communities, the practices of begging by the leprosy affected persons are quite prevalent among the older age group. Begging is a culturally accepted means of earning in Indian culture, as all different religious faiths have strongly supported the concept of offering to the poor. It is common to see the baggers on railway platforms, in front of temples or mosques. Displaying the disability and asking for arms is quite commonly practiced by the leprosy affected persons. There is no strong objection by the next generations against the practice of begging by their elderly parents, or other family members. Thus, the social stigma is still being self-percolated by these communities either in overt or covert manner.
- Most of these communities have their own place for worship and religious practices within the community that helped in stimulating their common identity, cohesion, and also a uniting factor. The spiritual dimension of health is an important component for maintaining well-being, but focus on other key dimensions of health, namely physical, psychological, and social are equally important. Many of the communities still have not prioritized the health and hygiene aspects in their community life. Thus, common investment could be seen for religious purposes, but not enough to construct public toilets or to maintain community cleanliness.
- Accepting donation is a common practice of the leprosy affected communities. It is reported by most of the communities that their colony is visited by individual donors and they receive different goods particularly during New Year or festival seasons. The community feels happy to accept such donations. A strong psychological justification prevails among the community people to call such donations as gifts. A few young individuals have felt that most of the people have an expectation, and also a psychological dependency over donation, though many times people may not require the goods that they receive. No one ever objected but few have an opinion that accepting such flashing donation is a self-diminishing practice, but difficult to discontinue. Often such events of donation are being reported in local newspapers and reiterate the stigma.

- Presence of NGO lead programs in the leprosy affected colonies were seen in almost all the colonies. It was reported by the residents that some or other NGO did visit their colony and provided few support in the form of educational facilities for the children, microfinance, livelihood training, provision of drinking water, construction of toilets, medical support services, etc. But, most of these investments to the leprosy colonies were sporadic in nature with a small number of beneficiaries. Thus, lack of coordinated effort among the NGOs in serving a community was quite prominent, with lack of integrated approach to bring a sustainable holistic change of the colonies.
- Development of the community always has an important impact on the life course of the people to bring favorable events and positive transit points to strengthen well-being and create more developmental opportunities. Developmental and welfare programs through the government and humanitarian agencies are crucial for such changes to be brought in the life of the leprosy affected persons and their family members. Thus, community participation, planned intervention, and systematic changes are crucial for the people. In driving such developmental agenda understanding and participation of the people of the colony is very crucial. A strong leadership and cohesive relationships are essential. But, unfortunately, only a few communities have an effective, charismatic honest leader to bring such developmental agenda in forefront by pulling the people at the same platform. Lack of education, exposure, and stigma are all a combined reason for not having many indigenous leaders in these communities that often become a major hurdle for positive changes. Within these small communities' internal dynamics, conflicts, lack of trusting relationship between the group members, poor leadership, and lack of an effective role model often discouraged the NGOs to work intensively.

Within the problem and critical issues, it is also essential to highlight the success stories of some of the communities that underscored the realization of potential and developmental energy of the leprosy affected individuals and communities for changing the life course. Community driven and community own processes of interventions are always found to be most effective to bring long-term sustainable changes that contribute toward well-being.

Community Success story-1 (Vandrikal Leprosy Colony, Kamareddy District, Telangana): The project of 'agricultural development and financing' was initiated in 2012, located in the small village of 33 families. The livelihood project was started with 10 beneficiaries who are affected by Leprosy and have different amounts of disability. The group was provided with the financial support of Rs. 305,500/- by a NGO. Presently, though the number of beneficiaries increased to 12, in reality the whole community has received benefits at different points of time. The community committee has developed the revolving community fund. Presently, they use this fund on a regular basis to give loans to the beneficiaries and collect the principal amount with 1% interest rate per month. The beneficiaries use the fund for cultivation to buy seeds, and fertilizer. Some of them bought cows and buffalo. Within 3–4 years all of them refunded the amount and started revolving the money regularly within the community members. Presently the group has a working capital of about 6 lakhs. The community stopped seeking any loan from outside private agencies and developed a sustainable pattern

of supporting each other. The youths of the community have a future plan of starting fertilizer business and keeping farm animals. In this community elderly men and women are well respected as it was promoted by the missionaries who established the colony and the NGOs supported the program further for development of livelihood. The leadership of the group is shouldered by the elderly men, and has developed a very strong systematic record keeping and documentation process. The leaders have gained a lot of respect and have a very strong hold on each and every decision in the community. The community has evolved a strong mechanism of internal regulation and trusting bonds. The community found the most democratic way of functioning and a participatory process of decision making that always helped to build a wider acceptance of the unanimous decisions taken by the leaders. They regularly hold community meetings and discuss various issues for development, community functioning, or resolve conflicts. This displayed a cohesive pattern of working together. The common community fund and individuals accounts of all the beneficiaries are maintained in the local SBI (State Bank of India) branch.

Community Success story-2 (Ratnagiri Kolhapur Hig. Shivaji Nagar, Ratnagiri, Maharashtra): The community is small with about 100 population and 26 households. About 30 of them are having leprosy and about 7-8 have considerable ailment. The residents of this community do not have any legal paper of land holding, thus continuously making advocacy with the local leaders and municipality to gain legal rights over the land and obtain legal documents for the same. In this colony a group of eight men was supported by a NGO to start an income generation activity. The group started a business of fixing the wooden platform (Centering) in the construction site that is required before concrete work. The group members were engaged as labour in the construction work for years and had the skill required for the trade. Presently, each one is able to earn about Rs.11,000-Rs.12,000 per month. They also bought materials like wood, bamboo, and various instruments. Significantly, the group has an important policy of supporting financially each other in case of illness and injury. In the next phase, the group has a plan to promote another income generation group of women with support from NGOs. The members of this income generation group are very well accepted by the community people and take various initiatives to improve the condition of their community. The group has been successful to bring different NGOs to their areas and has got support from the municipality to construct the common community toilet, fix the water storage tank for ensuring regular supply of water. From the municipality they have also got electricity connection in the common road and in their temple cum community center. The group members also maintain contacts with the community people and ensure that the children are admitted to school. They have talked to the local government hospital and ensured regular visits of Nurse in their colony for the treatment of the leprosy affected persons. It was seen that the income generation group became grassroots level entrepreneurs and able to facilitate the positive changes within the community over time.

Community Success story-3 (Bethel Nagar Colony, Chengalpattu, Kanchipuram, TN): The colony is located about 4 KM away from the main city of Chengalpattu and is connected with good roads. In the community about 120 families are living currently and about 70 older adults are leprosy affected. The people have come from different parts of Tamilnadu over the last 30 years. Many leprosy affected families were living in Tambaram, Chennai and they were shifted while the government occupied the land for airport and other projects. Still the community people do not have the legal documents of land holding, but they got the assurance that this land belongs to the Government and will not be evacuated. Each of the family has electricity connection, water points and toilet facilities. A community hall and church is built by a NGO. The local community leaders are closely associated with the local church and have good control over the community people. Often they have been able to negotiate with the political leaders and the government officials to get various support services for the community. For the last 30 years, the community leaders have regular weekly meetings. On every Monday each family deposits Rs. 40/- in the common account and further the money

is given as loan to any of the community members based on his/her requirement. With fixed terms and conditions the person returns the amount. Thus the community has a revolving fund to help each other. It was reported that the people are well connected with other communities and there is no visible stigma. But, still outsiders avoid establishing marital relationships. The community leaders in 2014 helped a group of six women to start an income generation activity of supplying packaged drinking water bottles and sealing grocery, with the financial support from a NGO. The women did not have any prior experience of business, but learned the skill of buying groceries from the wholesale market and selling in retail, home to home to earn the profits. The close interactions, mutual support, and conviction have made the women group a stronger social unit to work together. The group has developed a regular client base and supply to their customers in and around the colony, which has made selling of the products easier. Most of the customers buy the product on credit basis, and further money is collected in installment. This strategy has become beneficial for the customers and for the group too. The community received different government support and all the children are going to school. Youths are engaged in higher studies. Most of the families have stable sources of income.

The success stories have clearly pointed out some important points that are essential to promote well-being and sustainable development of the marginalized people.

- A strong honest community leader plays the role of catalyst to bring change. The leaders play the important role to bring the benefits for the people in the community and have power to liaison and bargain with the appropriate authority to derive benefits for the community.
- Presence of support services and humanitarian organization is not uncommon in the colonies, but the effective use of support and deriving a long-term benefit from a support is crucial to derive long-term benefits. While the NGOs provided mentoring and closely worked with the community leaders and community people, the interventions became more successful.
- People in the colony clearly identify the difference between the one time charity/donation and a welfare-oriented intervention that has long-term impact. In all the successful communities, the leaders were quite efficient to get a more welfare oriented program and even effectively distributed the goods, cash received from the charity to the needy people of the community.
- The successful communities have been able to build various community resources and focused on their next generation for development. The communities with common resources (e.g., community hall, common water supply facility, temple/church, etc.) were more cohesive and have different internal mechanisms to control like, having revolving funds to help each other, conflict resolution strategies, various celebration of community events together, etc.
- The successful communities had a plan for next and looked for further opportunities and were quite enthusiastic to challenge the difficulties and social barriers around them. Thus, the community people displayed a higher sense of achievements, self-confidence, and strong will power. It is seen that success is always community driven, independent of support they receive.

Recommendations

Considering the potential for development and issues of marginalization, deprivation of the leprosy affected persons, and their families, the specific recommendations are formulated to empower these communities, keeping the human rights and social justice principles in the forefront.

Empowerment of the individuals and communities: Working with the leprosy affected individuals and communities should be based on the concept of empowerment by engaging them in the process of intervention as a major stakeholder. Barker (2003) explained empowerment as "the process of helping individuals, families, groups, and communities to increase their personal, interpersonal, socio-economic, and political strength and to develop influence towards improving their circumstances" (p.142). Through the interventions it is most crucial to empower the leprosy affected persons and their family members. Thus, the whole community can promote an empowering attitude and environment. It is essential to move beyond charity and utilize every support in a planned manner with an immediate and long-term focus for betterment of the situation. It is assumed that an empowered individual has self-confidence and realization of his/her strength that is useful to derive a satisfactory living. While there is limitation at individual level due to disability, illness, or age, the community should be in position to extend a caring and compassionate support for the vulnerable population. Thus, empowering individuals and communities are equally important at the same time. Individual empowerment should focus on enhancing skills, knowledge and capacities, and community empowerment may focus on developing supportive net-works, leadership, volunteer groups, community resources (e.g., community funds, community housing, water supply, community hall, and other common resources), etc.

Cultivate Strength Saleebey (1997) described five important principles of strength-based perspective that have important implications to alter the situation of the people living leprosy colonies. First, every individual, family, and community has strength. This implies that the internal strength, the mutual understanding, network, and support of the people in the colony. Every human being is considered as a resource and those resources to be developed and capitalized for growth at any circumstance. In leprosy colonies, providing support to build human resources is an important step for enhancing well-being. Second, trauma, abuse, illness, and struggle are injurious, but they are also the source of challenge and opportunity. The life in the colony is a challenge, but the support provided by the NGOs and Government should be effectively used to create opportunities for development. Third is about the innate capacity of the people to visualize the change and bring better developmental opportunities for themselves. This is about taking individual, group, and community aspirations seriously and supporting the same for development (Zastrow, 2010, p. 72). Leprosy can't kill the aspirations and cultivating those aspirations are essential for positive changes and to gain well-being. Fourth, mentioned about collaboration with the client to ensure an equal footage as a stakeholder in the process of intervention. In the leprosy colonies, the community as a client becomes a major collaborative partner

in the process of ensuring development and well-being. Fifth is "every environment is full of resources" (Zastrow, 2010, p. 73). The strength perspective always tries to identify the resources that make use of the same in the best possible fashion. In the leprosy colonies too there are resources within the environment that should be identified and utilized.

Capability Enhancement Sen (1997) propagated poverty as a capability deprivation that also explains the situation of the leprosy affected persons. Capability is important to understand the freedom that the leprosy affected people and their family members enjoy to choose the life that they have reason to value. Considering this perspective it can be said that the leprosy affected people and their offspring have less choice in various social and economic spheres. Often they are deprived of adequate healthcare facilities, hygienic environment, safe housing, educational opportunities, skill training, etc. and they are pushed into impoverished living conditions. Living is a combination of various "being" and "doing" (Sen, 1999). While leprosy affected people live in an ostracized situation characterized by resource crunch, the "being" become poor, and the "doing" also become equally low productive. Thus, leprosy affected people and their family members suffer from poor capability. The capability specifically focuses on the ability to perform a different combination of complex activities. The capability approach measured the development of the society is a function of the level of well-being or standard of living of individuals within that society (Bhadra, 2013). Enhancing the capability of the leprosy affected persons and their family is essential to change the prevailing situation. The "being" can be improved by creating an adequate safe, secured physical environment, and the "doing" should be enhanced by inculcating various skills, for advanced livelihood opportunities.

Focus on Human Capital Development Human capital is a crucial component for development and for leading a successful life with meaningful engagements. The human capital is a combination of natural talent, i.e., intellectual abilities, aptitude, motivation, energy, and learned skill through socialization, education, and experiences (Becker, 1964). Every individual has innate abilities and talents by birth that requires adequate exposure, and opportunities for development. Leprosy is not a genetic disorder, so no one gets it by birth. Exposure to the bacteria causes the disease. Therefore, adequate preventive measures, quick diagnosis, and treatment are essential to prevent the spread of the disease and to restrict the disability due to leprosy. Effective and efficient medical intervention is required to prevent the spread of the disease. Such initiatives are taken up through NLEP, yet extension is required. Further, investment on human resource planning for the individual affected by leprosy and their family members is very crucial. In the leprosy colonies adequate infrastructure for healthy development of the children, nutrition support, health monitoring, immunization are essential with focus on educational and vocational skill development. Facilities, like residential school, scholarship, vocational education, livelihood supports, are all important for human capital development. Though such provisions for the leprosy affected person and their offspring have been taken up

through different welfare programs, still the effort is quite sporadic. It requires intensive focus, wide coverage, and close monitoring for desirable positive change to achieve holistic well-being.

Build Social Capital Social capital refers to the connections among individuals and the norms of social reciprocity and trustworthiness that facilitate civic engagement, social solidarity, and cooperation for mutual benefits (Putnam, 2000). Often the poverty stricken situation and the derived living condition imposed severe limitations for growth. The survival challenges are very high, and leprosy affected individuals are forced to adopt different kinds of menial jobs or begging for living. Such dehumanizing living severely destroys their motivation and energy to look for positive alternative means of living. In such a situation, facilitating mutual support, trusting bonds, joint planning, and developmental dialogue are very vital for strengthening community participation, and engaging the leprosy affected people as active stakeholders in the process of rebuilding their lives. Thus, community based, community owned programming is essential for civic engagement, to promote solidarity among the community members for deriving mutual benefits. In this process, engaging the neighboring communities, volunteers are also essential to reduce stigma and widen the scope of mainstreaming.

Strengthen endowment and entitlement status: Endowment and entitlement status are closely related with the development of the leprosy affected persons and their family members in long term. Endowment set includes all the tangible and intangible resources owned by a person for the purpose of having a livelihood. It may include the land, cattle, machine, tools and the knowledge, skills, abilities, etc. These endowment sets are essential for development. Often the people living in leprosy colonies have a poor endowment set. Entitlement set includes the possible set of goods that someone can acquire in a legitimate way. A person can get it from a NGO or Government through welfare scheme, from a financial institute or from the market. Thus, improving the entitlement status helps him/her to improve the livelihood venture. Poor endowment and entitlement are the major limitations for accessing developmental opportunities. Therefore, planned intervention is required for effective livelihood intervention by strengthening endowment and entitlement status of the people. Enhancing endowment and entitlement status facilitate better choice for selection of different opportunities in life, livelihood options, and thereby the people in leprosy colonies can enjoy better freedom.

Social Action to Political Voice Essentially, the people affected by leprosy and their family members living in the colonies, require a strong political representation and political voice for change. APAL as the representative body of leprosy affected persons to some extent became an important body to raise the voice of the community, yet the mission of mainstreaming and establishing the rights of the people in the leprosy colonies is a long way to go. Still more than half of the colonies are not having any land rights and about one-fifth of the colonies are located in the area, where no government services are provided. People are still largely dependent on charity and sporadic support services than having an integrated plan for holistic development.

For gaining a political voice an effective leadership and strong support of the right-based organization is required. In other way, fulfillment of human rights and living with dignity should be taken up as an inseparable agenda for any intervention in the leprosy colonies.

Psychosocial Support and Resiliency Building The comorbid psychological conditions are often a barrier for the development of the person affected by leprosy. The similar depressing environment equally demotivates the family members to take proactive steps for altering the situation. Therefore, a focused intervention is essential for strengthening psychosocial resources of the individuals, families, and communities at large in the leprosy colonies. Psychosocial support is the dynamic relationship between the psychological and social dimension of a person, where the one influences the other (International Federation Reference Centre, 2009). The psychological dimensions essentially include the internal, emotional, and thought processes, feelings, and reactions of an individual. The social dimensions specifically include relationships with others in personal and professional life, family and community networks, prevailing social values and cultural practices. Psychosocial support refers to the actions that address both the psychological and social needs of individuals, facilitate better family functioning, and strengthen community resources (Hansen, 2008). The provision of psychosocial support ensures reduction of distress and facilitates psychosocial well-being. Individual intervention should focus on positive coping, positive lifestyle choices that can facilitate responsible, accountable behavior. The family focused intervention needs to strengthen the saving habit, mutual responsibility to focus on upbringing of the children, as well as taking responsibility for the aged parents or family members. Positive atmosphere within the family, sharing responsibilities are important for a healthy family life. At community level, developing a caring community atmosphere, strengthening community resources, and developing community leadership are essential. The NLEP do not have a mental health and psychosocial support component, neither there is any other nationwide program to look after the specific psychological issues among the leprosy affected persons and the people living in the leprosy colonies. A community-based psychosocial approach, adopting cascading model of psychosocial training, reaching out to each members of the community, specific support to the vulnerable groups, carrying out various resiliency building activities, promoting positive coping, and disseminating empowering information are required to be designed and implemented through community owned process of recovery. Thus, a psychosocial support intervention for building resiliency is essential, that would help the people in the colony to focus on their existing, internal resources, and build positive energy for changes.

Conclusion

Leprosy is an age-old disease, but still it is causing serious human rights deprivation is a matter of concern while civilization is moving toward sustainable development,

in the path of ensuring social justice, equality, and equity. The ostracized condition and marginalization of the leprosy affected persons is a systemic default even in the twenty-first century till an integrated focus is developed by the key stakeholders, like, governments, local administration, humanitarian agencies, and the people of the colonies themselves. Medical condition of leprosy is no more worrisome, but the social impositions are still a matter of concern that requires intensive interventions. Medical programs are crucial for prevention of the spread of the disease; nevertheless, the social interventions are pivotal to remove the social barrier around the people living in the leprosy colonies.

Acknowledgements I deeply convey my sincere gratitude to CEO, SILF (Sasakawa India Leprosy Foundation), and her dedicated team for the opportunity to work on the consultancy project. I also express my sincere thanks to all the beneficiaries of the livelihood project of SILF, leaders of APAL for giving me enough time to interact and understand their issues, feelings, resources, and experiences of their life. The field visits were conducted during March 2015 to December 2017. I am thankful to authorities of Central University of Rajasthan, for giving me the opportunity to work on the last phase of the consultancy project.

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Chapter 4
Querida America, Testimonios of Faith, Solidarity, and Survival Along the U.S./Mexico Border

Belinda Hernández Arriaga, Corie Garcia, Amy Argenal, and Alex Chavez

Abstract This chapter shares experiences and narratives from Central and South American asylum seekers subjected to the U.S.'s MPP/Remain in Mexico policy and living in makeshift camps along the US/Mexico border. As part of ongoing work in a Matamoros, Mexico border camp, the research team gathered letters asylum seekers wrote and addressed to the U.S. government. Their letters written as "Querida America" share their voices and stories with hopes that the government will recognize their humanity in contrast to the increasingly xenophobic rhetoric. Their firsthand testimonios shed light on their spirituality, desires, dreams, and futures imagined past the MPP policy they are currently retained in. Thousands of families seeking asylum in the USA have been stuck at the border for over a year. They remain indefinitely subjected to deplorable and dangerous conditions as a result of U.S. policies and given current court closures.

Keywords Querida America · Testimonies · Faith · Solidarity · Survival · U.S. · Mexico border

Introduction

> Nos tiraron a la frontera, nunca esperabamos que ibamos a vivir en el suelo, en el cemento, vinimos a pedir asilo pero nos encontramos en la calle. Mis niños dormieron bajo un banco por dos semanas y algunos personas nos dieron de comer. Por el gracias de Dios estamos vivos y aqui. (asylum seeker 2019)

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_4

> They threw us at the border, we never expected to be living on the floor, on the cement, we came asking for asylum but we find ourselves in the street. My children slept underneath a bench for two weeks and a few people gave us food. Thank God we are alive and here.

The journey to the USA border for the many individuals and families who are forced to leave home and flee for safety or survival changes lives the moment they take their first steps to the unexpected. After listening to countless testimonios, meeting families released from ICE detention, and providing support for countless immigrant children and families, the degree to which their spirituality connected to their survival and well-being is remarkable. In sacred conversations and moments, these writers have shared with migrant families and individuals, they speak of their faith as the vessel that held them together in the darkness of their journey and the compass for the unknown ahead. The presence of spirituality in their lives is equal to the water they need to live. When we consider health and wellness for asylum seekers and refugees, we cannot dismiss the colossal role of spirituality.

As practitioners, advocates, researchers and allies, we must consider how we navigate spirituality as a tool for addressing crisis, for building trust as well as joining in with the community we are working with. We also must understand spirituality as a catalyst for hope in the face of inhumanity and despair as well as for their survival. This was evident in the faces and eyes of those we have journeyed with at the border. Asylum seekers have shared near death stories they experienced in their journeys, clinging on to prayer for life. They have faced floods with no protection, circling in the darkness of night to pray for a miracle. They have suffered repeated pains of hunger; they have believed that tomorrow would be a better day, praying for someone to see them for who they are. Letting go of their child's hands to cross the border, they have cried tears dripping with prayer to one day be united. Each step, each breath, we have seen miracles, we have listened to their testimonies, and through all of this, we have seen their activism, their fight for another day with the hope for humanity and justice. This chapter centers their voices and advocacy that is grounded in a spirituality that no borders can barricade. Our work positions the power of spirituality present in the lives of many migrants for survival, advocacy, and a sacred tool for building trust and relationships in our own work with them as allies.

This collective work frames the context of spirituality and advocacy in the lives and survival of Central American, South American, and Caribbean asylum seekers, informed by firsthand testimonios sent from where they live along the US/Mexico border, indefinitely subjected to the U.S. Migrant Protection Protocols (MPP)/Remain in Mexico policy. As part of ongoing work supporting asylum seekers in Matamoros, Mexico, at a makeshift border camp forced by MPP, the research team spent extensive time in community with individuals living there. We shared physical (and emotional) space at the camp, prayed in fraught moments, danced in others, and walked in solidarity when the time came to advocate with them. As researchers, ourselves Mexican and Central American, we witnessed communities struggling every day to survive, and the unrelenting strength of families surviving, and fighting for their right to claim asylum in the USA.

In our work to create moments of hope, self-advocacy was born out of a project designed as Querida America, handwritten letters that held the prayers and pleas of the asylum seekers living in the MPP camp. "Querida America" shared their voices and stories with hopes that the government will recognize their humanity in contrast to the increasingly xenophobic rhetoric used to discuss migration. Their firsthand testimonios shed light on their desires, dreams, prayers, and futures imagined past the MPP policy they are currently retained in. Their words speak to survival in the face of trauma. Thousands of families seeking asylum in the USA have been stuck at the border for over a year. They remain indefinitely subjected to deplorable and dangerous conditions as a result of U.S. policies with all courts and the border closed due to COVID-19. This chapter amplifies their testimonials, narrates the power of their faith in surviving the inhumane camp conditions, and highlights their advocacy to terminate the policy of MPP, rebuilding the right to asylum that has been dismantled in recent years.

MPP and the U.S./Mexico Border

To understand the experiences and day-to-day survival of asylum seekers at the border, it is important to understand the history and process of MPP. Further, context of history and policy frames the human rights disparities migrants at the border experience. In January 2019, the Trump administration put into place Migrant Protection Protocols (MPP), also known as the "Remain in Mexico" policy. MPP furthered the previous policy of "metering", a policy that existed prior to the Trump administration, and one that limits the number of asylum seekers that are allowed to cross into the USA (Cheng, 2019). Under MPP, those who apply for asylum at a port of entry, or along the border, are forced to return to Mexico to await their asylum hearings. Asylum seekers must put their name on a list with Mexican officials and wait until their number is called. Case updates, expected timelines, or legal assistance are often unavailable without access to a lawyer, leaving most asylum seekers in the dark about the process they are expected to navigate or how to effectively plead their claims.

In June of 2019, there were already about 150 families assembled into a camp in Matamoros, Mexico, right across the river from Brownsville, Texas's Gateway International Bridge. At this point, most of the families living in the camp were there due to "metering". However, by October 2019, MPP was in full swing, and the camp had begun to grow exponentially. By February 2020, there were around 4000 asylum seekers dispersed throughout Matamoros, with some 2500 living directly in the camp, and most there were due to MPP (Solis, 2020). At the time of writing this chapter, there are more than 60,000 asylum seekers waiting in impromptu camps along the US/Mexico border, near seven main ports of entry: from Tijuana/San Diego, CA through to Matamoros/Brownsville, TX, with a recent expansion to Nogales, MX/Nogales, AZ ("DHS expands MPP", 2020). These camps receive no support from the US government and very little aid from the Mexican government and rely

completely on the aid of humanitarian organizations, which under COVID-19 have made their situations extremely precarious (Mukpo, 2020).

Testimonio

While popular U.S. understandings of migration flatten, homogenize, and decontextualize migrants' journeys and motivations, there exist *testimonios* to return nuance and historical context via lived experiences. Though the concept of oral history is timeless and worldwide, *testimonio* is grounded in a specific history of public witness that cannot be divorced from a context of anti-imperialist resistance and human rights struggles in Latin America (Saporta Sternbach, 1991). In this context, *testimonio* was practiced verbally and/or written, with a specific aim of witnessing in spaces where justice is unlikely to be accessible, encouraging correction of historical records, and creating collective dialogues of solidarity and understanding (Blackmer Reyes & Curry Rodriguez, 2012; Zimmerman, 2004). Though the era has changed, the utility and promise of testimonio have not. Many migrants are still foreclosed from justice at home, as well as upon arrival to the U.S., severed from their families, community, or a sense of safety. Worse, they are under active threat: in recent years, the Trump administration has leveraged xenophobic rhetoric about migrants to stoke fear against them, as well as to build, justify, and maintain policies that ensure their subjugation, such as the Migrant Protection Protocols centered in this chapter. Testimonio-based perspectives of migration are critical: They exist as an important challenge to this rhetoric, as well as these policies. Not only do they challenge Western investment in and notions of objectivity, instead emphasizing power and "political machinations" (Saporta Sternbach, 1991) in every step of constructing truth, knowledge and history, they also affording intimate and firsthand access to what otherwise might be obscured by dominant narratives. For example, *testimonios* illuminate what the U.S. immigration system looks like to migrants within it, as opposed to lawmakers or members of the public who will likely never enter the real-life spaces (detention centers, tent courts, and the border zone itself) that comprise it.

The Matamoros border camp is one of those spaces, infrequently visited, and often misunderstood. Though "close the camps" has become an increasingly prevalent call in migration advocacy, context—about which camps, where they are located, who is stuck in them (predominantly asylum seekers from Central America and the Caribbean; with indigenous, disabled, and LGBTQ + populations present, as well as many survivors of domestic and sexual violence)—is rare. Rarer still is a direct mention of the "Migrant Protection Protocols" and explicit acknowledgment that these policies have not only caused, but also indefinitely extended, said camps' existence. The name "Migrant Protection Protocols" itself implies a certain framing that has been integral to the formation and maintenance of said policies (and the resulting camps): They exist to *protect* migrants, and therefore, their enforcement is ultimately, unambiguously for the good of everyone involved. As per the Department of Homeland Security's own press release about MPP: "DHS is using all appropriate resources

and authorities to address the crisis and execute our missions to secure the borders, enforce immigration and customs laws, facilitate legal trade and travel, counter traffickers, smugglers and transnational criminal organizations, and interdict drugs and illegal contraband" ("Migrant Protection Protocols", 2019). The language used by DHS, as well as that of the protocols' deceptively neutral-sounding alternate name "Remain in Mexico", belies the fraught physical and emotional landscape asylum seekers actually occupy along the U.S./Mexico border. Instead, asylum seekers' testimonios are more complicated and less homogenous than people would assume: their own narratives challenge conceptions of migrants as invaders/scammers, fearful subjects laden with trauma, or helpless beings in need of someone else's saving and guidance. (Interiano, 2018; Nyers, 2006). Using cultural wealth theory (Yosso, 2005) as an additional lens through which to frame migrants' narratives and emphasize the hopes, dreams, and positive qualities they provide in their own counternarratives, these stories in this chapter serve to complicate and reorient what it means to seek asylum, as well as what asylum itself can look like.

In-/visible Narratives of Migration

Framing has always been critical in the inception, construction, and maintenance of anti-immigrant policies. Though the Trump administration's constant barrage of xenophobic rhetoric has proved an especially visible case study of this process, policies based in exclusion have always been part of the U.S.'s nation-building, with who is viewed most capable of being or becoming a "real American" often determining who should or should not be let into the country (Hing, 2004). Narratives about migration are rendered in-/visible when convenient, as part of this discussion. Thinking about when and where the cultural and intellectual contributions of Central American migrants to the U.S. appear, if ever, Cordova (2017) reminds us of the ties between U.S. interventions abroad and influxes of Central American migrants and argues that their invisibility in broader culture is intentional. If the narratives and history of migrants from Central America are obscured, so too is the legacy of U.S. involvement in their exile, as well as the political structures that continue to destabilize and exploit the region to this day (Cordova, 2017; Fabregat et al., 2020).

Not only have positive narratives of migrants and migration history been obscured, they have been increasingly replaced with negative narratives—the arrival of the migrant caravan in Fall 2018 proved critical to Trump's reelection strategy, and from October–November of that year, U.S. media was publishing 50–100 caravan-centric stories per day (Ahmed et al., 2018; Fabregat et al., 2020). Much coverage decontextualized migration obscured the root causes forcing people to flee their homes and emphasized notions of illegality and invasion. In doing so, the Trump administration successfully weaponized concerns about sovereignty and safety to cast migrants as criminals, rather than asylum seekers following the INA's stated procedure by which "any alien who is physically present in the United States, or who arrives at the United States (whether or not at a designated port of arrival … irrespective of

such alien's status), may apply for asylum" (Immigration and Nationality Act of 1952, 1980). Menjivar and Abrego (2012) note that though the law is often cast as neutral, discourses and narratives about immigrants that render them suspect and/or lawmakers help justify their maltreatment, even casting it as necessary in pursuit of justice. This, they term, is "legal violence"—the means by which implementation of the law, in a way that criminalizes individuals pertaining to marginalized groups (such as migrants), normalizes and legitimizes physical, structural, and symbolic violence against them. Correction of negative and hypervisible narratives about migrants is critical, as it impacts their lives and especially their pursuit of asylum claims, and such begins by centering voices of migrants themselves.

Centering Faith, Cultural Wealth, and Community

When communities have been dehumanized and find space to share and analyze racist arguments constructed against them, they in turn have space to make new arguments and counternarratives, to defend themselves—as opposed to being defended by others who may lack the positioning or context to do so adequately (Yosso, 2005). Even well-intentioned humanitarian spaces may craft narratives ultimately damaging to refugees and asylum seekers: by (1) flattening them into the "barest of life" where their voices, presence, and agency are muted, leaving them instead rendered passive and in need of saving, (2) by providing humanitarian aid in a purportedly apolitical way that leaves binaries and power dynamics of giver/receiver, listener/crier, helper/victim binaries untouched, and without acknowledgment of or intervention in the root causes that continue to spur migration flows (Nyers, 2006). Turning instead to a cultural wealth-based model emphasizing the unique types of capital that migrants hold—like their ability to resist, create, and aspire in the barest of circumstances—not only paints a more holistic and realistic view of their lives, but also affords a more critical, thoughtful perspective of the support (emotional, resource-based, or otherwise) that said migrants would actually find useful, both within and beyond the liminal legal spaces they are currently located in.

Methodology

The research team, part of a larger group of Bay Area activists known as Bay Area Border Relief, spent between ten days to two weeks over the last several years, visiting asylum seeking families, either at a respite center in McAllen, Texas, or at the camp in Matamoros, Mexico. These trips were designed to support families and talk to children about their experiences during Border Patrol detention and under the policy of MPP. Trips took place every few months throughout 2018 and 2019, including the first part of 2020. The research team gathered in person narratives on a number of different trips from 2018 until the present. We also continued to engage

with asylum seekers through WhatsApp chats, through the sending of videos and welcoming newcomer families, through continued accompaniment as some have been able to enter the USA and locating to Northern California. On the most recent trip to support migrants living in the camp in Matamoros, Mexico, in February of 2020, the research team brought letters from school aged children in the Bay Area to distribute to the people living there. The team came with art supplies to have the children in the camp write letters and pictures back to respond to the children from the Bay Area. This originally started as an exchange between children, those in the Bay and those living in Matamoros. However, one of the residents of the camp who helped us organize the logistics of these art workshops asked if he could also write a letter. This grew into a three-day activity in which increasing numbers of adults would come to write a message, having grown curious at the sight of other letter writing, or prompted by friends and neighbors in camps writing their own letters. There was no initial prompt for the letters, and the content was open. However, over time, more and more of the messages were directed to the American public, the U.S. government, and many to the Trump administration directly. Their letters became their *testimonios,* a space where people could share their pain, their hopes, their dreams, and their experiences. Letters contained content both light-hearted and desperate and often extended into longer narratives that filled full sheets of paper, front and back. One child shared, "mi sueño es ser residente de los estados unidos y ser la mejor patinadora" (my dream is to be a resident of the United States and be the best skater) (BABR, n.d.). Another man shared, "nosotros no salimos de nuestro país porque queremos, salimos por tanta corrupcion solo te pido queremos salir de esta situación tan crítica que estamos viviendo" (we did not leave from our country because we wanted to, we left because of all the corruption. I only ask you to take us out of this situation, so critical, that we are living) (BABR, n.d.). Letter writers often articulated that they wanted their messages to be shared. At the end of the activity, we collected over 300 letters, which were then scanned, translated, and coded. The letters were then used to start the #QueridaAmerica campaign, a social media campaign in which each day a letter was highlighted with a message or an image around MPP (Bay Area Border Relief, n.d.). This chapter shares theme of their messages collected that hopes to capture their voices, their spirituality, and their fight to survive and be recognized as human. The chapter also shares reflections from the accompaniment work done walking with families suffering under MPP.

Welcoming the Stranger

After their long and arduous journey to the U.S. border, asylum seekers are processed in Customs and Border Protection's (CBP) system; their belongings are confiscated, children are separated from their parents, and individuals are stripped of their cultural wealth. Almost all sense of autonomy is lost when CBP transmits unwelcoming and intimidating messages meant to exert their authority and power on human beings imploring support. While in the camps, families have little to no control over their

asylum case, their next court date, or the outcome that could alter their lives indefinitely as they anxiously await a final judicial ruling. It is then that families turn to one of the very few cultural aspects they can maintain in this stressful and inhospitable climate in order to feel comfort, strength, and hope—their faith.

Although many families feel at the mercy of CBP officers, the agency asylum seekers display when practicing their faith is beyond words. It is one of the few sources of power that families can control in the midst of insurmountable feelings of helplessness and uncertainty. When all else seems lost and hope is surviving on a thin line, families invest more time and energy into the propelling forces of prayer and faith knowing this as their most powerful tool to handle unpredictable situations. It is unquestionable that faith is among the most valuable cultural aspects that families preserve and cultivate in the camps and is untouchable by CBP.

The camp for many has become a sacred space, whether for good or bad. The land has held the secrets and agonies of families forcibly torn apart, both physically and emotionally. The Rio Grande River has taken the last breaths of some attempting to cross, whether through drowning or violence at the hands of others. The border has remained alert, watching families in hunger, living in makeshift tents barely holding on for dreams just out of reach of the imagined promise of the USA. Memories of family have risen out of the dust; God has created a home, resurrected by the prayers of families, the support of pastors and Sister Norma of McAllen, Texas. Even with all of the support, the reality is that anyone entering the camp from the outside is clearly an "other", and rightfully so. For many on our team, we struggled to find hope in one of the most inhumane spaces at the feet of our border. Though prayers often did not seem like enough, in our efforts to align with the asylum seekers, we connected to the treasure of spirituality and joined in building *capillitas* (altars) of hope. Instead of us welcoming them, they welcomed us, the American strangers who in many ways represented the policies that blocked their entry for survival.

The first altar began with one niña, only nine years old and living in a sparse tent with her father. They escaped near death in Honduras, and since arrival to Mexico had struggled to figure out how to survive the MPP process. Her eyes were exhausted, but she held her father's hand tightly as they explained how their faith kept them going: "No tenemos a nada, pero tenemos a Dios". (We do not have anything but we have God). She looked at us for answers, but the only hope we could offer was prayer. Rushing in between the lines of cars at the border to buy supplies at the tienda, (store) the thought came to buy some relics to make a small altar in the family's tent. The idea of making a capillita (altar) brought a sense of peace. While we could not give more, we were excited to give them symbols of their faith to create a space for prayer. We bought lights and several relics, handing them over with great care. Immediately a small altar was resurrected. For the next several months, this tent became sacred with asylum seekers from all over the camp coming in to pray. "Esto nos da tanto alegria, y nos ayuda, estamos aqui 24 horas" (This altar makes us so happy, and it helps us, we keep a 24 h vigil). During our time away from the camp, we received countless photos and stories of prayer for miracles. The altar was eventually moved to an open space at the foot of a nearby tree—where more could come and comfortably visit.

At a second trip to the camp, months later, we returned with another gift for their altar and saw the *capilla* space had grown. The space had chairs and handwritten notes left at the altar. Rosaries and crosses were at the foot of the altar with flowers off to the side. We stood in silence as we were moved by the spirituality felt and presence of the community. There was a collective spirit of solidarity as they invited us to pray, to be or to witness. The bridge for our work began as our Querida America project began to form.

Querida America Narratives

Todos Somos Humanos/We Are All Human

Narratives around the criminality of asylum seekers run rampant through mainstream news sources (Menjívar & Abrego, 2012). The constant use of the term "illegal" to describe those who migrate, as well as those who are seeking asylum, is not only used by the staunchest critic of open border policies, but also runs through even more liberal media sources (Guskin, 2013). The need for asylum seeking families to speak back to narratives of illegality and criminality came through in the constant cries of humanness from asylum seekers. Over and over again, the letters expressed the verbiage "todos somos humanos/we are human". Again and again, letters expressed intimate views of who the writers were as people. They would often start with a description of themselves, their families, where they were from, and how long they have been in the camp. This initial statement of humanity is important to note, because it again places asylum seekers as mothers, fathers, children, citizens of places that have not respected their human rights, as people of faith. This call for humanity is a form of their survival as well.

Often letters communicate that they are "good" people, with varying iterations of "Nosotros no somos malos, somos seres humanos/we are not bad, we are human beings" appearing in many letters. Another letter directly addressed Donald Trump to share who they are, "Hola, Donald Trump le envio este umilde saludo esperando lo recibe con mucho cariño/Hello Donald Trump, I send this humble greeting hoping you receive it with much care". The letters continued to express the basic humanity of those who have had to migrate, how they speak back to narratives of criminality. One woman shares that "soy una persona humilde, muy luchadora/I am a humble person, I am a fighter". Those living in the camps were well aware of the narratives that had precipitated their arrival. They knew what was being said about them, not only in the U.S. media but the Mexican media as well, and used these letters as a way to reaffirm their humanity.

Another clear expression of their humanity was their faith. Letter after letter spoke to the tremendous suffering the families are enduring at the camp. As each wrote about the dangerous conditions they are fleeing from or the decaying conditions they are living through, they continued to "bless" or send blessings to President Trump.

Even in crisis perpetuated by his policies, the letters consistently sent blessings to Trump with prayers sent to the administration. One letter begged Trump for help and ended with "Que Dios te bendiga siempre/May God bless you always". The idea that their faith is rooted in prayer for the other, even those that persecute you was evident in the countless well wishes, prayers, and hope that exuded from their Querida America letters.

Solidarity, Community, and Collective Advocacy

Within many letters, "Yo/I" and "estoy/I am" shifted into "nuestro/our" and "somos/we are" and back, with letter writers often linking their individual narratives to shared struggles. It cannot always be assumed that "somos/we" refers to the broader community of asylum seekers, as opposed to the "we" of a letter written on behalf of one's own family or traveling unit. However, an astounding amount of letters explicitly referenced, or pled on behalf of, *el campamento* as a whole. These pleas and/or narratives took shape in different ways. One father saw his own motives for migrating reflected in that of other asylum seekers and used his letter to emphasize the human toll of life under MPP, as opposed to the safety they many fled seeking:

> *The American Dream… It is sad to see so many how many families are here suffering, how many innocent children are waiting for a miracle. A president who doesn't feel the pain of others… We didn't come just to come, we came obligated to protect our families. My name is [REDACTED] and I came protecting my wife and daughter. Tell me, what would you all be capable of doing for your children? We are not delinquents, we are honorable people protecting our families.*

Similarly, a pregnant mother wrote her full letter from a collective standpoint, articulating the shared struggle of "our pregnancies", consistently using "we" to emphasize each challenge shared by expectant mothers—exposure to the elements, illnesses resulting from the cold and lack of safety—and ultimately urging readers to "lift your voice on our behalf".

Solidarity across countries was also evident, with several letter writers noting the diverse array of nations represented in camp both generally ("…we have many families from different places suffering along the banks of the Rio Bravo, please let us all cross….") and specifically, with one letter writer devoting a full page to list all the countries he knew were represented in camp ("Venezuela, Colombia, Nicaragua, Guatemala, Ecuador, Honduras, El Salvador, Costa Rica, Haiti, Cuba, Peru"), with great care, as well as an expression of "Somos familia!" In recent months, residents of *el campamento* have erected a banner of flags from several of the most frequently represented nations—Venezuela, Honduras, El Salvador, Cuba—in a prominent location of the camp, a visual representation of the homelands left behind, and (re)claimed space on tenuous, if not hostile terrain. Yet though imagined community borne of shared national/cultural identity was a significant unifier, a majority of letters called for the liberation of *all* of their fellow asylum seekers, without regard to where they came from: "…I beg God to touch Donald Trump's

heart, that he grant us asylum, for all countries…" "I only ask for an opportunity for all who are in this place…." "…I hope that the border opens for all of my immigrant brothers and sisters…".

The community and collective advocacy found in so many letters calls to mind a saying from the early, hopeful days of Nicaragua's Sandinista revolution and often attributed to feminist poet Gioconda Belli: "solidarity is the tenderness of the people" (Power & Charlip, 2009). There is a distinct tenderness in ceding space in one's own letter, a rare chance to share your plight with whoever will listen, to advocate for the collective. This tenderness exists in stark contrast to the brutality and forced proximity, both physical and emotional, that MPP has entailed. In terms of the latter, it is worth noting that asylum seekers are scheduled by CBP to attend court hearings in groups, leaving them to detail their most traumatic and graphic memories in front of other camp residents they may not know well, if at all. Further, said hearings take place in makeshift courtrooms—portable buildings along the U.S. side of the Rio Grande River, shrouded under giant white tents to obscure them from public view—where immigration judges themselves appear via remote video calls. Though asylum seekers are interrogated, doubted, and denied dignity or humanity in the official spaces purportedly meant to protect them, they create their own spaces to share trust and faith in each other, validate each other's stories, and uplift each other in calls for collective liberation.

Seeking a Better Life

Relocating to a foreign country is usually not the first option most families resort to despite the compelling circumstances that force migrations. Regardless, these tragic and abrupt experiences make the dangerous and precarious journey worth the sacrifice for many. A common theme addressed by several *testimonios* was the pursuit of a "better life", though families had numerous notions of what that might look like and who they were making sacrifices for. Among these were better employment and educational opportunities for themselves and their children, access to quality health care, the ability to own property, political and financial stability, and family reunification. Above all, families yearned for emotional and physical safety as well as basic human rights that would allow them to live a dignified life in the USA.

A genuine cry for help and change was deeply felt in every *testimonio.* Some families surrendered the few assets they had to criminal organizations, while others found their lives in jeopardy with no trustworthy government entity to denounce crime and threats with the hope that justice will prevail. All of these experiences compelled the refugees to seek a "better life" elsewhere for themselves and their families in search of new beginnings. One woman in the camp stated, "I ask God to give us the opportunity to be in a better place, and to be able to give my children a better future, to be able to give them security, to be able to take them for a walk without the fear that something bad will happen to them, to be able to give them the opportunity to study, that they may have a better life than mine. That they can be

happy". These pleas for help and a better life were echoed in multiple *testimonios* from adults and children alike. Another commonality across *testimonios* was that their notions of a better life never seemed preposterous. Much of what was desired appeared to be normal and routine everyday life for most Americans—things often taken for granted. These pleas were consistently coupled with their faith and prayers for justice and asylum.

The power of their spirituality in the darkest of times to bring hope when our borders have shut them out was interwoven in their words. One mother who escaped near death in Honduras and had been in the camp for six months at the time of her letter wrote: "Le pido a Dios cada dia que nos permite a mis hijos y yo entrar a este gran país" (I ask God every day to let my children and I enter this great country). Their faith in God as being able to break through the cruel barriers of MPP resonates powerfully in their letters, our conversations we had with them, and in their strength to carry forward. Day after day, they wake up to "dar gracias a Dios / give thanks to God" for being alive. Another letter pleads to God "toca el corazón de Donald Trump" (touch his heart). Asylum seekers at our U.S. Borders are holding on to faith when the USA has turned their back on them, only asking for safety and opportunities to a life of dignity.

Conclusion

The USA government has condemned asylum seekers to live in camps in dire situations, many for over a year now as the MPP policy continues, with no end yet in sight. As researchers walking in solidarity with families, mothers, fathers, children, and human beings, we share their testimonios to speak back to the prevalent, negative narratives that reinforce the "other". We share experiences of spirituality and faith as survival, resilience, and hope. Through politically constructed negative images of asylum seekers, the popular imagination is content to keep "them" out, keep "our" country safe. Testimonios from those who live in the camps, who have risked their lives to migrate to a place of refuge, challenge these negative narratives of criminality, invasion, and fear, to speak instead to their humanity, their family, their faith, and their dreams.

As we close, we return to an image sent to our team during Hurricane Hanna, one of many storms to flood the camp in rapid succession. As the rain came down, structures swayed, trees buckled under the force of nature, and their tents began to fill with water, threatening to destroy what little they owned. During this fraught moment, the research team received images of them gathered together in the dark. Though stressed, running on little sleep, and panicked by the escalating danger headed straight toward them, they gathered together in prayer. In the dark of night, abandoned by the world along the banks of the Rio Grande River, they kept vigil as a community: harboring and supporting one another. As the river rose at the foot of the border wall, their lives were in imminent danger. Singing, praying, and standing strong as one community, they lifted their spirits with prayer to cloak them in protection.

Their silhouettes in the dark were illuminated by flickers of light that captured their humility and beauty in the face of trauma. Their voices, their strength, and their prayers can never be drowned out by border walls or natural disasters.

As researchers, this work of Querida America amplifies their testimonios as we stand in solidarity with them in our advocacy against the cruel policy of MPP. This chapter reflects their deep wishes to share their experiences as widely as possible as they fight and pray for hope that someone will acknowledge their humanity and take action for change.

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Chapter 5
Evolution of Belongingness: Its Past, Present, and Future

Anjali Gireesan

Abstract Belongingness is a social construct that all of us strive to achieve one way or the other. It is considered to be a fundamental aspect of being human which makes them a part of something greater than themselves. Though it has been the core concept, its meaning and methods have constantly evolved and modified according to changes brought about in our surroundings. This chapter deals with understanding of this process and its implications for our society. In order to lay the foundation, it will be first explored from different theoretical perspectives. Also, the major mental health outcomes and pain of ostracism will be discussed to establish the importance of belongingness. Thereafter, we will comprehensively explore the different manifestations of belongingness. An emphasis will be kept on how the meaning of belongingness changes in the period of crisis and intervention strategies will be discussed to cope with such situations. Lastly, the concept of sustainable belongingness is proposed.

Keywords Belongingness · Perspectives · Ostracism · Mental health · Sustainable belongingness

Introduction

Belongingness is a concept that has been there with us since the time human civilization began. "The feeling of belonging is distinguished by the need to establish links that become significant and necessary for an individual's overall development. It emerges from the individual's experience and interaction with the world" (Peter et al., 2015). It is true that the meaning of this construct has changed over the years. Evolutionarily, belongingness aided and ensured the survival of our ancestors. From that point onwards, the face of belongingness has changed drastically. It has become a multidisciplinary topic that has been explored for its effects. The valence associated,

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_5

role, and its applications are some of the factors studied in the context of belongingness. The huge body of literature and the chronology of the same are indicative of its significance and versatile nature. From the terms that are associated with it to the in-depth study of its different outcomes on the basis of its use by the people and their environment, belongingness has evolved into an all-encompassing factor in the society. In this chapter, we thus discuss this evolution to understand the present-day scenario, its applications in various fields, its implications in our surroundings and the possible future positive outcomes that may be capitalized for the benefit of the social environment. We arrive at the concept of sustainable belongingness that will aim to keep all the systems around an individual in equilibrium and thus may in turn maximize his or her potential.

Belongingness: A Theoretical Perspective

The understanding of belongingness as a theoretical construct begins with the 1950s when two eminent psychologists gave two different but influential theories. Eric Erickson postulated the psychosocial stages of development wherein belongingness was conceptualized as one of the major milestones of human development. According to this stage theory, each age period is characterized by a conflict that needs effective resolution. This in turn results in the form of a well-adjusted individual who is empowered socially. During young adulthood, developing intimacy with one's surroundings is important. People, who are not able to develop this aspect, withdraw into themselves and experience isolation. Those who successfully form intimate relationships, emerge with the virtue of love. Erickson defined love as "the mutuality of devotion forever subduing the antagonisms inherent in dividing functions." Thus intimacy requires adjustments on the part of the individual. Important behaviors that become a part of this stage (ritualization) are all directed to gain affiliation. Lack of true relationships and genuine social bonds result in elitism where a sense of isolation prevails, though a person might be surrounded by people. Around the same time, Abraham Maslow proposed the Need hierarchy theory of motivation. This time belongingness was considered important to drive many important behaviors of human beings. According to him, needs of individuals vary from time to time. The chronology of behaviors is decided as and a particular need gets satisfied and hence we move on the next one. Once our physiological needs are satiated and an individual is comfortable in his physical surroundings, belongingness takes the center-stage for motivating the next set of behaviors. Friendships, family, romantic affiliations, and participating in community endeavors satisfy the need for emotional bonding that result from this need when prominent. The role of group cooperation, social identity, social comparison, and a strong need for affiliation becomes important at this stage.

Baumeister and Leary (1995) presented belongingness as one of the fundamental motives to live as human beings. According to them, there are certain characteristics of a fundamental motivation:

- It should elicit observable consequences under variety of conditions
- These consequences should have an emotional component
- It should align and maneuver our cognition as well
- The absence should lead to negative effects
- It results in purposeful behavior
- It operates on the principle of universality
- It should have an independent effect when compared to the other fundamental motives
- It should have effect for broad array of behaviors
- It should have far-fetched implications that are holistic in nature.

They believed that belongingness satisfied all the above conditions and hence gave the belongingness hypothesis. Human beings have an all encompassing drive to engage in quality and long-term interpersonal relationships. These relationships should largely be positive and satisfying in nature. In order to fulfill this motivation, two conditions need to be followed. (1) Interactions need to be in place with social surroundings. These should be frequent as well as positive. (2) These relationships should be stable and expound genuine concern which is reciprocal in nature. Interactions that are volatile and sparse are unsatisfactory and do not satisfy this drive. Thus the positive personal contacts should be stable and be present for a long time. Belongingness as a fundamental motivation appeals to the innate human affiliative tendencies. This hypothesis clearly shows that there is an ever present interpersonal component behind different needs of people.

Maalouf (2001) brought out a different aspect of belongingness. As an integral part of identity, belongingness to a group affects a wide variety of behaviors especially when the same is threatened by some external factors. Allegiance is an important part wherein one decides to which people we relate to the most. The continuum is wide from it bringing people together in harmony at one end of the dimension to turning the same people violent to protect this allegiance at the other end. This showcase of belongingness is one of the most prominent ways of asserting one's identity.

Yuval-Davis (2006) analyzed belongingness at three different levels. According to her belongingness is a dynamic concept that cannot be viewed with rigidity. The three levels of analysis are social locations, identification, and emotional attachment to various groups, and ethical and political value systems (Fig. 5.1).

1. ***Social Locations***: Our society is not devoid of differences. Any category that a person identifies with has a location in the social hierarchy. Thus an individual shows belongingness to this particular social location. At any point of time, it is difficult to identify with just one category. An individual may be a woman belonging to a young adult group hailing from Asia. Each of these categories has a different positionality and associated belief systems. All these are complementary to each other. It is the addition of the belongingness that the individual shows to each of these categories that sums up the individual in totality.
2. ***Identifications and Attachments to Groups***: Identity narratives are important to an individual and belonging to a group is of significance to this identity. Constructions of belongingness demonstrate the emotional labor a person is

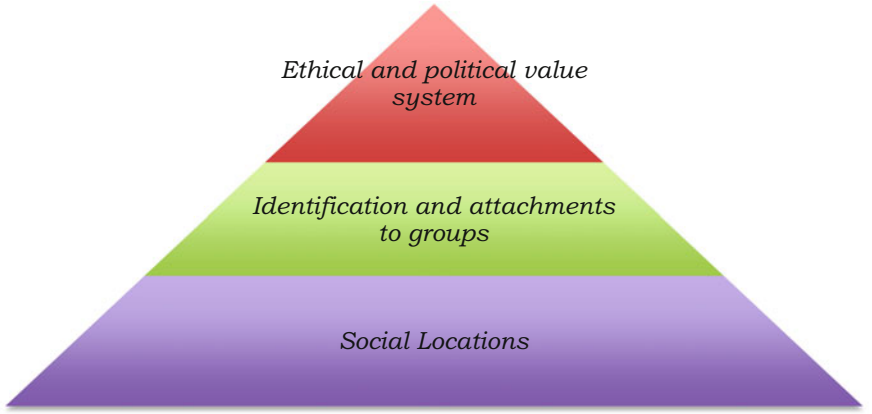


Fig. 5.1 Three analytical levels of belongingness

ready to undergo in the pursuit of attachment. The emotions are strong in extreme cases of either ends of the belongingness paradigm. When a person perceives that he has strong ties to the collective group, a surge of positive emotions fuels him. When these ties are weak, the person goes through the turmoil to make these bonds stronger. Thus, it is observed that there is a connection between the social location and the identification of the individual.

3. ***Ethical and Political Value System***: The social locations that we are positioned in and the identity that is formed in accordance with it do not exist in vacuum. These are subject to constantly being judged and weighed for their value. The more accepted is a particular ideology, higher is the person ranked and this in turn increases the positive valence associated with belongingness.

Antonsich (2010) explored through a systematic review how understanding belongingness should not limit itself to territorial belongingness (place-belongingness) or excessive emphasis on it being a part of identity. The appropriate role of belongingness needs to be explored in both the contexts. While discussing belongingness, the politics associated with it cannot be avoided. Personal and social contexts of its existence should form the integral part of any discussion on belongingness. The simultaneous presence of this construct in its multiple forms needs to be observed, appreciated, and explored.

Youkhana (2015) is of the opinion that cultural materialism, societal demands, and contexts as well psychological factors of living together define and influence the evolution of belongingness. He believes in the space-sensitive perspective on social relations. In this view, it has been advocated that belongingness is dynamic and it goes beyond any established socio-cultural differences as well as is pervasive across boundaries. This in turn sees collectivism as a more dynamic process than the rigid nature emphasized upon in the past literature.

Lähdesmäki et al. (2016) gave a comprehensive way of looking at belongingness. The five main domains of belongingness include.

(1) **Spatiality**: It refers to the physical space that an individual belongs to. Places, like, home, school, workplace, etc., all have special meaning for a person. However, most of the research that connects belongingness to the space concentrates on issues of migration, mobility, and associated emotions to this aspect. Hence, spatiality depicts the transient nature of belongingness and views its experience in a different light altogether. Once situated in a place, it is important to feel comfortable there which comes from developing this sense. Thus affective state is very closely related in this sense and in bringing out the significance of this aspect.

(2) **Intersectionality** and (3) **Multiplicity**: Intersectionality mainly refers to the convergence of multiple social identities existing in an individual. In essence, this relates to simultaneous belonging of people to multiple places and groups. It is dynamic and thus constantly changes itself because of the intersectional nature of these various social categories.

(4) **Materiality**: The physical surroundings and the active participation of the individuals in the same have a role to decide the level of belongingness that people experience. The food people eat, clothes that they wear, the profession that they adopt, etc. thus contribute to this sense of belongingness in the materialistic way. In most cases, these tangible aspects help initiate the process of belongingness in any new culture or society. These give identification to a culture and thus it becomes easier for the person to blend into the group that an individual wants to belong to.

(5) **Non-belonging**: The concept of belonging somewhere includes the concept of exclusion as well. This aspect becomes the main factor in distinguishing between different groups. It has formed the basis of identity politics. Identity politics is "the politics in which people engage when they mobilize on the basis of, and when they define their experiences, their political problems, and their aims in terms of the good of identity-groups" (Hayward & Watson, 2010).

Terms Associated with Belongingness

There are many terms associated with the concept of belongingness. In this chapter, belongingness has been viewed as a broad term that encompasses all the concepts related to human interaction. It is important that we present the terms here in their original sense as well which will further help to make the sense of evolution of this construct.

Sense of Belonging: Lee and Robbins (1995) proposed that sense of belonging consist of three aspects. These are:

(1) ***Companionship***: This is the first aspect of belongingness that develops during infancy. The companionship becomes deeper and more refined as the child develops emotionally as well as cognitively. Gradually it extends from inanimate objects to people in the surroundings.

(2) ***Affiliation***: This aspect develops during adolescence. When an individual starts forming peer relationships and gets as comfortable as a family with them. It

reinforces the social status and self-esteem of the child and leads to adoption of a unique ideology that becomes the part of the identity. At this point, it is important to form genuine relationships and avoid forming superficial social bonds.

(3) ***Connectedness***: This aspect continues to develop throughout adult life. The space, people, and the group that the person actually belongs to become clear and he starts setting boundaries and demarcating them with clarity. The absence of connectedness leads to feelings of isolation and detachment from the surroundings. The extreme end of this dimension makes the individual lead a solitary life.

Attachment: Attachment is an emotional bond that connects one human being to another. It focuses on the one-to-one relationship between two people. This relationship lays the foundation of all adult relationships. This is closer to the companionship aspect of the sense of belongingness.

Loneliness: When one experiences deficiency in social relationships and it has a negative valence associated with it, it results in loneliness. This construct is actually the lack of belongingness and is based on a situation as compared to belongingness that may be developmental nature.

Perceived Social Support: Social support refers to the social resources available in our surroundings that an individual may depend on. Here the focus is different. In perceived social support, the focus is on the deficiencies in the social environment whereas in belongingness the deficiency lies within the person.

Thwarted Belongingness: According to Interpersonal Theory of Suicide, thwarted belongingness is a painful mental state when the fundamental motive of need to belong remains deficient.

Perceived burdensomeness: According to Interpersonal Theory of Suicide, is a "mental state characterized by apperceptions that others would 'be better off if I were gone,' which manifests when the need for social competence that is posited by frameworks" including self-determination theory is unmet.

Mental Health and Belongingness

Human beings have different needs that drive them toward practicing a particular behavior. The set of needs may be universal but the degree to which each of them exists in an individual varies from person to person. According to McClleland, there are three needs that drive the behavior. These are (1) need for achievement, (2) need for affiliation, and (3) need for power. All these exist in certain combinations. A basic fulfillment of each of them is required for a person to feel comfortable and satisfied in the environment. Of these, need for affiliation directly relates to belongingness, where the person seeks approval of the significant others to function at the optimum level, mentally as well as physically. In this section, we discuss the constantly combined

mental health aspects that go hand in hand with the fulfillment as well as fulfillment of need for affiliation. These are anxiety, depression, life satisfaction, and self-esteem.

Anxiety

Anxiety is an emotion that is important for survival. The bodily changes that accompany this emotion prepare us to anticipate and deal with emergency situations thus safeguards our mental and physical self. Assessment of any situation as a threat is subjective in nature. Feelings of nervousness and worrying are all a part of anxiety. Excessive indulgence in this emotion is harmful to the self. Sense of belongingness has been observed so as to be related to the management of this emotion. Social support actually creates a safe haven around an individual resulting in decreased intensity of anxiety. This is especially true for adolescents, young adults, and the elderly. For example, for students, belongingness creates the feeling of a safe environment in a classroom that facilitates better engagement in their respective lessons. It also fosters optimism and hope in them increasing their resilience and thus aiding in effective management of anxiety that generally is a part of academic stress (Hood & Antonelli, 2020). Creating an identity for self is very important in adolescence. An individual at this stage has an ambivalent relationship with his social surroundings. Excessive preoccupation with self-image and constant need for approval from others may result in social anxiety. There are direct as well as indirect effects of belongingness on this type of anxiety. Positive peer connections that include school belongingness, number of friends, experience of victimization, and peer affiliation as well as social comparison help in keeping the social anxiety at a minimal level (Rapee et al., 2020). Increasing sense of belongingness can further help in managing already existing anxiety problems as well. For example, Shalka and Leal (2020) conducted a study to explore the differences in sense of belonging between students who identify as having PTSD and those who do not. It was observed that the students with PTSD did experience less of belongingness but support from staff, clinicians, and other students in the campus can help in mitigating the associated emotions. Interpersonal needs become important in the context of attachment anxiety and depressive symptoms. Perceived belongingness and perceived burdensome mediate the relationship between these two variables (Øverup et al., 2017). Even during an uncertain event and a situation of crisis, belongingness can help in managing anxiety. In order to study the mental health consequences of coronavirus pandemic (COVID-19) in Spain, an exploratory study revealed that loneliness emerges to be a strongest predictor of depression, anxiety, and Post-traumatic Disorder (González-Sanguino et al., 2020). Thus psychological support to control the experience of loneliness is imperative during these times. Anxiety and belongingness thus have a reciprocal relationship. In situations where sense of belongingness is low, probability of anxiety is high. In turn, the pre-existing anxiety in an individual can be balanced by improving the sense of belongingness in accordance with the context and surroundings of the individual.

Depression

Depression is a mood disorder that negatively impacts us cognitively, affectively, and behaviorally. There is a constant, but unexplained feeling of melancholy and loss of interest in the activities that are important or used to give pleasure earlier. Some other symptoms of depression include:

- Changes in appetite
- Pervasive experience of fatigue
- Feelings of worthlessness
- Difficulty in paying attention to even simplest of tasks
- Suicidal ideation.

It is normal to feel sad when there is a grieving situation around us. The painful feelings are intermittent in nature during this time. During a depressive episode, these feelings are constantly there and are present for a minimum of two weeks without much reduction in their intensity. Etiology of depression is varied but a sense of belongingness has been observed to mediate many of them. Starting from the family, when there is discrepancy between family values and performance of an individual, interpersonal shame is experienced. This in turn affects the level of thwarted belongingness and perceived burdensomeness that has negative outcomes for incidences of future depression. Thus, those students who experience reduced sense of belongingness in their family are vulnerable to depression (Carrera & Wei, 2017). Belongingness is also increasingly considered as an effective strategy in practice of suicide intervention. There is a clear interdependence between depression symptoms and sense of belongingness with a clear contribution to acquired capability of suicide (Wang et al., 2020). Not only, family social support, but peer social support is also of significance here. In a study conducted to understand the mediating effect of self-reported social support on the association between disclosure of suicide attempt and suicide risk factors in a sample of undergraduate college students, it was concluded that a combination of family and peer social support results in better perception of overall social support and it also aids in disclosure of suicide attempts reducing the risk of future suicide attempts (McClay et al., 2020). The protective factors for depression are also related to sense of belongingness. Prevention and intervention strategies among college students need to include enhancement of Emotional quotients. This effectively manages the level of perceived rejection and facilitates better well-being among them as belongingness partially mediates the effects of EQ (Moeller et al., 2020). The relationship has been observed to exist across different populations. Though a huge literature concentrates on adolescents and youth, other populations have also been considered. For example, the depression emerges out to be a serious mental health issue among bisexual women. The sense of belongingness needs to be improved both in the LGBTQ community as well as in the heterosexual community, as they are often evaluated negatively, for reduced depressive symptoms (McLaren & Castillo, 2020). In military veterans with depression histories, as well the level of perceived burdensomeness, family support, and peer support emerged to

be strong determinants of suicidality (Bell et al., 2018). In geriatric population, death ideation has been consistently observed. This also has been significantly associated with presence of depressive symptoms and is influenced by perceived burdensomeness. The research also suggests that loneliness is an important factor to be assessed while studying death ideation in older adults (Guidry & Cukrowicz, 2016). From this discussion, it is clear that the relationship between belongingness and depression is strong and needs to be considered while formulating the prevention, intervention, and skill development modules for reducing depression.

Life Satisfaction

Life satisfaction is the individual's overall perception and feelings about one's life. It has been defined as "*the degree to which a person positively evaluates the overall quality of his/her life as a whole. In other words, how much the person likes the life he/she leads"* (Veenhoven, 1996). Life satisfaction is a more pervasive and stable concept than happiness and it is an umbrella term that further constitutes of many other factors. It is subjective in nature. Thus it becomes important to determine its predictors that can be worked for enhancement of life satisfaction. When it comes to a sense of belongingness and life satisfaction, much domain-specific research has been carried out. For example, it was observed that to facilitate better life satisfaction among students, there needs to be an understanding between variables like parental involvement, sense of fairness and school belongingness (Datu & Valdez, 2019). The relationship with family is the first foundation of belongingness a person experiences. Thus many studies have explored different aspects of the same. Secure attachment style propagated in childhood directly affects belongingness and indirectly affects life satisfaction. Both the variables are significant predictors of life satisfaction in adolescents (Çikrikçi & Gençdoğan, 2017). Also to designate a causal model of life satisfaction, a Canadian study showed that interaction with neighborhood, social contact, time with family and friends and greater sense of belonging to community had more positive outcomes for life satisfaction. Thus life satisfaction needs to be understood more holistically than the present scenario (Branch-Allen & Jayachandran, 2016). Peer support and intimate relationships in this context are strong predictors of life satisfaction. The intensity of such relationships (measured by the frequency with which an individual meets their friends) and the quality have been observed to be positively associated with life satisfaction (Amati et al., 2018). The pervasive nature of life satisfaction also needs to be taken into view. Thus longitudinal studies have been conducted to understand different factors contributing to the same. For example, Nie et al. (2019) conducted a 12-month long study for understanding children's life satisfaction. Family dysfunction and loneliness experienced by the children were shown to have important implications for life satisfaction experienced and both need to be considered when designing intervention strategies to understand the same. Sense of belongingness in a community is also related to the experience of life satisfaction (Guzmán et al., 2019). Hence community environment

and the way people get enmeshed into it have benefits at the individual as well as the group level. Work is a very important part of an individual's life. There have been very few studies exploring sense of belongingness at work and life satisfaction. A study based on the self-determination theory showed that belongingness and psychological empowerment moderated the relationship between passion and work satisfaction (Pathak & Shrivastava, 2020). Thus belongingness to a place, group, and other contexts helps in improving the life satisfaction experienced by people.

Self-Esteem

Ostracism is one of the most painful experiences in society. That is the reason that need to belong is considered as one of the most basic motives for human survival. An individual is considered to be his or her essence only in relation to a society. These experiences with the environment not only shape the different relationships around but also are essential to become more aware about self. Thus the relational values kept on different relationships have their consequences on the health of an individual at physical, psychological, and social level. Taking this stand, the sociometer model of self-esteem was developed where it was theorized that the level of self-esteem experienced by an individual is actually a parameter that measures the social acceptance with different societal agents like friendships, communities, instrumental coalitions, mating relationships, and kin relationships (Fig. 5.2).

According to this theory, any person engages in scanning the social environment for a minimal level of acceptance from the same. Initially, the importance of these

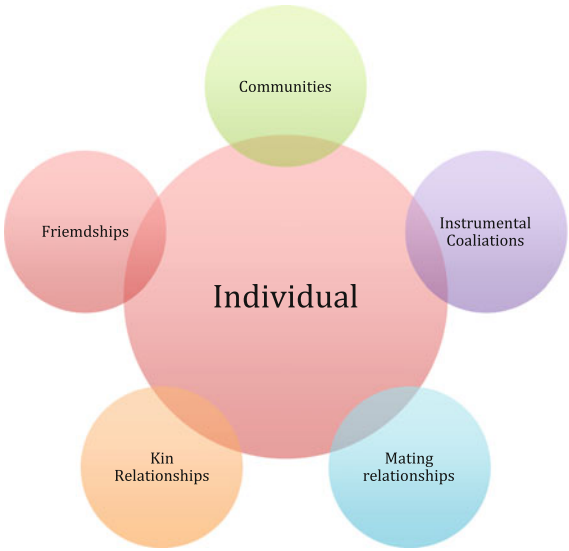


Fig. 5.2 Social agents from which an individual derives self-esteem

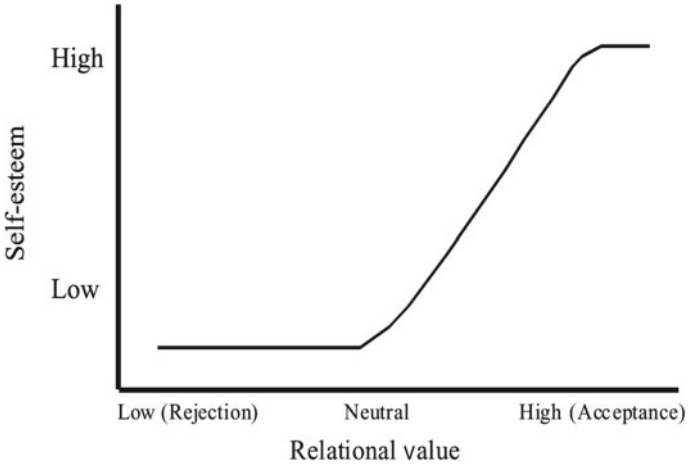


Fig. 5.3 Curvilinear relationship between self-esteem and relational value. *Source* Leary (2005)

significant others does not matter. For example, a new student in his classroom will attempt to get accepted or at least try to exhibit behaviors that do not create animosity between him and his new classmates. Sociometer theory says that interpersonal threats are essential to be detected and this process works at an unconscious level. Hence our behaviors are automatically tuned to seek approval from others as well as avoid rejection. This perspective advocates that self-esteem in itself does not hold any value for the individual. It is actually a product of belongingness and relational value that he or she experiences in his social environment. The level of self-esteem is an important parameter to gauge the changes in the social environment and thus act in accordance to it. We thus perform behaviors that get us accepted in the environment raising our self-esteem. Performing philanthropic actions and engaging in socially desirable behaviors is the most prominent testimony to the sociometer theory.

There are certain people who say that they remain unaffected by the opinion of other people and thus their self-esteem is largely independent of this relational value. Leary and colleagues conducted two experiments to discern the same. In Experiment 1, the participants were asked certain questions about how strongly they feel that their self-esteem is unaffected by the opinion of others. For Experiment 2, participants who scored higher on this aspect were selected and then divided into two groups. The participants were then required to talk about themselves on the intercom for five minutes. All got fictional feedback on this in terms of interest to know them further. One group of participants was rated higher than the other group of participants. They were all then measured for their self-esteem. The results showed that even though these participants had pre-existing belief that they are unaffected by opinions of other people, the approval and disapproval showed significant effects on their self-esteem. Approval led to higher self-esteem than disapproval. According to Leary, self-esteem and relational value have a curvilinear relationship. As demonstrated in

Fig. 5.3, interpersonal relationships are thus important for the overall well-being of an individual (Leary, 2005). There are other studies that have shown similar results.

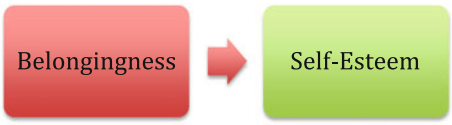
Gailliot and Baumiester (2007) conducted a study to understand the contribution of belongingness to self-esteem. They made the participants write about their social acceptance and social rejection. It was observed that participants showed higher self-esteem while writing about social acceptance than social rejection. Even though acceptance may have certain components of rejection as well, this was a better parameter of high self-esteem especially with people experiencing high social anxiety.

Similarly, a study with 263 adolescents examined the effects of general belongingness and basic psychological needs on self-esteem. The results of the study showed that there are significant relationships between all these variables and general belongingness was a significant predictor of self-esteem (Demirtas et al., 2017).

There are other viewpoints as well on the relationship between these two variables. Some studies say that it is the self-esteem of the individual that gets to decide the level of belongingness that an individual enjoys in his social environment. One such view is the personal agency perspective. It advocates that the personality traits of a person lead him on to choose a particular type of social environment. Thus, people who are high on self-esteem will choose a socially rich environment and naturally feel a sense of belongingness. In adolescents it is seen as a self-regulating trait that looks upon various other traits. According to Erikson, it is the period of identity formation. A person has multiple identities of which social identity forms a very important part. So adolescents actually operationalize the decisions to be a part of a group or community that they want to be associated with. This gives them a sense of satisfaction with self which then gets internalized as the association continues (Perrins et al., 2018). Still there are other perspectives that say self-esteem and belongingness are two independent variables that work together to produce certain effects. For example, Haug (2018) conducted a study to understand the protective factors against psychological distress. Using Minority stress theory, they conceptualized the distress experienced by the LGBT community in a University setup. They found that self-esteem and belongingness work together as protective factors in order to combat the psychological distress endured by them.

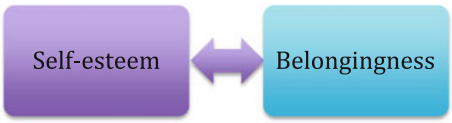
From the above discussion, three important scenarios emerge in case of self-esteem and sense of belongingness:

(1) Belongingness is the determining factor of Self-esteem.



(2) Self-esteem of an individual determines the level of Belongingness experienced.

(3) Self-esteem and belongingness work in tandem with each other and affect other psychological variables.



Social Capital

We have many people around us. Some we consider as friends, some are acquaintances, some are family and others are strangers. The degree of our relationship is different with each of these social agents. All of them cannot be considered as our support or a resource for us. Thus, social capital refers to the resources in the social environment that are accessible through the social networks of an individual or a group. When this capital is available within the groups that have similar characteristics, it is called bonding social capital. When the same is accessible across different groups who are varied in terms of their socio-economic status or demographic variables, then they come in the category of bridging social capital. In an institution with a structure and hierarchy, the connections formed are based on obedience, conformity, and rules. But this process eventually transforms into respect and trust among the people. Access to such a capital is called the linking capital. Each of these capitals depicts different degrees of sense of belongingness and the purpose behind each of them is different. But a threshold level of access to all of them is of essence. Social capital has been mainly studied through two approaches:

- **Cognitive Approach**: Cognitive approach to understand social capital was propounded by Robert Putnam. These are based on belief systems relating to trust, reciprocity, and support. The general trust that an individual has in social surroundings is called "thin trust" and is related to the general personality trait of the individual whereas trust that is shown by the individual in his intimate relationships is referred to as "thick trust." This depends on the connectedness and belongingness that an individual experiences in the particular relationship.

- **Cohesion Approach**: Social cohesion depicts how closely knit are the individuals together in the social surroundings. A cohesive group is homogeneous and has the least amount of differences. They have similar goals and everyone works in harmony with each other here. One may say that a sense of belongingness is very strong in a cohesive group. Two hallmarks of this construct are minimal presence of estranged relationships and maximum presence of well-connected people. Social capital can be made better by emphasizing cohesion. Such a group would be ready to engage in collective action, show unity in the face of crisis, and will be successful in formulating and implementing the social norms.

According to Lin (2001), social resources are different from personal resources. This results from the actions of an individual in his/her social environment. Thus the degree and intensity of the relationship that is exhibited decides the availability of these resources to the individual. Another parameter that comes within the purview of social resources is the social identity that a person enjoys. This comes from the degree of belongingness experienced within the group. Psychosocial resources on the other hand are a mix of personality traits and environmental factors that includes optimism, coping style, and social support. The likelihood that a particular social capital may be mobilized in the times of need and want depends on the type of ties an individual has with the same. More often than not, strong ties with the social capital increase the probability of it being readily available. Weak ties are used for information propagation and transmission through various means across distances. "Closeness" experienced in a relationship and the social role that an individual has in his environment are the strongest indicators of the type of ties an individual has with the group. According to Nahapiet and Ghoshal (1989), social capital has three dimensions: structural dimension that includes the network ties and organization, cognitive dimension, and the relational dimension as shown in Fig. 5.4.

The Social Capital benchmark study gave four categories of Social Capital. These are

(1) **Social Trust**: Social trust has been conceptualized as the trustworthiness with which a person generally views his surroundings. The measures used to look at this construct include trust at public places like malls and places of worship, trusting other people and coworkers to be honest and loyal, reduced suspiciousness in the surroundings and showing trust toward the law maintaining agencies of the society.

(2) **Formal Membership and Group Participation**: The membership of different organizations also gives access to different types of social capital. These include memberships with NGOs, clubs, religious groups, and frequency of participation in these activities of these organizations as well.

(3) **Altruism**: The participation in the society at large for the good of the people around helps in creating a good social capital. Altruistic acts are generally responded with reciprocity. Civic participation, civic volunteerism, media engagement, performing philanthropic acts, and political participation all are a part of altruistic acts.

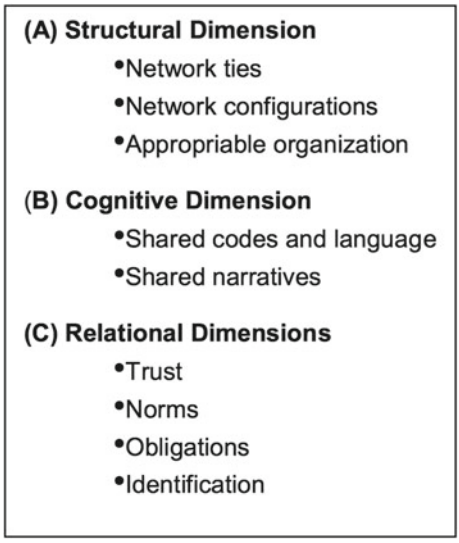


Fig. 5.4 Dimensions of social capital. *Source* Ali-Hassan (2009)

(4) **Informal Interaction among the Individuals**: The interaction with the environment facilitates higher quality social capital. The important measurement points here include the degree of community ties, industrial clusters, informal interactions, social interactions, social networking, social network biodiversity, social support, and social ties.

Technology and Belongingness

People have attempted to fulfill the need of belongingness through use of technology as well. Social media has given an easy platform of interaction and communication that keeps pace with changing society but also is successful in addressing the fundamental needs and motives of human beings. Most of the people today, across various age groups, are familiar with and acquainted with social networking sites and have an account on at least one of these platforms. People cherish this type of networking and actively participate in all the endeavors. Though there are many benefits, in the context of belongingness following points are significant:

- Social media has been recently used to demonstrate unity and togetherness in many cases. The anonymity that this platform provides has paved the way for expressing opinions without the hesitation or fear of being judged by others.
- It has helped people in establishing connections with those people who were lost in space and time. For example, there are many groups on WhatsApp and Facebook that have friends and acquaintances from school and colleges for adults who have already reached middle and late adulthood.

- During pandemic times, it has helped tremendously in keeping intimate relationships intact. For example, group video calls on WhatsApp and google meet have allowed people to see loved ones who might be in different time and geographical zones as well.
- It facilitates easy belonging to multiple groups and communication with them at the same time. For example, a person might communicate in the family and friends and work group simultaneously with ease and investment of a minimum amount of resources.

Self-esteem is very largely dependent on the type of relationships that are there around an individual. According to sociometer theory of self-esteem, the quality of these relationships shapes the esteem in such a way that the person feels a sense of belongingness to his surroundings and thus truly valued. Social media has aided in increasing this relational value in every sector (Fig. 5.5).

As discussed earlier, social media is an easy platform to form relationships without actually investing resources. It has been demonstrated that those who may experience low levels of belongingness, use applications like Facebook to compensate and thus feel a sense of belongingness. Higher is the intensity of its use, lower may be the sense of belongingness experienced in the real world (Tras et al., 2019). When the users of these platforms have weak social ties offline, they are more vulnerable victims of cybercrimes (Kaakinen et al., 2018). Gao et al. (2017) conducted a study to understand the effect of sense of belongingness on the social networking sites (SNS) addiction. They based their conceptual framework on the belongingness

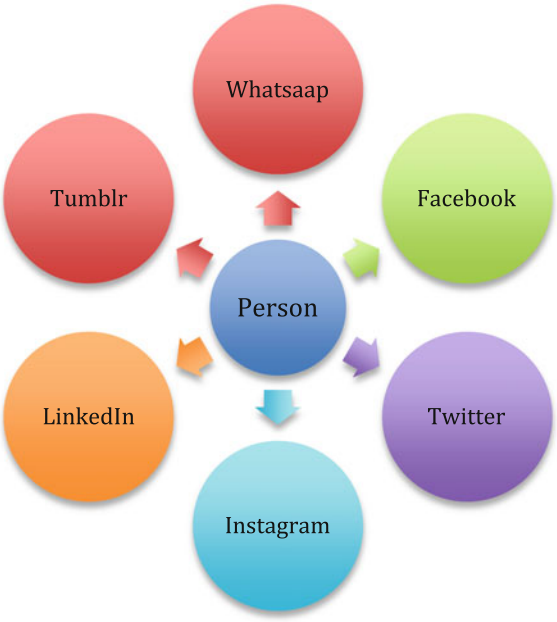


Fig. 5.5 Positive relational value that a person derives from different social media

theory and empirically tested it on 278 SNS users in China. The results showed that social presence had a positive impact on sense of belongingness and enjoyment. Sense of belongingness showed positive associations with enjoyment, pleasure, and arousal but not with SNS addiction. This construct thus may become a mediating variable for SNS addiction and thus usage of SNS needs to be closely monitored. There are similar studies that express this addiction as a form of Obsessive–Compulsive Disorder. It is mainly termed as Online Social Networking (OSN) OCD. The researchers explored the relationship between OSN belongingness and OSN OCD. They looked upon the positive as well the negative effect that OSN usage has on belongingness. It was observed that belonging to an online social network satisfied the need of purposive value, self-discovery, maintaining interpersonal interconnectivity, social enhancement, and entertainment value. But when the same platform, if used for fulfilling only purposive value and social enhancement, may lead to OSN OCD. Thus, one should refrain from engaging in unhealthy socialization to mitigate the risk of the same (James et al., 2017).

Apart from social media, other types of technology have also ensured smooth running of different communities that are important to foster a sense of belongingness in people especially during the COVID-19 crisis. For example, conduction of online classrooms, organizing workshops and conferences, posting real-time videos of religious institutions, conduction of various official meetings following the norms of social distancing, etc. has become feasible because of huge improvement in the available technology in the environment. In addition, periodic studies ensure that these platforms become better to address the different needs of an individual. Conducting online classes has been a challenge for many schools with teachers and school authority putting in special efforts to streamline the lessons into this new system. School belongingness is an important part of the identity formation process of any student. Hence there is a requirement of enhancing the same. The inability to use physical proximity as an important resource poses its own challenges. Some of them are as follows:

- Ensuring a normal classroom environment
- Promoting classroom engagement
- Facilitating attention of the students
- Designing group work in the online platforms
- Promoting positive student–teacher relationship as well student–student relationship.

Sense of belonging improves and enhances the experience of learning and makes sure the learner perseveres in the journey of knowledge attainment. Thus the engagement in the classroom, the culture of learning, and the perceived support in the classrooms are of prime importance during the online teaching and learning (Peacock et al., 2020).

Ostracism

The deliberate exclusion of an individual or a group of individuals from the society is called ostracism. Ostracism is not the opposite of belongingness. Here the society is not willing to accept the people in question as a part of their community. The functional value of ostracism is that it makes the group more cohesive and comprehensive. It is painful to the person who is treated in such a way. Although there is a lot of research spread across various cultures and populations on ostracism, seminal work has been done by KD Williams. He postulated the model of ostracism and gas described in detail about the various stages of ostracism. This model describes appropriately as to how one reacts, appraises, and hence copes with the episodes of ostracism. According to this model, there are three stages of ostracism (1) reflexive stage, (2) reflective stage, and (3) resignation stage (Fig. 5.6).

Reflexive Stage

This stage includes the initial reaction of the person when he faces ostracism. This is accompanied by changes in both the physical self and psychological self. Physically, there has been observation in the different changes in the brain. As ostracism is perceived mostly as a threat, there is increased blood flow and arterial constriction. There is a significant increase in the blood pressure as well as the cortisol level in the body. Cortisol is a hormone secreted during emergencies and deals with the

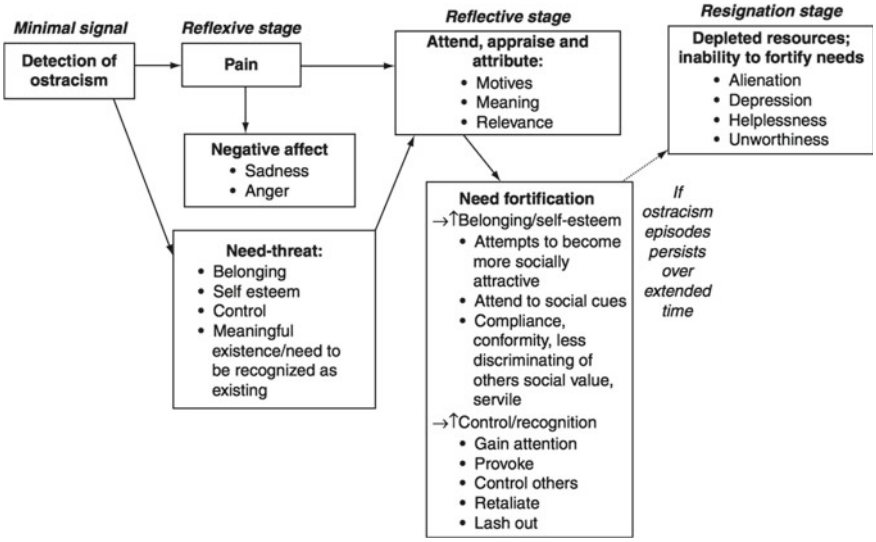


Fig. 5.6 Ostracism: a temporal need-threat model

stressor present in the environment. Also, there is an increased activation in the dorsal anterior cingulate cortex which generally is the region of the brain responsive to physical pain. This is observed in the case of both intentional and unintentional ostracism. In certain other studies activities have also been observed in amygdala while experiencing ostracism. Psychologically, ostracism paves way for experiencing emotions like sadness, anger, and other esteem factors. It also increases the feelings of hurt and pain. Activation of these emotions compels the individuals to report higher levels of self-reported distress when compared to individuals who do not face ostracism. The immediate response to ostracism is that of pain and distress and they can be seldom moderated by individual or situational factors.

Reflective Stage

In the reflective stage, the individual begins to appraise the ostracism episode cognitively and tries to formulate a plan of action for dealing with the same. This stage is one of the major challenges for the researchers to understand and work on. The process undergone in this stage actually decides the behavioral outcomes a person will adopt in response to the ostracism experienced. There are four major responses here:

- **Fight**: Rejection sensitivity is an important trait that is generally considered when one is trying to understand the action plan for countering ostracism. Those who are high on this dimension may either use fight or flight response toward the same. People who employ this response may become aggressive and tend to deny the episode altogether. They may try to dominate the agreeableness of the people around them. Jealousy is one other emotion that may promote fight response in ostracism. People may also respond with derogatory responses to others in tandem with their rejection sensitivity.
- **Flight**: In the flight responses, the individual tries to avoid the social situation altogether. Rejection sensitivity is high for these people as well. But here fear of rejection makes them turn away from the situation because they want to safeguard their self-esteem and do not want to take any further risks. People adopting this style of response are more prone to experiencing perceived burdensomeness.
- **Tend-to-befriend**: Those who are low on rejection sensitivity can respond to ostracism through "Tend to Befriend." They would be positive toward people and try to please them in all possible manners so that they are reintegrated into the group and the societal system. They are agreeable and trust others to see their efforts. They are open to all types of social information and are sensitive to both verbal and non-verbal cues of the people around them.
- **Freeze**: Sometimes people react to ostracism with a numbness that is evident in all their behaviors. This may be due to their inability to accept the situation, dearth of resources to cope with the situation or the inexperience of tolerating such situations.

Self-esteem emerges about to be a very important determinant of the reaction a person would choose in the scenario of ostracism. Those with high self-esteem generally have positive expectations about the future. Hence, they would try to reintegrate themselves into the society. Those with low self-esteem, generally, have bleak expectations about their future. They would turn away and avoid the society altogether in the face of ostracism.

Another explanation for choosing a particular mode of response relates to the effect that ostracism has on our fundamental motives. There are four fundamental motives that have been shown to have connection to ostracism:

- Need to belong
- Need to manage and regulate Self-esteem
- Need to regulate Personal control over the environment
- Need to a meaningful existence.

The situation might be universal but each individual reacts to them in accordance with the motive that is threatened by the ostracism episode. According to the need fortification hypothesis, when ostracism harms the personal control and meaningful existence paradigm (power and provocation cluster), it usually results in aggression and fight response. The antisocial behavior is an easy way to gain attention and exert and establish dominance in the surroundings. When need to belong and esteem needs are threatened (inclusionary need cluster), then there are positive efforts from the individual to restore the equilibrium that has been disturbed by the ostracism episode and establish harmony in the surroundings. The acts are pro-social in nature and benefit people in the social surroundings. But care needs to be taken so that these people do not further become vulnerable and become victims of manipulation.

Resignation Stage

When the individual has completely depleted his repertoire of resources to cope with being excluded from the group, it results in resignation. This stage is characterized by negative effects with constant feelings of alienation, depression, hopelessness, and unworthiness. This happens when the ostracism episode persists over a period of time. Some manifestations of this stage include:

- **Cognitive Deconstruction**: People become numbed at this stage. They do not show any reaction and resign themselves to their present situation.
- **Lack of Self-regulation**: The activities that keep us engaged in our surroundings cease to exist. A person is not able to show an optimum level of interest in his activities of daily living and thus shows low self-regulation.

- **Decrease Resilience**: At this stage, the person has already exhausted the resources to combat and endure the stress that ostracism has induced in him. People enter a cycle of learned helplessness which makes them vulnerable. This significantly reduces their resilience. Long-term ostracism may also lead to suicidal ideation and suicide attempts as well.

Politics of Belongingness

When belonging becomes the basis for assigning boundaries, both social and spatial, it is termed as politics of belonging. It generally involves a component of conflict among the groups having a similar sense of belonging. According to Yuval-Davis (2011), "The politics of belonging comprise specific political projects aimed at constructing belonging to particular collectivity which are themselves being constructed in these projects in very specific ways and in very specific boundaries." Politics of belongingness thrives on concepts like focusing on collectivism and collective self-esteem. Certain social issues are so close to the identity of people that they cannot refrain from engaging in such conflicts. According to Eva Youkhana (2015), "The politics of belonging are the political arenas related to different notions of belonging, be they ethnic, national, cultural, and/or religious, or cosmopolitan." Some examples of such conflicts are as follows:

- **The Case of Ayodhya Ram Mandir-Babri Masjid**: This case witnessed conflict between two groups of ideologies where each group believed that they were right and advocated in a staunch manner for proving their group right.
- **The Israeli-Palestinian Conflict** : This is considered to be one of the oldest conflicts which still persist. Mainly this conflict is between Jewish Zionist project and Palestinian National project over the land that both claims is theirs respectively. Both the groups are fighting for establishing the identity of their group through this political issue.
- **Capitalism versus Socialism**: Capitalism is the ideology that the economic and political powers rest with the private owners rather than with the Government. Here the resources remain with a small group of people. Socialism on the other hand advocates that the resources of a nation should be owned by the community as a whole and everybody should be treated equally. Both the ideologies get support and thus it creates an opportunity of conflict between two groups of people who show strong belongingness to their communities, respectively.

Social Distancing

Belongingness is a fundamental need of human existence. Till now, physical proximity and frequent contacts with the environment were needed to fulfill this need. But now a pandemic has changed the mode and face of this need. COVID-19 has

made social distancing a reality in the present scenario. The belongingness hypothesis seems to have been compromised and a new ethos needs to be established to fulfill this need. But any modification needs time to be internalized and implemented. The transition phase is tough especially for people who thrive on physical proximity, people gatherings and celebrating togetherness. Whether it be work, leisure, or obligations, all areas of human functioning that are based on the foundation of belongingness and working together have been affected This change has forced many people to experience social isolation and loneliness. "Pulling apart" effects can be seen in different communities. According to Durkheim, hazardous events that cause social distancing can result in mental health problems and suicides. To understand the trajectory of various psychological processes in reference to social connectedness, many studies are being brought into force. For example, in an exploratory to understand the motivations of the youth to follow the rules of social distancing, 683 adolescents participated via social media. The observations were interesting as the majority of them showed pro-social motivations to follow social distancing. This included social responsibility and not wanting others to get sick. These behaviors were found to be associated with adolescents' anxiety symptoms, depressive symptoms, burdensomeness, and belongingness (Oosterhoff et al., 2020). Thus social distancing can be made compulsory and implemented appealing to these motivations of the youth. Enhancement of sense of belongingness and designing intervention including the same can actually help in fighting against this pandemic and reducing its spread and transmission. Another psychologically vulnerable population during this crisis is the geriatric population. Their social connectedness is limited because of their physical limitations as well. Thus there needs to be an intervention in place that may take care of their needs. Conwell et al. (2021) conducted an experimental study to promote social connection in the elderly using a cognitive-behavioral model. An intervention based on this perspective concentrates on modifying three aspects of an individual about a particular task. These are at the thought, affect, and the behavioral level. This model ensures that changes brought with the intervention are long-term and are relatively stable across time if practiced in its true spirit. They devised a "connection plan" based on the model of safety plan generally used with patients who are at risk for suicide. It is a versatile plan that may adapt itself to a myriad of settings. They have also provided case examples that help to understand the connection plan and the associated strategy in a better and functional way. This plan is helpful in promoting connectedness in the later life of an individual. One such example will be discussed here (Fig. 5.7).

The Case Example

This case is of elderly widowed man who has no children. His schedule included interacting with his neighbors' children and going to church using the taxi service. He was dependent for transportation because of a hip fracture and impaired vision. He did not have any other family members at his close disposal. Now because of

Fig. 5.7 Connection plan

social restrictions imposed due to COVID-19, he is not able to go to church. The church only posts videos of the Mass. Neighbors children cannot visit him frequently because of the safety concerns. He is having issues about spending most of the time alone at his house. His major concerns are as follows:

- Increased feelings of loneliness
- Fear that his existence may be forgotten altogether
- Feeling depressed and anxious
- Having trouble to distract him from the negative thoughts.
- Getting frustrated.

The solution of this problem requires a clinician to follow two important steps:

1. Identify the social obstacles in the elderly man's life
2. Devise new ways of social connections which are possible in the current scenario.

When a detailed discussion was initiated with him, following were the major problems observed:

- Feelings of being stagnant at a place because of lack of transportation
- Reduction in social gatherings as a result of social distancing.
- Preventing others from becoming a burden on others during this tough time (Table 5.1).

In tandem with the connection plan shown in figure and table, the clinician first identifies the thoughts, feelings, and actions that can be channelized to form new connections and then discusses with elderly gentleman to work upon. The negative

Table 5.1 A cognitive-behavioral intervention plan

Change your perspective		
Use these three prompts to change your perspective and use helpful self-talk	Engage in a mindfulness activity or prayer to connect with a sense of our shared humanity and that we are all in this together. Resources	Examine the evidence: write down your thought (e.g., no one cares about me) and list the evidence in support of that thought and the evidence that contradicts that thought
How can I view the situation from a different perspective?	Headspace app	
Think of someone optimistic whose opinion you highly value: how would they perceive the situation?	Tara Brach, Ph.D., Guided Meditation	
Remind yourself: Don't believe everything you think!		

Change your body sensations		
Practice noticing and tolerating feelings and body sensations instead of resisting them and pushing them away. Resources:	Soothe your body and mind	Change your temperature
Download the free pdf for "Tolerance for Uncertainty: A COVID-19 Workbook" (Dr. Sachiko Nagasawa)	Create pleasant sensations for your five senses: music, good smells, pet your dog/cat, and look at art, sips tea	Warm-up: take a warm bath, hold warm towels (right out of the dryer), or sip warm tea
	Calming activities: progressive muscle relaxation and guided imagery exercises	Cool down: splash your face with cold water or hold a cold pack (or ice cube)

Change your body sensations		
Change your actions—new ways to connect		

(continued)

Table 5.1 (continued)

Change your perspective		
Help others: write emails or letters and take care of pets	Connect with people in safe ways: provide (or receive) phone/video calls and remind yourself of good memories (e.g., photographs); call warm-lines for support	Do things that remind yourself of your connection with nature, a higher power, or our shared humanity: get fresh air, make art, listen to music, watch birds, and look at flowers

thoughts are replaced with more positive or neutral thoughts which subsequently results in a more positive self-talk.

Existing paradigms	New Paradigms
Thoughts	
" I am being Forgotten"	" My neighbors have not forgotten me"
" I am useless"	" They would appreciate spending time with me"
" I don't matter"	" I matter, but circumstances make it difficult for others"

The feelings of anxiety are addressed by practicing positive imagery and breathing techniques that have been taught as a part of the therapy. The positive imagery includes imagining a happy memory from the person's past accompanied with deep breathing. This exercise is practiced in the therapy session with the clinician first and then told to be practiced at home as well. It helps in conditioning the anxiety with the positive feelings that the imagery and the breathing bring about. For making new connections, he brings about some changes in his behavior and actions. These include taking initiative to call the church friends, learning how to set up video calls from the children of his neighbors and asking his church friends to check up on him once in a week. After reinforcing these actions during the therapy sessions, a follow up is conducted after two weeks. The gentleman now reports to be more confident and is able to help his neighbors by keeping their children engaged on video calls in useful activities like reading story books. Thus he feels more useful and mattered.

The Downside of Belongingness

Belongingness has been shown to have positive outcomes in multiple scenarios. But no construct exists without some side-effects. Belongingness is no different. We

discuss two downsides of belongingness in this section: (1) prejudice, (2) in-group and out-group bias.

(1) Prejudice: Prejudice is one of the most harmful attitudes that one may harbor against certain groups of people. The basis of this negative evaluation is a group membership. It is a premature assumption that colors our judgment when it comes to assessing people and may not be based on complete facts. Belonging to a particular community or society thus becomes the basis of such discrimination. There are two types of prejudice (1) implicit prejudice and (2) explicit prejudice. Implicit prejudice relates to the unconscious negative assessment and thus one is generally not aware of. The action emanating from this belief is not with the intention of harm to anyone. Explicit prejudice is the hostile attitude against a social group that is consciously held that may or may not be expressed. When one acts on the basis of these negative beliefs, it leads to various negative consequences, though the intensity of each action varies. These were listed down by Gordon W Allport and are as follows:

- **Antilocution**: Expressing one's prejudices verbally is called antilocution. This is a passive form of aggression that does not have immediate effects and may not translate into a full-ledged violence. It is natural that when a group of people, who have the same kind of opinion about a social group, come together, and discuss this topic and further strengthen their views on the same. But it may induce prejudice in people who earlier did not have such kinds of presumptions.
- **Avoidance**: In this type of action, any association with the members of the disliked group is avoided. Deliberately sitting at a different table, avoiding occupying residence in a particular geographical region, consciously refraining from friendly relationships, etc. are some of the actions performed. Though the act is on the part of the prejudiced individual, it gives distressing signals to the disliked group about not being accepted.
- **Discrimination**: Here the antagonism is expressed more actively. One makes conscious efforts to exclude the disliked group from his social surroundings. The acts are seen in various kinds of social settings like employment, educational institutions, professional, and recreational opportunities and breaching their fundamental rights. It is a clear and overt form of segregation that goes beyond the personal boundaries that are generally the limit in case of avoidance action. The burden of this action falls on the individual as well as his surroundings.
- **Physical Attack**: When the sentiments and emotions against a particular group of people are of extreme negative valence, it results in violence. Destroying property, looking for events to ridicule and humiliate the group, and depriving the said group from any privileges all are examples of the physical attack.
- **Extermination**: This is the most violent outcome of prejudice. An attempt is made to completely annihilate the disliked group from the surrounding. One of the most prominent examples of this is the holocaust that resulted in the large-scale massacre of Jews in Germany. Communal riots are another example of such acts.

Dasgupta (2004), in an exploratory study, observed that.

- First, individuals who belong to socially advantaged groups typically exhibit more implicit preference for their in-groups and bias against outgroups than do members of socially disadvantaged groups.
- Second, these implicit prejudices and stereotypes often influence people's judgments, decisions, and behaviors in subtle but pernicious ways
- Finally, a new line of research suggests that implicit biases exhibited by individuals who belong to socially disadvantaged groups toward their own group may have unintended behavioral consequences that are harmful to their in-group and themselves.

This brings us to the second downside of belongingness.

(2) In-group and Out-group Bias: The group that an individual belongs to identify with is called in-group and the group to which the person does not belong to is called an out-group. Forming an in-group bias has a neural basis as depicted in Fig. 5.8.

In each of the mediating processes, a different type of neural connection is involved (Molenberghs, 2013).

- *Social Categorization*: The medial prefrontal cortex
- *Action Perception*: Inferior parietal lobule, mu suppression, and motor-evoked potential
- *Empathy*: Cingulate cortex, Temporo-parietal junction, Prefrontal cortex
- *Face Perception*: Fusiform face area and amygdala.

The pioneer work in this field has been done by Henri Tajfel. He observed that when we segregate people on the basis of group membership, it leads to a tendency to favor members of their own group. This is called in-group favoritism. This may occur on the basis of non-essential things as well. Also, the positive traits of the in-group members are highlighted generally whereas the negative traits are talked

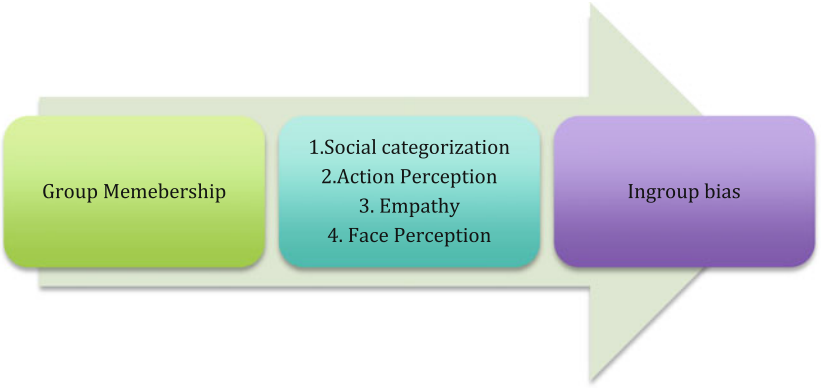


Fig. 5.8 The neural basis of forming in-group bias

out specifically. This helps in balancing the group image. This often leads to singling out of members harming different aspects of the social identity of the said individual. When people perceive the members of the other group in an unrealistically negative way, they are engaging in behaviors that are serving their group in one way or the other. This is known as the group serving bias. There are various reasons because of which people show in-group favoritism (Jhangiani et al., 2014):

- Gives one an easy way to categorize the social environment.
- Person experiences belongingness to the group.
- It helps us in enhancing our self-image through having a positive perception of our social environment.
- It is also practiced when our self-concept is jeopardized or is under some kind of threat.
- People who are high on authoritarianism and social dominance orientation practice it.

Sustainable Belongingness

In this chapter, we have seen various phases of belongingness. It has evolved from the concept of an individual need to a force that can actually change the way a society is functioning. It is observed that belongingness does promote and have positive outcomes:

- It is a crucial part of self-enhancement for an individual
- It occupies both physical and mental space of an individual
- It creates a network of protection for people by ensuring readily available resources at the easy disposal of a person.
- It helps in creating and sustaining harmony in the society.

At the same time, belongingness has certain negative outcomes as well.

- Exaggerated belongingness leads to creating false perceptions about self and others
- It can pave the way for conflict and rift between people.
- Belongingness sometimes gives an individual to escape responsibilities and thus compromises on the true potential of the individual.
- It can be capitalized by people who may not have positive intentions to motivate the same.

Conclusion

The above discussion highlights that there is a strong need to practice belongingness that creates a stable environment for both the individual and the society. It is important to determine the logical and objective basis of belongingness to the groups. Merging

of social locations should facilitate the flourishing of an individual rather than create confusion within the person. Thus, sustainable belongingness is when the positive outcomes of the concept outweigh the negative outcomes and hence ensures the protection of belongingness that each individual experiences within his community.

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Chapter 6
Play and Play Spaces for Global Health, Happiness, and Well-Being

P. Aneesh Kumar, S. Syama, Shalini Srinivasan, Shinto Thomas, and K. Alphonsa Jose

Abstract Play has a significant role in an individual's learning and holistic development. Play and recreation are a need and right. Research on play indicates that the significance of play is neglected among the current generation. Play spaces are shrinking, and physical play is becoming extinct in most communities. This current scenario may or have led to poor physical and mental health outcomes. The proposed book chapter aims to present play and play spaces in physical and mental health. The literature of play theories in child development shows the role of play in socio–emotional, physical, and cognitive development. The current paper brings together literature on play across the lifespan, highlighting how play and recreation impacts children, youth, adults, and older adults' physical and mental health. The change in lifestyle patterns has contributed to the neglect of play and recreation. The paper throws light on the need for the attention of professionals and policymakers for interventions and advocacy at both local and global levels in promoting play and preserving natural play spaces.

Keywords Play · Playspaces · Health · Well-being · Lifespan · Happiness

Introduction

> When you asked me what I did in school today, and I said, 'I just played.' Please don't misunderstand me. For you see, I am learning as I play. I am learning to enjoy and be successful in my work. Today I am a child, and my work is play.—(Wadley, 1974)

Children are constantly engaged in doing something, whether they are alone or in a group. They are always ready to play. Play is an essential aspect of development all through the lifespan. Play and recreation are right for every individual. Play is the potential platform to learn new skills and behavior. The place and situation do

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_6

not matter; children play indoors or outdoors, maybe in a school classroom or even around the living room. Sometimes they play alone, sometimes with their parents, family members, neighbors, or friends. Children make games and rules while playing. Quality playtime has a positive impact on overall development and well-being. Play enhances happiness and reduces health and mental health risks.

Play creates a medium for the children to interact with their environment and with others within the environment (Arthur et al., 1999; Bae, 2009). It helps create a space where parents engage fully with their children (Arthur et al., 1999). Play is an integral part of education and learning as well (Hyvönen, 2011; Isenberg & Quisenberry, 2002; Rautio & Winston, 2015; Wallerstedt & Pramling, 2012; Wood, 2009) where a child learns many concepts that are not formally taught in any education system or school. Through play, children develop various skills such as creativity, resilience, confidence, social, negotiation, problem solving, critical thinking, team management, group work, and self-advocacy (Isenberg & Quisenberry, 2002; Pramling Samuelsson & Johansson, 2006; Lillard et al., 2011). In addition to this, children learn about their emotions and how to handle them through playing. They experience joy when they feel happy with the play while feeling anxious and fearful during competitive play. Play also helps the individual to develop social relationships and provides an opportunity to create friendships.

Keeping in mind that children are a part of the vulnerable population in today's world, parents are afraid to allow their children to play freely, considering the impending dangers all around us. The increasing cases of child abuse are one such dangerous factor (e.g. Poddar & Mukherjee, 2020; SS Teo & Griffiths, 2020). Further, children are exposed to getting injured during the play, such as breaking bones, head injury, getting wounded, while some children end up disabled due to the injuries during play, and maybe death. The fast-paced and pressured lifestyles contribute to the vulnerabilities as well. At the same time, the SARS-CoV2 pandemic catalyzed it with the characters of staying home and social distancing, leaving children increasingly attracted to the virtual fantasy world (Wiederhold, 2020), which reduces real physical, social play. Neglecting physical play could create potential consequences in development.

What is Play?

Since play is of many types and forms, complex inside out, a single objective definition is not enough to explain all that it encompasses (Bodrova et al., 2013; Duncan & Tarulli, 2003; Garwood, 1982; Solnit, 1987). There are many definitions and categorizations of play. Jean Piaget, William James, Sigmund Freud, Carl Jung, and Lev Vygotsky have viewed play as integral to human development. Play can take the form of improvisation or pretense, interactive, performance, mimicry, games, sports, and thrill-seeking (Kenney, 2012; Rautio & Winston, 2015), such as extreme or dangerous sports (e.g., sky-diving and high-speed racing).

Play is defined as "a physical or mental activity that has no purpose or objective outside of pure enjoyment or amusement" (NCHPAD, 2004). Social play, free play, and mixed-age play are all found to play a role in developing a child's socio-emotional skills. The term "hunter-gather education" introduced by Peter Gray is crucial for a child's development. Hunter-gather education means playing outdoors in their neighborhood with the same age or different age-group peers (Gray, 2011a, b, c). Children instantly learn from other children, and they try to imitate them rather than older people. Children have a different idea of play when compared to adults (Nicholson, Shimpi, & Kurnik, 2014). Children can learn a lot while playing. Mixed-age play among older children would develop characteristics like leadership, parenting, and responsibility (Gray, 2011a, b, c). Mixed-age play has many benefits (Gray, 2011a, b, c), even more than same-age play. Consider this situation where a four-year-old child is playing with a two-year-old, then the four-year-old would learn how to care for little ones, and the elder one would teach the two-year-old; it could be a simple rhyme or how to play Peek-a-boo.

Recreation, play, leisure, and games are terms we have often used interchangeably, although there are slight differences between them based on the motivation and purpose that they serve for the individual. Research has also shown developmental benefits of positive experience of play, recreation, and leisure activities (Caldwell & Witt, 2011). Playfulness is a concept that can describe the extent of playful disposition in an individual, guided by internal motivation (Schwartz & Wrzesniewski, 2016), a typical process with self-imposed goals (Abuhamdeh & Csikszentmihalyi, 2012), and a tendency to attribute their meanings to objects or behavior (Barnett, 1991; Staempfli, 2007). Recreational activities are what individuals engage in when they perceive they are bored and have nothing else to do. Leisure activities have been described as positive ways individuals fill their free time (Caldwell & Witt, 2011).

History and Philosophy of Play

Evolutionary biologists who have studied animal play have identified that play is vitally important, as it allows the practice of essential skills for survival. The play has also been significant for the mental and physical health of animals and social development within species (Burghardt, 2014). Social interaction among mammals has been shown to influence the play (Bekoff, 1972). The research on the play behavior of mammals can be related to children. Beyond this basic science, the work of philosophers has enabled us to identify the significance of play in human life and understand how "play" is conceptualized in various ways in different contexts (Pellegrini et al., 2007).

Ancient philosophers like Plato considered play and leisure as essential, and that even Socratic dialogue includes playing as a medium to learn (Hunnicutt, 1990). Dewey believed that play without specific goals is not crucial (Makedon, 1993). The importance and need for play gained prominence over the years. Psychologists and educators give importance to play, and it is not separated from learning; it is a basic need of a child. Play is thought of very differently in some Asian philosophies. Play

in Hindu cosmologies—for example, as depicted in the ancient Sanskrit text, the Rig Veda—is much more integrated into the cosmos as a whole. In this worldview, play is not oppositional to the social order but a part of it. Thus, concepts of play are fundamentally different across cultures, and so is its complicated and puzzling nature.

Play—Cognitive, Social, and Emotional Development

Play is a child's natural medium for self-expression.—Virginia Axline

Axline points out that play acts as a robust foundation for children's holistic development and provides an effective medium to express, share, and most importantly, allow them to be a significantly active part of the world. Every human being strives for control over moments, experiences, and overall, in life. Children acquire sense of control, power, and choice through play.

Play is an essential aspect of development not only in childhood (Bodrova & Leong, 2005; Whitebread, Basilio, Kuvalja, & Verma, 2012) but throughout the lifespan (Benveniste, 1998; Raphael-Leff, 2012). Play impacts children's cognitive, social, emotional, and physical development across cultures (Sallis et al., 1997; Herrington & Brussoni, 2015; Goldstein, 2012; Isenberg & Quisenberry, 2002). The social and cognitive development of children who do not play enough is often low compared to those who play (Farmer-Dougan and Kaszuba, 1999). Children play in many ways. Most children play with their imaginary friends, and they create a fictional world. Pretend play, such as creating fantastical works, plays a role in developing a child's thinking capacity, understanding their surroundings, and building their perspectives (Bergen, 2002; Lillard et al., 2011). A child's emotions and managing emotions develop through play. A child would learn to express their feelings, like love, caring, helping during play. Also, the child would learn to manage emotions like anger and fear through play.

The social development of a child occurs through play. Playing with friends makes the child mold their socially desirable behaviors, control their emotions, and accept and understand others (Isenberg & Quisenberry, 2002). They learn many social behaviors from play. Playmates have an essential role in a child's social development (Hepler, 1997). As an infant plays with toys, parents, and caretakers, it learns attachment, caring, and friendship (Goldstein, 2012). Later the child goes to preschool and socializes with other children. Socialization would also impart the ability to bounce back from fights or arguments that may happen among peers (Jabborova & Umarova, 2020). Children also learn to appreciate others' points of view, learn to accept their failures, and celebrate other's victories. Play can thus act as a medium of connection between children.

Play has been long recognized as a critical aspect of childhood experiences and development (Hirsh-Pasek & Golinkoff, 2008; Hyvönen, 2011; Nitecki & Chung, 2013; Pramling Samuelsson & Johansson, 2006; Yelland, 2011). Some of the earliest

play studies in the 1890s by G. Stanley Hall sparked an interest in the child's development. This process of play influences the development of fine and gross motor skills (Butcher & Eaton, 1989; Dadkhah & Farahbod, 2004), language, socialization, personal awareness, emotional well-being, creativity, problem solving, and learning ability (Hyvönen, 2011; Pramling Samuelsson & Johansson, 2006). Play helps children be active, make choices, and master tasks in hand. Those who seldom play seem rigid and unresourceful in the face of stress or lose the healing capacity for humor. Play impacts sensorimotor, cognitive, and social development. Neuroscience research has uncovered essential links between role play and neurogenesis (Caillois, 2017).

Theories and Types of Play

American Psychologist Peter Gray looked at a variety of definitions of play and distilled them into five principles. And a few of those principles are that play is self-directed; we choose to play. And secondly, that play is intrinsically motivating. It is about the means and not the end outcome. Third, it is about involving our imaginations. It is asking ourselves the "as if" question. And so, play can be perceived as a social and cultural activity. It enables us to reflect on our social and cultural worlds, play with those worlds, and ultimately escape them when we need one (Hutt & Bhavnani, 1972).

Types of Play

1. Corinne Hutt (1979) was a British psychologist who identified three broad categories of play that provide a helpful framework for thinking about play.

There are many different types of play within these broad categories, such as

> Epistemic play—*Exploratory play in which knowledge of things is acquired*; Ludic play—*Play that draws on past experiences and includes symbolic and fantasy play*; and games with rules, including games of skill and chance (Hughes, 2002)

2. Bob Hughes, a British playworker, attempted to define 12 different play types. In reality, it might be challenging to identify some of these play types when observing a play episode. Also, a single play episode might demonstrate a number of these play types simultaneously. For instance, Hughes described symbolic play as a play where one thing represents something else or Rough and Tumble play involves physically active play like fighting or chasing. He categorizes play into socio-dramatic play, communication play, creative play, deep play, exploratory play, locomotor play, fantasy and imaginative play, mastery play, object play, and recapitulative play (Hughes, 2013).

Theories of Play

1. Classical play theories vs modern play theories: While classical play theories focus on the physical and intuitive aspects of play, modern play theories concentrate on children's psychological and emotional development and how it is influenced by play. Classical theories help develop physical and mental abilities that would be beneficial for children as adults. Modern theories help children express their emotions, manage stress, and create a sense of self through play (Burr et al., 2019; Fisher, 1992; Linsey & Cowell, 2003)
2. Vygotsky and Piaget have continuously emphasized the importance of play in a child's development (Bodrova et al., 2013; Garwood, 1982). One of Vygotsky's colleagues pointed out accurately that increasing instructions and control on play can tamper with the natural course of childhood development, as children will be expected to consistently mature prematurely (Broderick & Blewitt, 2015, p. 116).

Play allows children to build competencies and skills in a non-stressful and pleasurable way. Piaget stated that their cognitive structures need to be exercised and that play provides the perfect setting for this exercise. Vygotsky was exclusively interested in the symbolic and make-believe aspects of play (Kirkham et al., 2013). Language and communication skills may be enhanced through roles and rules in play (Andresen, 2005). It can benefit young children's literacy skills. A child needs to interact with peers, adults, and their environment to learn and grow. Piaget proposed that a dynamic interaction that allows assimilation and accommodation will lead to adapting behaviors, changes, and gaining new knowledge in context with prior knowledge.

Using play to relate to others is done in the following stages: *Engagement*—A child follows another and watches to express emotions; *two-way communication*—Responses by the child through gestures and expression of feelings; *Shared Meanings*—Use of words to describe and care-taking themes and familiar ways of acting; and *emotional thinking*—The child can differentiate what is real from what is not and starts more complex play.

Play spaces foster an interactive mode of learning which leads to cognitive development. Babies and younger children are in constant awe of their environment. They observe, babble, and stare. With relatively shorter attention spans, they take notice of newer stimuli and respond to them. In particular, children are more often than not always ready to play with anyone, anywhere, exploring themselves along with their environment in this process (Glenn et al., 2013). Play allows children to learn focus, problem solving, accommodation, cooperation, be creative, explore, and understand different points of view.

Impact of Play Across the Lifespan: Health, Happiness, and Well-Being

The meaning of play differs according to the age group, although the impact remains more or less the same across age. Play helps children release their energy and help them to develop physical, cognitive, social, and emotional skills. Play does not and need not stop at childhood. Play impacts an individual at all stages of life, both physically and cognitively, and helps foster growth and development.

Play enhances creative thinking through means of imagination, pleasure, and social understanding (Fredrickson, 2001). At the present moment, when one primarily spends most of their time in front of the screen, it limits the body from channelizing and burning stored energy; as opposed to playing outdoor games like football, hockey, tennis, swimming, and so on. Positive emotions like adjustability or patience may replace other negative feelings like irritation and frustration. The body starts weakening or becoming fragile after a certain age may be actual if seen physiologically. Individuals encounter obesity, blood pressure, diabetes, and the likes of physical conditions after a certain period (Farley et al., 2007). But cognitive functions have to be developed and maintained throughout the lifespan. Physical activity may help reduce distress and keep one physically agile, preventing contracting lifestyle disorders and fostering the individual's cognitive ability.

Infancy and Early Childhood

Infants and toddlers depend on mothers or primary caregivers for play. The first play space for infants and toddlers is considered as the home. Infants and toddlers play with their caregivers and toys and all the safe materials in the household. Primary caregivers have the responsibility to make a safe environment for the infant, play with them, give them the play materials, and help them sit and play (Pierce, 2000). Levin and Rosenquest (2001) discussed the importance of toys in infants' play. Toys are also a part of determining the quality of play. Pretend play increases creativity, imagination, and expression of feelings (Russ, 2003), and children can engage in pretend play through various mediums such as play dough, drawing or painting, dress up, or playing with dolls. Play using blocks, puzzles, and cards can help recognize the characteristic features of the objects and organize ideas and develop logic. Outdoor games, dance, and sports help to develop physical strength, flexibility, and coordination skills. Music and musical instruments help develop rhythm and musical skills ("Why play matters—Family Lives", n.d.)

Adolescents and Youth

Play is an activity for adolescents to engage physically and mentally without a specific objective. For example, quizzes, crossword puzzles, and sudoku help to improve knowledge. Treasure hunts enhance physical activity. Play is an entertainment and a platform for creative expression. Burr et al. (2019) reported that children gain motor skills and creativity (Taylor, Kuo, Spencer, & Blades, 2006; Woolley & Lowe, 2013) as well as learn risk management skills by engaging in risky outdoor play (Christensen & Mikkelsen, 2008).

Adolescents commonly face many emotional irregularities and thoughts during puberty. Play acts as a relief for emotional irregularity and to cope with stressful situations. Due to the drastic hormonal changes and imbalances occurring in the body, adolescents go through phases of identity confusion and thought fluctuations; play helps overcome adolescent issues, improve self-control, and manage emotions. Play and playfulness moderate adolescents' health and well-being in stressful situations (Augustine, & Kumar, 2016; Byrne & Mazanov, 2001; Harkness & Bundy, 2001 as cited in Staempfli, 2007). More interestingly, the type of playfulness demonstrated varied in different contexts; for example, in school, a structured setting play was different from leisure, unstructured setting (Liberman, 1975; as cited in Staempfli, 2007). The play activities that adolescents usually engage in are traditionally hobbies that they take up in their leisure time. Play can make influential contributions to human health and development.

Adulthood

Play is not just limited to children. It extends or plays a vital role throughout one's life. A common misconception of play is that it is only for children (Cohen, 2018). Usually, adults prefer to work rather than engage in play and recreational activities. In contrast, nowadays, workplaces promote play as there is evidence for the benefits of play in job satisfaction, productivity, and effectiveness. Workplaces conduct many recreational activities to reduce job stress. Play helps to reduce the stress releasing hormones and keep people healthy. The benefits of play in adulthood include stimulating creativity, uplifting mood, building interpersonal skills, increasing energy, and decreasing the risk of burnout (Guitard, Ferland, & Dutil, 2005; Yamamoto, 2021).

When one reaches adulthood, play can help maintain or boost energy levels, helps to relieve stress, and also helps with interpersonal interactions and bonds. Researchers state that play leads to the release of endorphins or happy hormones. It also helps in the secretion of substances which helps in the growth of brain cells. Adulthood consists of family, career, marriage, children, children's education, and many more. Looking after themselves would foster healthy growth as well as smoother transitions through stressful or demanding situations. As we grow older, we naturally spend less time on play. People are always busy with their job. They may not spend time with

their children or family members. The kind of fast life makes them frustrated. It is necessary to play at least once a week for adults. It would have many benefits for adults. Play makes them relaxed and healthy. The ability to plan their life, strategize, and organize various aspects of their tasks in life are specific skills essential for healthy functioning.

Play has equal relevance among adults. Playfulness has shown greater job satisfaction and increased work productivity among adults (Staempfli, 2007). Play helps to reduce stress among adults. Adults play with children and with other adults. There are varieties of games adults play like card and video games, chess, carroms, football, volleyball, cricket, badminton, and so on. Outdoor play increases physical activity and keeps them healthy. Playing with friends may help create a balance between personal and social life. It facilitates social interaction which is not related to familial or occupational tasks. Play is essential for the health and well-being of adults. Play is not an age-restricted activity and is relevant in all stages of life.

Older Adults

Games have a positive impact on older people. Play helps to reduce memory loss and improve cognitive skills. Kramer and Erickson (2007) found that short exercises prevent brain volume reduction and increase the gray matter in the prefrontal cortex among older people. Physical activities make people energetic and increase blood flow. Regular indulgence in such activities prevents the body from burnout. Play makes older people healthy and reduces the chance of getting diseases. A research by Burr and colleagues focused on the lifespan perspective on the perception of the importance of play in older adults. It focused on how they recall their play from childhood and compare how it has changed over the years. The research used memories of play in older adults connected with the eighth stage of Erikson's psychosocial development. Playing memories help in contributing to the meaning of life; it can help the individual look back and reflect on. Older adults emphasized the importance and benefits of play as it helps with problem solving, being active, happy and creative, and helps keep an open mind (Burr et al., 2019).

Special Population and Play

Disabilities—be it of any kind—will impact the child's potential to play and learning from such a play (Baker & Donelly, 2001; Spencer-Cavaliere & Watkinson, 2010). Children with disabilities will have a different perception and understanding of the concept of play and even learn from it differently. The process of play will impact children with various disabilities differently. Thus, defining play in terms of disabled

children is challenging (Brodin, 1999) yet crucial. It is because of difficulty in understanding the unique, interactive effect each limitation of the disability has on children's play. The unique nature of different impairments makes it challenging. The value of the specific play would be taken into account only when they obtain specific developmental goals (Goodley & Runswick-Cole, 2010). The play would be mainly related to the kind of impairment a child has. Play helps to develop the skills and abilities of children with disabilities. Play helps them to improve their fine motor skills. Children with special needs engage in play slowly than the normative rate of typically developing children and may spend less time playing. Here, parents or caregivers involve and direct their child's play forms.

The physical, social, personal, and environmental barriers may reduce children's play experiences with special needs (Missiuna & Pollock, 1991). Play helps them overcome the fear and complexity they may have internalized by observing and comparing themselves with other people. The factors influencing play among children with special needs are the child's unique capabilities, the influence of parent–child and peer relationships, caregivers, and the use of toys and resource aids (Missiuna & Pollock, 1991). Woolley (2013) discussed the barriers of creating and using inclusive play spaces for disabled children. Inclusive play spaces are rare as there is a lack of awareness of how beneficial they can be. Unfortunately, these kinds of issues are omitted from policies and limit the rate of change in available play spaces.

Medical disabilities may hinder a child from engaging in certain kinds of play and limit their exploration and learning through play. *Sensory disabilities* can restrict the child's orientation to play precisely to visual and auditory related play. Their disability makes it difficult for them to learn imitation through observation and sometimes in manipulating objects the right way. It also has substantial effects on their interaction with other children and forming bonds through play. *Social and emotional disabilities* hinder engagement in play, and sometimes these children with disabilities are avoided by other children because of their atypical behavior. When children are fearful of joining in or participating, even that can inhibit their interactions.

Communication disabilities are problematic because they make it difficult for other children to understand them and may inhibit the child from entering a group in the first place. Then, the child may feel misunderstood, and others might have trouble understanding and empathizing. *Physical disabilities* affect play to the extent of movement restriction. They may thus have problems in using the object or using it the right way and feel excluded from certain types of games. *Cognitive disabilities* will mostly lead to a delay in or absence of play skills development because of not always understanding the play and its rules and even delivering what is expected of them. They may also have problems engaging in abstract levels of play. There are entirety of types and strategies of play that can help integrate play and play skills with children with disabilities. Playing with the use of toys would include Replica play and symbolic play. The former is where children replicate familiar situations, and the latter is where the child uses an object to represent another. Through parallel play and associative play, the development of social skills can pick up in these groups

of children. In the former, children play side by side, and in the latter, children play with each other in an everyday focused activity.

Children with a chronic illness may have challenges to play and play development. Stimulating play can enhance a child's adaptability to stressful conditions. Play can be used to develop interventions for children to better cope with illness and stimulate healthy development. There are many benefits of play for children with disabilities. These children benefit from strong emotional bonds and connections with their peers. Excluding play from the lives of children with disabilities can result in consequences such as unhealthy complications in children and an increase in psychological and behavioral problems, further resulting in neurological dysfunction and unhappiness and lack of mental well-being.

Understanding Play in Context: The Ecosystems Approach

How individuals interact with the external environment at different levels of society determines their developmental and psychological outcomes. The ecological systems theory explains the child's development in the context of the relationships formed in the environment. Developed by Bronfenbrenner, the ecological systems theory is the foundation of understanding how the environment plays a role in each individual's journey (Bronfenbrenner, 1992; Darling, 2007; Ryan, 2001). There are five levels of the environment that an individual is a part of or is influenced and impacted by—*the Microsystem, Mesosystem, Exosystem, Macrosystem, and Chronosystem.* Play is impacted by the interactions that take place within and between the systems. In this section, play is understood in the five systems part of the ecosystems theory. For instance, the microsystem can depict primary caregivers interacting with their child in the form of play.

The Microsystem—Adult Perspectives on Play

Play strengthens parent–child bonds and helps in better outcomes for both parent and child (Lin, 2010). Parent–child play includes pretend play and playing with accessories like dolls, balls, lego, snake and ladder, or developmentally appropriate games. Piskernik and Ruiz (2020) supported that the gender of the parent is not associated with the quality of play. Mothers and fathers tend to show similar standards when they play with their children. The play would create a feeling of a secure environment among children (Ginsburg, 2007). Quality playtime with children is equally essential as quality study time, especially in a world where it is hard to maintain a work–life balance.

It is essential to provide children with free spaces to play to develop healthy self-esteem, self-respect, physique, cognition, and emotion. Many parents who are worried about the safety and well-being of their children with respect to engaging in

risky play behaviors (McFarland & Laird, 2018) may feel that children should not play on concrete grounds because they may slip and fall. For example, parents might not want their children to play on playgrounds because the sand is dirty. But then resilience, risk-taking, cooperation and competitive spirit, socialization, building muscles, strengthening bones, and fostering imagination, creativity, independence will happen only when play spaces and the child's playfulness is not suppressed (Boreham & Riddoch, 2001; Gray, 2019). When a child's activity is not recognized and is viewed negatively, by saying that play is a waste of time, these vital functions will either develop very late or might not develop to the extent that it is appropriate for the child's age. Parents tend to put pressure on academic performance (Deb et al., 2012) and may consider play as a luxury.

A comparative study of Euro-American and Asian preschool children revealed the cultural differences in the concept of play among parents and children (Parmar et al., 2004). While Euro-American parents consider playing necessary for a child's development, Asian parents give less importance. It reflects in their activities. For example, Asian parents prefer educational toys, while Euro-American parents prefer fun toys. A study conducted by Roopnarine et al. (1990) among infants and their parents found that Indian parents emphasize affection rather than play. Parents tend to show love, while they spend time with their infants rather than playing with them. Alongside, teachers suggest that the students from Asian backgrounds also learn to use thank you and sorry words after they start preschool.

The Mesosystem—School and Play

The philosophies of mainstream, inclusion, and integrated education in schools hold on to the principle that "*together we learn, we learn to live together*".

Play helps in fostering the child's active engagement and helps create their imaginary world. The preschool period is vital for children because they start to interact with people other than family members (Ashiabi, 2007; Azlina & Zulkiflee, 2012). So, preschools should promote play and include more play-related activities in their curriculum. Children would learn more through play-based activities in preschool. It has been observed that play-based learning may decrease once children start to go to school. Movement is essential to learning. Children learn, understand better, and retain their attention for longer when not restricted to one particular place. Children's play and activities in preschool time impact their lives (Cools et al., 2009). Free play helps the children move according to their wishes and increases creativity, self-confidence, and independence. Lately, even preschools are overwhelmed with academic activities, and children cannot find free time to play outdoors. Parents and educators stress children's academic achievements.

There are instances and situations where teachers use punishment and negative comments that can affect a child and create a sense of doubt within them. While it is challenging to manage so many students single-handedly, it is vital to understand the root of children's restlessness. They have all this energy that is not being utilized

in play. It is concerning when even children in kindergarten spend time on tasks such as reading, recall, and writing rather than our usual understanding of kindergarten where children play with themselves and others and learn through playing.

The "No Child Left Behind" Act (Simpson et al., 2004) in the USA makes the early school curriculum achievement-oriented rather than play-oriented (Zigler et al., 2004). Studies show that it causes academic stress among kindergarten teachers and students as well. The concept of free play and imaginary play has disappeared from the kindergarten system. Our children are highly packed with academic activities. It is sporadic to find children playing in schools for as long as they want and how they want. Schools provide slots for games and play, but they come with rules and instructions, reducing any scope for free play. For example, in countries like India, play is not a part of schooling. Children are accustomed to instructional activities throughout school life. There is very little importance given to free play. Activities like clay molding, aerobics, and drawing are the preferences in kindergarten; the concept of free play is almost absent. Another important factor that restricts free play is the financial strength of schools to provide equipment, playthings, and even play spaces. Overpopulation leaves barely any free room for consideration of converting it into a play space; the economic status of parents and the school level management might not allow them to afford accessible play areas.

Nowadays, many schools provide play opportunities. Sudbury Valley School in the USA promotes learning through play (Gray, 2011a, b, c). Children are free to learn what interests them. Children within the age group of four years to eighteen years are typically the school-going population. They are free to sit with anyone irrespective of their age. It is not necessary to pass exams or submit weekly assignments. If they need to graduate, then they have to defend a thesis. They independently solve the problems; for example, if there is a bullying situation, children learn how to deal with it on their own. Adults should give them the opportunity and freedom to explore, creating an environment where children are more prone to learn. In most schools, students are seated in a designated seat for the entire day. They take notes, submit homework, and "try" to study and excel in academics. Schools need to work towards maintaining a balance between curricular and cocurricular activities.

The Exosystem—Impact of Technology

Nowadays, children are exposed to video games, mobile phones, and computer games (Marsh, 2010). Many of them prefer gadget games over outdoor, rough and tumble play games. It can affect children's physical and mental development. There is no denying that technology does have many benefits and has tried being inclusive of play and learning through video and gadget games (Johnson & Christie, 2009). Computer-assisted games help improve a child's cognitive development (Rieber et al., 1998). It would help to increase self-regulated learning among children. Children exposed to excessive screen time is an area of concern. An increase in screen time leads to several physiological, cognitive, and emotional problems. It has resulted in

a significant lack of interest in outdoor play and major health-promoting physical activities. It has led to children being more vulnerable to future health problems, such as obesity. Apart from that, they also increase the risk of being addicted to technology, more prone to aggression and misbehaving. Technology is like a double-edged sword. On the one hand, it still engages children in some form of play, but on the other hand, it robs them away from open, physical, outdoor play. It almost seems like gradually, technology has overruled socially engaging physical play.

A pressing concern regarding play in a contemporary context is the impact of technology on reducing physical activity. With the rise in video games usage and its easy accessibility through smartphones—children are drawn toward the visual world created by computer graphics. Video games are used as a convenient scapegoat for many issues affecting today's youth and children. There is also an increase in sedentary lifestyles in children (Marsh, 2010). Health experts and parents say that kids need to get up off the couch, put down the video game controller, and start moving around. There is a significant lack of interest in outdoor play and major health-promoting physical activities. It has led to the child's vulnerability to preventable health problems in the future—such as obesity. Apart from that, they are also vulnerable to technological addiction, aggression, and misbehaviors.

The Macrosystem—Culture and Play

Culture and play are related. Parlakian and Sánchez (2006) mentioned how identifying cultural biases and acknowledging them can enhance an individual's play. They also explained how people from the same ethnic background can also have differences in how they play. The same article mentioned the implications of cultural knowledge and how it impacts how we view play—how flexible, encouraging or inhibited we are about it. Schools' and colleges' curriculums also derive information from the status quo. Most of our play revolves around age-old traditions.

Children naturally play with the materials available for them in their surroundings. Some play with marbles, kites, while some play with natural objects in the environment. Depending on the surroundings and availability of resources, children engage in various activities. These traditional games were designed based on the growth and development needed for the specific region to ensure survival. For example, if a child resides in a sandy place, s/he should have a good grip and balance to avoid falling and getting hurt.

Play is subjective to the context and hence is different in different cultures. If you pick up any community-based game that you thought was exclusively only part of your culture, you might find different versions of the game elsewhere. For instance, during the hunter-gatherer stage, children used to play with sticks and run around, and today you see them play a similar game, except it is mainly on a computer screen. Cultural differences in social interactions between adults and children influence how a child presents themselves in a social setting. Play involves interactions in a sociocultural environment. European-American culture provides self-focused narratives in

play, whereas several Asian communities emphasize relations and family traditions over the self. Play is viewed as both a reflection of cultural mastery and a mechanism through which children acquire the cultural values with which they construct and reconstruct their daily interactions.

The Macrosystem—Community and Play

As the concept of nuclear families is popularized, it increases the chances of children being alone at home and left to play by themselves. A child playing alone has only so much scope, thus limiting the options or access to various types of play. It hampers the opportunity of developing social skills while playing. If you ask your grandparents about their childhood, it would be so common to hear joint family stories and how fun it was always to have siblings and relatives to play with. Subramanian, Bandyopadhyay, & Jana (2019) elaborate how urban India faces a splurge in residential and industrial buildings—making it scarce for children to play. Uprooting buildings and large-scale housing projects have taken away most open spaces to accommodate the rising population. It has affected possible play spaces for children residing in that locality. Connecting the tedious construction process poses many risk factors for children to be playing freely in the open. Parents are hesitant to send their children outside their homes, restricting play to a safe and supervised boundary. While safety is prioritization and concern, it impacts the development and psychological well-being of children (Little et al., 2011).

The Macrosystem—Play as a Right

The United Nations Convention on the Rights of the Child (UNCRC) considers play as a fundamental right of every child (Freeman, 2009). Right to play and recreation are largely neglected, and children's voices are not heard while designing or implementing these rights (Harcourt & Hägglund, 2013). Most community members do not consider that children have rights (Deb et al., 2016). Play spaces are also shrinking in most communities. There have been environmental and social movements to protect play spaces.

Play as a Therapy Tool

Play is therapeutic by itself. It has been established as a therapeutic approach in the field of psychotherapy. It is considered one of the effective interventions in child psychotherapy (Ray et al., 2001). It is commonly used as a treatment approach for trauma and abuse related concerns (Reyes & Asbrand, 2005), developmentally

delayed (Guarton & McCarthy, 2008), and behaviorally maladaptive (Packman & Bratton, 2003) children. Play therapy is formed on the belief that play can be cathartic when engaged in it (Leblanc & Ritchie, 2001). Free play is effective for marginalized and vulnerable children and those with emotional difficulties as well. Research identifies that children who are deprived of free play tend to develop psychosocial problems. Retrospective research identifies that people who were less exposed to play had antisocial and maladaptive behaviors.

Play helps children and youth as a coping strategy for those who are the victims of domestic violence and abuse. Interviews conducted among children and youth belonging to the age group of eight to eighteen reflect children and adolescents who are exposed to domestic violence and abuse tend to go away from houses and play with their friends in open spaces or at friends' houses (Fellin et al., 2019). Play is seen to help children cope with anxieties and conflicts (Warren et al., 2000). Because tensions are relieved in play, children can cope with present problems. Play helps children to release physical energy and pent-up tensions.

Decline of Play

> A report from the United Kingdom found that children spend, on average, four hours per week playing outside, as opposed to their parents who reported spending just over eight hours per week playing outside as children. (The National Trust, 2016 as cited in Burr et al., 2019)

Long gone are the days where all the children in the neighborhood would come out and play. Current generation play is limited to video games and mobile games (Wang et al., 2014; Subramanian et al., 2016). The SARS-CoV2 pandemic and lockdown have increased the dependence on the internet (Masaeli & Farhadi, 2021; Zhu, 2021). Children love to play using gadgets rather than outdoor or indoor games. There has been an unfortunate decline in outdoor play (Dickey et al., 2016). Schools and parents are additionally giving more importance to academic activities rather than to playing (Ashiabi, 2007; Miller & Almon, 2009). Parents are also focusing on the child's future and academics, affecting children's physical and mental state. When you look at kindergarten education lately, it focuses more on a child's reading and writing skills, even though its purpose was for social interaction and preparation for school. Play is given less importance. Schools allot only forty-five-minute intervals once or twice a week for students to go out and play. That limited time also contains instructions from the teachers. They are not allowed to play on their own. Free play is neglected. Do schools then foster the play or try to decline the play? They do not realize that play and academic success are not mutually exclusive (e.g., Isenberg & Quisenberry, 2002; Overstreet, 2018; Wood, 2009; Wood & Attfield, 2005).

According to Peter Gray, play is the natural condition for learning; play is educational. A child would learn to learn, teach, and be a socially interactive person through play. Play helps the child to be creative. Children who play more in their childhood

days are more capable and intelligent when they transition to adolescents and adulthood when compared to the children whose academics get more attention in their childhood. The decline of play leads to several psychological and mental health issues. It would lead to depression, anxiety, anger, and so on. Lack of self-control and emotional regulation is also a result of the declining play. Childhood obesity, for example, is a result of declining children's outdoor play (Fjørtoft, 2001). The decline of play also leads to psychopathology (Gray, 2011a, b, c; Ginsburg, 2007).

The increased focus on academic rigor and competition has affected the time children should ideally spend exploring themselves. There is minimal scope for creativity with a lot of time spent on routine cocurricular and extracurricular activities such as dance, music, karate, abacus classes for children. The scope of free movement-play is yet again restricted by emphasizing setting targets and winning competitions. Previous studies show that over the last 20 years, there has been an increase in the rate of participation in extracurricular activities. There is evidence of the effect of excessive amounts of scheduled activities for children, producing detrimental outcomes (Rosenfeld & Wise, 2001; Thompson & Barker, 2004 as cited in Burr et al., 2019). Parents are often unaware of the importance of freedom for children and end up micromanaging their activities.

The education system noticed a shift in the focus on teaching more specific academic skills that would qualify their students to enroll in competitive and aptitude-based exams that are more achievement-oriented. This shift has relegated play to a marginalized position, sparing early childhood curricula that once held a dominant role (Holmes et al., 2006; Baumer & Radsliff, 2009; Miller & Almon, 2009; Nicolopoulou, 2010; Azlina & Zulkiflee, 2012; Overstreet, 2018; Tobin & Kurban, 2018). Brown (2018) studied being play deprived can have negative consequences on early child development. Long-term impacts of play deprivation during early child development include loneliness, anxiety, depression, poor self-control, and lower levels of resilience (Clark et al., 2016; Gray, 2011a, b, c; Wilson & Christensen, 2012). Another rising concern among children is weight gain and poor physical well-being due to inactivity from not playing (Farley et al., 2007; Herrington & Brussoni, 2015). Children who find themselves unable to play because of difficult home settings may have difficulty forming social bonds. Play facilitates development of complex social and emotional learning experiences.

Play deprivation during early childhood is correlated with the predilection of felons for violent, antisocial criminal activities stemming from aggression (Dickey et al., 2016). The research suggested that the play experience of homicidal individuals was vastly different from that of others as their childhood was typically characterized by isolation, abuse, or bullying. On the other hand, when the first interactions of a mother with the child are interrupted or do not occur, it could also lead to disrupted development. The child grows up perceiving the world as threatening and unsafe, which makes them less ready for play. Play-deprived children may have more explosive reactions to circumstances rather than a sense of belonging and engage in automatic and repetitive activities in later childhood and fail to engage socially (Overstreet, 2018).

Over the years, despite the awareness of the importance of play, it is on a decline (Holmes et al., 2006). To support this statement, Jung and Jin (2014) reported in their research that even when teachers and future professionals are trained with a play inclusive approach for classroom settings yet are not seen or able to implement them. The hurried lifestyle has led to more highly scheduled timelines for children, and this causes anxiety and stress in some. The caregivers overschedule a child's playtime, causing activities to be rigid and may not allow them to explore their interest areas. With an increase in technology, children are starting to prefer staring at screens rather than engaging in rough and tumble play, lucid and imaginative play. Children spend their prime years living a sedentary lifestyle involving less physical, cognitive activity, and low socio-emotional interactions. Even schools are cutting down on children's playtime to increase academic activities (Azlina & Zulkiflee, 2012).

Children are at work when they play. The play has a significant role in child development and learning. It is the right of every child to play. Student mental health in schools has become a serious concern (Suldo et al., 2014). Schools and teachers have many objectives to meet every new program is left to the schools to implement. There is existing pressure from systems and institutions to meet short-term achievement goals and outcomes that result in perceiving the role of play than to be unimportant (Bodrova & Leong, 2003 as cited in Jung & Jin, 2014; Holmes et al., 2006). The supposed rat race that is perceived as life begins even earlier now that children, youth, and adults end up in a vicious pressure cycle of completing tasks. Parents also put a lot of expectation and pressure on school systems. Parents who tend to be involved in their children's education and learning help create an environment of tremendous success, competence, achievements, and lesser dropout rates (Hoover-Dempsey et al., 2005). At times, these well-intentioned involvements can pressure the child to perform better and reach set goals while also ensuring schools and teachers focus more on academic orientation, goals, and achievements. While the intention can be in the best interests of their children, children end up facing increased academic stress and pressure.

Future of Play

1. To ensure the existence of play in future classrooms, current and upcoming teachers need to be trained and familiarized with teaching in a play positive environment. Their styles would then be shaped by their preparation to enter the field of teaching and their personal experiences and beliefs on play (Jung & Jin, 2014).
2. Research has shown that engaging in play at work has improved the well-being of employees and helps reduce stress and burnout. At the same time, it increases job satisfaction and a sense of competence in employees at the workplace. It helps in fostering a creative mind-set for ideas and opportunities and is beneficial in problem solving. The Conservations of Resources theory is based on motivation

and social support (Hobfoll et al., 1990), adopted to understand the depletion of energy resources in individuals in various contexts. Play as a medium could increase and regulate psychological and psychosocial resources within their employees (Petelczyc et al., 2017).

3. Despite the rapid development of infrastructure and technology in major urban hubs, there is scope for generating inclusive play spaces in suitable areas as natural playgrounds present opportunities to connect with nature. There is great value placed on the direct learning experiences while interacting with nature (Wang et al., 2018).
4. Training and educating parents on increasing positive therapeutic interactions between parent and child is seen to be adequate to help with emotional difficulties or behavioral concerns (Post et al., 2011; Leblanc & Ritchie, 2001). When parents engage in play activities with their children, their bond increases and opens the door to understanding and resolving concerns. It allows the parent to teach the child appropriate behavior and socially accepted interaction. It could help in restoring a work–life balance at home during the lockdown as well.

Conclusion

Observing children or adults at play can help us identify the cognitive and affective processes expressed in play behavior. Cultural practices, rituals, literature, art, poetry, music, and dancing have evolved from play. The play has nurtured human civilization and interaction. "Being in play" is not a polar opposite of working, and vice versa as opposed to the infamous quote, "All play/work and no work/play makes jack a dull boy" (Ferreira & Esteves, 2013; Overstreet, 2018). Playfulness can be a creative, joyful, and innovative way of approaching life wherein we are less stressed, able to explore ways of solving problems, self-directed, intrinsically motivated, and use our imaginations to reach our goals (Gray, 2019). Both Holzman (2014) and Chon (2013), in their TEDx talks titled "Play Helps us Grow at any Age" and "The Importance of Play", respectively, mentioned that when we are in play, we indulge without the constant worry of messing up or being wrong.

Unfortunately, most studies and discussions about children's play have been through the adults' lens. Lately, there are increasing efforts for the voices and opinions of children to be heard in such areas that are about them and affect them directly. We would understand their point of view and perspective on the increased pressure from parents and school to focus on academics and live a hurried life. Overall, it is necessary to engage in play across the lifespan, for there is no age limit to having fun. Play thus has enormous implications for the development of society as they learn gendered, societal, and cultural norms and behaviors from their personalized manifestation of play.

Recommendations

Throughout the chapter, we have seen the many benefits of engaging in play. Play is free, flexible, and each one's need and right. Play has no limit based on age, gender, ethnicity, race, disability, or other challenges. By acting as a medium or a tool, it helps individuals learn, socialize, work, and so on. Play, in general, has taken a significant step back from being an essential part of childhood through adult leisure. Individuals are more focused on being ahead of this fast-paced lifestyle that they have not realized the consequences of yet. Academicians can learn how to integrate play and play-based techniques in teaching and education. Practitioners can promote the existing evidence on the positive impact of play and its effect on well-being. Play and play therapy are effective mediums, tools, and therapeutic approaches for many psychological, physiological, and psychosocial constraints. Policymakers and community members need to know the need and power of play and play spaces to prevent them from becoming extinct.

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Part II
Mental Health and Well-Being of Students and Workers in Organizations

Chapter 7
Adolescent Health and Well-Being: Issues, Challenges, and Current Status in India

Nandita Babu and Mehreen Fatima

Abstract Adolescence is the developmental stage between childhood and adulthood marked by considerable growth in physical, cognitive, and socio-emotional domains. It is considered as a preparatory phase for adulthood, and therefore, well-being during adolescence would predict well-being during adulthood and age ahead. During this stage of life, children have specific needs that vary based upon gender, socio-economic status, and overall cultural belief system of the community. In order to understand the process of development during adolescence, it is extremely important to study the systems like family, school neighborhood, and community in which the adolescents live. Few researches in India have studied these processes to understand the adolescent's need at large. With about 373 million persons between the ages of 10 and 24 years, India has the largest number of young people of any country in the world and that makes it a more viable area for research, intervention, and policy implementation. To meet the 2030 Agenda for Sustainable Development and its Global Strategy for Women's, Children's, and Adolescents' health, the Government of India have prioritized adolescent health in various programs and policies. However, in spite of all the attempts by researchers, practitioners, and policymakers, there is still a major gap which needs to be filled up to reach the 2030 SDG goals. Therefore, the need of the hour is to follow a multidisciplinary approach toward research, policy formulation, and intervention for psychosocial and physical health of adolescents. This chapter is an attempt to discuss the major issues of adolescent development in the socio-cultural context of India, identify the research gaps, and analyze the policies and programs for positive developmental outcomes for the young people in India.

Keywords Adolescent · Health · Well-being · Issues · Challenges · Current status · India

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_7

Introduction

Adolescence is the developmental stage between childhood and adulthood characterized by marked changes in the physical, cognitive, and socio-emotional domains. It is a transition phase characterized by novelty seeking, risk taking, and desire for freedom, in which the individuals are preparing for the challenges of adulthood and also developing a sense of personal identity (Nebhinani and Jain, 2019). When individuals enter adolescence, they are dependent on nurturing adults to fulfill their needs of food, safety, shelter, etc., but also actively seek freedom in the face of limited agency to make important life decisions. In India, the adolescent population is the largest among the world, with around 373 million individuals between 10 and 24 years of age. They form a heterogenous group, having diverse needs depending upon their age, sex, marital status, educational attainment, occupational status, financial background, place of residence, etc. Saraswathi (2013) has used the metaphor of "kaleidoscopic" to describe such a diverse population of Indian adolescents that varies on the basis of their gender, region, caste, and class. This metaphor also apprises us to be careful while making generalizations from the studies on adolescents, given the wide geographic area of India.

The adolescent years can again be classified into early, middle, and late adolescence. The early adolescence is said to occur between 10 and 14 years of age. It is usually in this stage that the growth spurt occurs and the physical changes become easily noticeable. The boys and girls become much more conscious of their gender and actively behave in ways consistent with their gender. Middle adolescence lasts for around 15–17 years of age. During this stage, the growth spurt continues and the adolescents also gain interest in romantic and sexual relationships. In this sense, the stage marks the beginning of development of sexual identity. The late adolescence is said to be the period from 18 to around 24 years of age. By the time individuals reach late adolescence, they have almost completed physical development. The risk-taking behavior, which is common in early and middle adolescence, tends to decline in late adolescence. The person gains much more emotional stability, and the relationships with others also become stable.

The ancient Hindu concepts or frameworks are quite similar to the contemporary ideas when it comes to understanding adolescent age (Sitholey et al., 2020). The Ashramadharma in Hindu tradition considers 100 years to be the average life of a human being and recognizes four stages of human life, namely Brahmacharya, Grihastha, Vanaprastha, and Sannyasa. The first stage, i.e., Brahmacharya, deals with the adolescent years of one's life, as the stage lasts from 0 to 25 years. Brahmacharya is considered to be the stage of being a student, in which an individual acquires specialized knowledge and education in different domains, gains relevant skills, and also receives vocational training of his/her caste-based occupation. It prepares the individuals for the next stage, i.e., Grihasta, in which the person has already acquired education and is set to take up household responsibilities.

In the ancient Hindu tradition, there was a positive regard for children and they were valued. Education was given paramount importance by the traditional Indian

society, and knowledge or wisdom, and not the gray hair would beget respect. A child who was knowledgeable could even teach adults elder to him. Equal attention was given to the girls' education as well. Nevertheless, they were taught in different schools meant for girls, where they were taught by female teachers. It evidenced lesser degree of discrimination with respect to gender, except for what they were taught. While the boys were prepared for the role of provider in the future, i.e., to earn for livelihood, the girls were not required to earn and were expected to be skilled homemakers.

The ancient Indian texts also provide evidence for the mention of physical as well as psychiatric disorders of children in ancient India. Vagbhata's Astangasangraha, a classical text in Ayurvedic, dedicated six of its chapters to childhood disorders, including the details, causes, as well as the treatment of the disorder. Kasyapa Samhita, yet another classical text in Ayurveda, is a pediatric book that divides childhood into three stages—Garbha (i.e., unborn child in the womb), Bala (i.e., childhood), and Kumara (i.e., adolescence). It alludes to the fact that adolescence was considered a separate stage in development even in ancient India, and their issues were studied separately. Likewise, the contemporary society recognizes that there are some common issues which are faced by adolescents irrespective of their gender, religion, region, caste, or class. Owing to these different challenges that the adolescents face in this phase, they remain vulnerable to many psychological and physiological difficulties that also have consequences for adult life as well. It is, therefore, very important to address the needs of the adolescent population and ensure their well-being, as they are the future representatives of any country in the world.

The various nations have consolidated and collaborated their efforts that have led to the formation of international organizations, so as to ensure a better future for people across the globe. The UN 2030 Agenda to meet Sustainable Development Goals, which is one such inclusive effort aimed at providing a better and prosperous future for everyone around the globe, also takes into consideration the children's, adolescent's, and women's health. The youth and adolescent mental health is acknowledged and addressed in the thirds Sustainable Development Goal (SDG) out of the total 17 SDGs, which is aimed at ensuring good health and well-being of all the individuals across the globe and so automatically encompasses adolescents as well. The UN has also identified adolescent and youth mental health as a global public health challenge which needs to be addressed (UNFPA, 2013; UNICEF, 2011). It provides us with a unique opportunity to work in the direction of adolescents' mental health, which had largely been neglected until the twentieth century, despite being crucial for mental health at all the stages up in the development ladder.

This chapter attempts to elucidate the concerns and challenges of adolescents, particularly in Indian context, by taking into consideration the principles of universalism as well as cultural relativism, while describing how adolescents' social or psychological issues are manifested and interpreted. The Government of India has also prioritized the adolescents' mental health by making it a political commitment, in their efforts to meet the UN 2030 Agenda for Sustainable Development Goals, in

the form of various programs and policies, and some of which have been outlined in the chapter ahead.

Developmental Milestones and Developmental Challenges During Adolescence

Developmental Milestones

The adolescent years are considered to be a stressful period, with easily recognizable physical, psychological, social, cognitive, emotional, and behavioral changes. The growth spurt occurs at around the age of 11–14 years in girls and 13–17 years in boys, whereas puberty hits at around 11–14 years in girls and 12–15 years in boys. The morphological changes in the organ as well as rapid changes in other bodily systems, such as the endocrine system, are all responsible for this visible growth spurt. The secondary sexual characteristics begin to emerge in early adolescence and are fully developed by late adolescence.

In the domain of cognition, it is the stage of formal operations as identified by Piaget (1954), which is at a precursor phase in early adolescence but becomes more developed in middle and late adolescence. The thought process becomes more abstract, and the individuals begin to think hypothetically, for instance, they can conceive a situation in their mind and analyze it, considering the various possibilities so as to plan their course of action accordingly, without actually experiencing the situation. This type of thought process is referred to as hypothetical-deductive reasoning. However, there remains a possibility of reverting to concrete thought processes in early and middle adolescence, under stressful situations. The metacognition begins to emerge, as they begin to think about their own thoughts, i.e., reflecting upon these thoughts for analysis and self-introspection. However, the cognitive development in adolescence remains uneven and is influenced majorly by one's emotional development or emotionality.

The significant changes take place in the socio-emotional domain in the adolescent phase and include one's increased efforts to explore his/her own identity as well as transforming relationships with others around, including parents and peers. In this developmental stage, the individuals have an increased need to gain independence from the adult caretakers, for which they begin to distance themselves from their parents psychologically and get closer to their peers. They seek acceptance from their peer groups by conforming to the roles and traits expected out of them. The peer relationships or friendships are based on loyalty and mutual trust, and the interest also develops toward opposite sex friendships and romantic relationships. The sexual identity is also developed by the end of late adolescence.

The maltreatment in adolescence can lead to emotional disturbances such as frustration, emotional outbursts, increased anxiety, depression, as well as attachment

issues. The individuals may also end up having low self-esteem, identity confusion, difficulties in forming and maintaining relationships, as well as self-defeating behaviors, which further add to their problems.

Developmental Challenges

The adolescent years are indeed characterized by a state of disarray, with respect to the extent as well as number of challenges faced during these years. Although all life stages entail challenges of different kinds, it is the formidable nature of these transitions in adolescent fears that is so overwhelming for individuals. Some of the challenges during adolescence include biological challenges such as physical and sexual changes, identity confusion and development, emotional instability, among others.

Physical Transformation—Physical transformation is one of the most obvious and apparent developments during adolescence. The individuals go through rapid physical changes during adolescence, a period of maturation referred to as puberty. During puberty, the individuals go through bodily changes, for instance, secondary sexual characteristics begin to appear. The puberty hits boys at around 11 years of age, which usually begins with the enlargement of testicles and penis, and the voice deepens. The puberty begins in girls earlier at around 9 years of age, as their breasts begin to enlarge and pubic hair appears. Menarche, a girl's first menstruation, happens rather late in the order of events in puberty. There is also a sudden growth in height of both girls and boys, and by the time puberty ends, the height of boys has already surpassed that of girls.

Sexuality—With all the physical and hormonal changes taking place, the adolescent years also witness the emergence of sexuality among boys and girls. In this sense, the adolescent years can be seen as providing linkage between the asexual kid and sexual adults. Adolescence is a period of sexual exploration, wherein the adolescents add the aspect of sexuality in their identity. Developing a sexual identity is a rather lengthy and multipronged process, involving identifying one's sexual orientation, controlling one's sexual arousal, and behaving in socially desirable ways to avoid any undesirable consequences. The development of healthy sexual identity can be achieved by imparting sexuality education. However, sex education has remained one of the most controversial topics in India, with a large section of society advocating a ban on sex education. Even when imparted, the focus has been on limiting it to giving information about avoiding premarital sex, in view of "public discourse." Khubchandani et al. (2014) have suggested that even though we are culturally bound, the scientific evidence of sexuality education should not be neglected as it can positively serve the rapidly growing adolescent population.

Identity formation—As the physical and sexual development takes place, another challenge that the adolescents face is the formation of a unique individual identity. The adolescents incorporate their personal experiences which, along with the physical and sexual maturation that takes place, shape an individual's identity. The extent

to which an individual is likely to attain a stable identity also depends upon their psychosocial functioning as well as overall well-being at this stage. The familial relations are of particular importance for providing a conducive environment for the stable identity development in Indian adolescents (Sehgal, 2017).

Emotional challenges—Another challenge that the individuals face is the emotional instability during adolescent years. The adolescents are often torn up between being a responsible adult and being a child with his/her desires. Additionally, they are also going through significant physical and psychological changes, all of which lead to emotional difficulties and problems, which manifest in the form of mood swings and emotional breakdowns. Lavanya and Manjula (2017), in their study on 419 Indian college students aged 16–25 years, found that emotional regulation in the domain of positive re-appraisal, self-blame or other blame, acceptance, rumination, etc., is significantly related to their psychological problems, such as depression and anxiety and/or somatic problems.

Developmental tasks

In order to overcome these challenges that arise at a specific period in one's life, a person has to successfully complete certain tasks, referred to as "developmental tasks," a concept introduced by Robert Havighurst in the 1950s. He did most of his research between the period of 1950 and 1975, in which he identified the developmental tasks of six to twelve years old and twelve to eighteen years old. Although, in line with other researchers of his time, he also did not recognize adolescence as a separate developmental stage in his researches, but he did propose that individuals advance from infancy to old age while going through different developmental stages, each consisting of distinct developmental tasks. Few researchers have adapted the developmental tasks identified by Havighurst (1952) to determine the developmental tasks during adolescence (e.g., Manning, 2002). If the individual is unsuccessful in achieving the developmental tasks of the stage in which he is, it can lead to difficulties in performing the tasks associated with later stages.

One of the major tasks in this developmental stage is to adjust to a new physical sense of self- or physique and accepting one's body the way it is, as this is the stage in lifespan development wherein marked physical changes take place. Another developmental task that adolescents have is to acclimate themselves to the new intellectual abilities and increased cognitive demands in academics and to establish their occupational or career goals. The adolescents also aim to attain psychological and emotional independence from parents while forming stable peer relationships with both the sexes. The adolescents also have the developmental tasks of managing their sexuality by gaining an understanding of what constitutes feminine and masculine, gaining a personal sense of identity by embracing their own morality and value system, as well as gaining control of their impulses and attaining behavioral maturity by gaining control over indulging in risky behavior.

Culture-Specific Developmental Challenges

The human beings are part of a broader socio-cultural context that impacts their overall development in a myriad of ways and should be understood within the context of those environmental systems. It can be done by delving into the ecological systems theory by Bronfenbrenner (1979) that describes how individuals' growth and development is affected by their environment. Bronfenbrenner's ecological model consists of five environmental systems, namely microsystem, mesosystem, exosystem, macrosystem, and chronosystem, all of which are represented through concentric circles. At the center of the model is the individual who is surrounded by the different environmental systems represented by different circles, that can affect one's development by providing protective factors as well as exposing the individual to risk factors.

Microsystem is an individual's immediate environment, i.e., the environment within which a person lives. It involves one's family, peer groups, school, church, etc., and mesosystem refers to the interactions between different microsystems. The interactions within or between these systems directly influences the development of adolescents. The parents tend to have an impact on adolescents, and mindfulness-based parenting can be especially effective for raising adolescents in India, as spirituality holds a special place in our culture (Sondhi, 2017). The families are the primary source for instilling social and cultural values in the young adolescents and giving knowledge about the righteousness of behavior; and therefore, weak family ties may also pose certain challenges for adolescents.

Kamaraj et al. (2016), in their study on 1051 Indian adolescents in the age range of 10–19 years, residing in Chennai, India, on their perception of health-related quality of life, also found that Indian adolescents have low quality of life in the psychosocial domain. The issues that they had were mainly associated with social support, family relations, and interpersonal relations. It indicates that adolescents had a poor perception of their personal and social relationships.

The adolescents also spend a large amount of time with their peer group which makes it explicit that peer relationships are as important for adolescent development as familial relations. The peer relationships are specifically crucial for psychosocial development, as Palaniswamy and Ponnuswami (2013) have found that overall social change that happens during adolescence is positively correlated to peer influence. Adversely, the peer relationships can also lead an individual to indulge in risk-taking behavior, such as consuming drugs, rash driving (Steinberg, 2008). A correlational study by Goel and Malik (2017) on 14–17-year-old adolescents found that whereas school and family involvement was negatively correlated with risk-taking behavior, the peer involvement was positively correlated with risk-taking behavior.

The schools are also the part of the microsystem that has the direct consequences for academic and social development of the adolescents (Chandrasekaran et al., 2017). As such, the government can impart programs through the medium of school so as to ensure that it reaches a wider population and is implemented successfully. One such effort is the School Health Program under Ayushman Bharat, which is a

joint initiative launched by the Ministry of Health and Family Welfare and Ministry of Human Resource and Development in 2018. It is aimed at reaching the children and adolescents in government and government-aided schools, in order to promote health and preventing diseases, improving access to healthcare services, so as to minimize emotional or behavioral disorders, violence, injuries, substance abuse, and risky sexual behavior. The objectives of the program include providing age-relevant information to the students about health and nutrition, inculcating health-promoting behaviors, early intervention and treatment of diseases, promoting safe drinking water usage and safe, hygienic menstrual practices in adolescent girls, health and yoga practices; and encouraging research on children's health, wellness, and nutrition. The framework of the program is laid down in the manner that it is in line with and will also help in achieving the Sustainable Development Goals (SDGs).

The exosystem involves the environments that a child is not directly in touch with, or does not participate in, but that nevertheless influence their development or functioning, for example, neighbors, parents' working organizations, mass media, local politics. One of the important factors that influences adolescents' development in the ecosystem is the occupational status of the parents. For instance, in urban India, as a result of rapid industrialization and development, both the parents of the children are generally employed and live in a nuclear family set up (Ahmad et al., 2020). As a result, a copious amount of psychosocial (involving emotional as well as behavioral) difficulties and challenges are faced by Indian adolescents. Psychosocial challenges involve the internalizing or externalizing behaviors, uncontrolled behavioral issues, emotional difficulties like anxiety or depression, educational difficulties, etc. The emotional difficulties of adolescents often go unnoticed as they are not easily visible to the caregivers or teachers, who are only concerned with behavioral difficulties. The adolescents that grow up in the single-parent household usually mature earlier than their other counterparts. The early-maturing adolescents also tend to face more internalizing and externalizing problem behaviors than the late maturing adults (Kanwar, 2020).

Within the ecosystem, the adolescents are also likely to be influenced by mass media, as adolescents are more gullible and easily influenced by what they see in the mainstream media compared to any other age group. For instance, we have a research evidence which suggests that the mass media has played a significant role in influencing the food habits of individuals (Priyadarshini et al., 2013), there is a relation between media violence and increased incidents of violent or aggressive behavior amongst children (Tanwar & Priyanka, 2016), and that watching sexually explicit content in media can lead to irresponsible sexual behavior in adolescents (Agarwal & Dhanasekaran, 2012).

The macrosystem involves the overarching attitude or ideology of culture within which a child is embedded. The macrosystem influences the microsystems and mesosystems that in turn again influence the development of the child. The cultural or social context in macrosystems may differ depending upon the socio-economic status and poverty, religion or ethnicity, geographical location, etc., which have a direct as well as indirect influence of adolescent development. For instance, epidemiological

and individual studies have found varied prevalence of psychosocial issues among adolescents in India, depending upon the geographical location.

In a cross-sectional study by Sinha Roy et al. (2020) on 420 adolescent girls and boys residing in urban slums of Kolkata, West Bengal, to determine the prevalence of psychosocial difficulties, it was found that as many as 34.76% of adolescent boys had anxiety, whereas 51.43% of adolescent girls suffered from conduct disorder. Educational difficulties were found to be most common among Muslim males. In a study on male adolescents residing in rural and urban areas of Aligarh, it was found that only 17.9% of them were suffering from psychosocial problems (Ahmad et al., 2020). In this way, it is apparent that the prevalence of psychosocial difficulties is varying depending upon the geographical location, which is obvious given that India is such a diverse country.

The socio-economic status also tends to influence the adolescent development, as the living conditions of low- versus high-income groups differ significantly from each other. The families that live in extreme poverty often have children growing up in streets which make them vulnerable to physical and/or sexual abuse, drug abuse, bullying, violence, and neglect, which can be extremely distressful. The Integrated Child Protection Scheme, launched by the Ministry of Women and Child Development in 2009, which is aimed at protecting vulnerable children and preventing them from any possible harm, for example, abuse, exploitation, abandonment, neglect, at both family and community level, can prove to be beneficial for them. It capitalizes on government–civil society partnership in order to impart its services, and by doing so, it ensures the well-being of children.

The poor health among adolescents also finds its origin in low-income households due to poor access to healthcare service and non-fulfillment of nutritional needs. The NFHS-3 data suggests that there is clear impact of socio-economic status on health, as thinness as well as stunting was more common in rural areas compared to the urban areas of India. In general, the young adolescents face the issue of malnutrition, as NFHS-3 data suggests that 47% of adolescent girls were thin and only 2.4% of them were overweight; around 58% of adolescent boys were thin, and 1.7% of them were overweight. They were also highly prone to suffer from eating disorders such as anorexia nervosa or bulimia nervosa, due to their dissatisfaction with their bodies.

The Rashtriya Kishor Swasthya Karyakram, an initiative launched by Ministry of Health and Family Welfare in 2014, can be effective in overcoming this challenge, as it is aimed at reaching out to the adolescent population of the country, including both males and females, married or unmarried, living in rural and urban areas, and in and out of school. In this way, it is one of the most inclusive health programs which is not just restricted to sexual and reproductive health, but it has expanded its scope to include mental health, among other important domains, such as preventing violence and substance abuse and improving nutrition. It relies on community-based interventions to promote the holistic development of Indian adolescent population.

The challenges are also compounded by the cultural mores that are redolent of deeply held patriarchal beliefs of our society. In contrast to the belief/practice in ancient Hindu tradition, the adolescent girls in India bear the additional brunt owing to their female gender. They are faced with or are prone to face issues such as

gender discrimination, sex trafficking, early marriage and adolescent pregnancy, eve teasing, rapes, which make their safety issue the most prominent of all the challenges faced by them. Consequently, the Government of India has introduced several programs specifically for the girl child. For instance, Kishori Shakti Yojana is a scheme launched by the Ministry of Women and Child Development in 1991 and is viewed as an initiative that promotes holistic development in adolescent girls in the age range of 11–18 years, which aims to improve the nutritional health of the adolescent girls by promoting awareness about the nutrition, health, hygiene, and family care and making them the productive members of the society by using this awareness to gain a better understanding of their social world.

Balika Samriddhi Yojana, yet another scheme launched by the Ministry of Women and Child Development in 1997, is aimed at changing the negative attitude of the families and community, in general, toward the girl child and the mother that gives birth to the girl child. It also aims at increasing the enrollment of girls in school, as well as assisting them in taking up income-generating activities.

The centrally sponsored scheme, Rajiv Gandhi Scheme for Empowerment of Adolescent Girls—SABLA, launched in 2011, has now replaced the existing nutrition program and Kishori Shakti Yojana and is focused around two major domains—nutrition and non-nutrition components. The nutrition component is concerned with providing supplementary nutrition to the 11–14-year-old girls attending Anganwadisanda nutrition provision of 600 cal for all the 14–18-year-old girls. The non-nutrition component of the scheme is concerned with addressing the developmental needs of the adolescent girls, by providing IFA supplements to out-of-school girls and giving them provision of health check-up and referral services, nutrition and health education (NHE), ARSH counseling, life skills education. It also aims at providing vocational training to the adolescent girls in the age range of 16–18 years.

The cultural taboos surrounding sexuality have also led to challenges relating to reproductive and sexual health among Indian adolescents, including sexually transmitted diseases or infections, as a result of indulging in unprotected sex and early pregnancies. The sexuality is often repressed in Indian culture, and sex education is considered to be a personal matter that does not find space in public discourse. As per the National Family Health Survey (NFHS-3, 2005–2006) data, as many as 2.7% boys and 8% girls had begun indulging in sexual activity even before they turned 15, leading to the early pregnancies in adolescents. Although, the awareness of contraceptives was quite high in the adolescents in the age range of 15–19 years (96% in boys and 94% in girls), indulging in unprotected sex despite the awareness could be the main reason for the transmission of sexual diseases in this age group. Approximately, 10.5% adolescent girls and 10.8% adolescent boys in the same age group reported having a sexually transmitted infection (STI) or symptoms of STIs.

The trend of early marriage in several rural parts of India, which is again rooted in cultural beliefs, also contributes to early pregnancy and child birth, as even though the child marriage per se is illegal, the act of marriage in a way “legitimizes” the sexual relationships between the couples in the early age. Early marriages also render the young girls prone to sexual and physical violence, as the NFHS-3 data indicates that around 34% married adolescent girls reported being physically, emotionally,

and sexually abused by their partners. Nevertheless, there tends to be a decrease in the violence as the age of marriage increases. Hence, it is well-established now that early marriages are not only leading to early pregnancies and childbirth, they are also subjecting the young adolescent girls to the acts of violence inflicted by their own partners.

The Government of India has come up with various policies to ensure the sexual well-being of adolescents. For instance, Adolescent Reproductive Sexual Health (ARSH) Program, launched in 2005, is one of the key component strategies identified under Reproductive and Child Health (RCH-II) and is meant for both married and unmarried adolescent boys as well as girls. It aims to provide promotive services, including provision of antenatal care, emergency or reversible contraceptives, advice on sexual and reproductive health (SRH) services; preventive services, including services to prevent Tetanus or nutritional anemia, nutritional counseling, provision of early and safe termination of pregnancy, and post-abortion care; curative services, including treatment for common sexually transmitted infections (STIs) or RTIs, as well as menstrual disorders; referral services, including provisions of counseling and testing centers, prevention of disease transmission from parents to kids; and finally, outreach services, including regular health check-ups and community camps, health education, and co-curricular activities.

However, the vision of the program appears to have remained unfulfilled, as the review of the program does not provide much evidence of its successful implementation. For instance, Minhas et al. (2019), in their study conducted in the Sonitpur district of Assam to review the implementation of ARSH Program, found that the target population of the program lacks awareness due to meager efforts by authorities for promotion and advertisement. There is also a scarcity of grassroot workers, and even the employed workers have minimal motivation to reach the areas with poor connectivity, which could also be the reason behind irregular implementation of the program.

Another program that strives to provide information to youth regarding sexual and reproductive health is Adolescence Education Program (AEP). Initially launched in 2005 jointly by Ministry of Human Resource Development (MHRD) and National AIDS Control Organization (NACO), it aims to equip the 10–19-year-old adolescents with the accurate, age-appropriate and culturally relevant information, so as to prevent HIV infections, bring down the possibility of catching any other infection, reducing substance dependence and indulgence in other risky behaviors. It also aims to empower adolescents so as to help them make healthy choices. It subsumes ARSH program under it, along with National Population Education Project (NPEP) and School AIDS Education Program (SAEP), in its attempts to upscale these programs.

Furthermore, there are several government programs and policies that obliquely serve the sexual and reproductive health of adolescents in India, such as, National AIDS Prevention and Control Policy, launched by National Institute of Health and Family Welfare in 2002, School Health Program, which was launched in 2008 under the National Rural Health Mission, and National Plan of Action for Children, launched in 2016 by Ministry of Women and Child Development, to mention a few.

The chronosystem, which is the final dimension of Bronfenbrenner's model, is concerned with the changes that take place over time, or the socio-historical context that can influence an individual. The notion of adolescence has also changed over the years. Although the ancient text of Dharamashastara had recognized adolescence as a crucial phase in development, the concept of adolescence has been refined in contemporary India, with youth finding its space in the programs and policies formulated by the legislature. The National Population Policy launched by Government of India in 2000, for instance, had specifically emphasized the adolescents as forming an important age group that has remained invisible so far in the policies, and therefore, their needs require greater attention and deserve to be addressed. It has especially mentioned adolescents in the sections pertaining to nutrition, information, contraceptive usage, sexually transmitted diseases (STDs), and other issues. The policy also had mention of developing a health package for adolescents in the future, which to date has remained an unfulfilled dream.

The Government of India, however, has now come up with National Youth Policy (NYP, 2014) that seeks to provide the framework for the development and empowerment of youth in the age range of 15–29 years, by identifying and prioritizing the key areas in which the actions are needed to help the youth achieve their full potential and through it, help in nation building. The prioritizing areas include education, entrepreneurship, employment and skill development, health, sports, community engagement, youth engagement, social values, politics and governance, inclusion, and social justice. The aim is to create a productive and healthy workforce, instill social values in them, promote their participation in politics as well as community services, and to provide equal opportunities for all.

Mental Health Concerns of Adolescents in General and Specific to India

The mental health issues faced by adolescents have emerged as yet another challenge faced by adolescents that has gained considerable attention over time. According to a report published by WHO (2019), as many as 50% of mental health problems arise in adolescents but often go unnoticed and untreated. Depression has emerged as one of the leading mental health concerns among adolescents, and suicide is the third leading cause of death among older adolescents in the age range of 15–19 years. Emotional disorders are also very common, causing anxiety, irritability, frustration, anger, mood swings, emotional outbursts among those in the age range of 10–19 years. These emotional disturbances can adversely impact the different domains of an individual's life, including academics, relationships. Childhood behavioral disorders share the burden by being the second leading cause of mental health diseases among young adolescents in the age range of 10–14 years and eleventh leading cause for the adolescents in the age range of 15–19 years. Childhood behavioral disorders, which

include conduct disorders as well as ADHD, can even lead to criminal behavior in adult life.

The adolescence period also marks the onset of eating disorders in a number of adolescents and affects more females than males. Anorexia nervosa, bulimia nervosa, binge eating, etc., which are characterized by problematic eating patterns such as calorie restriction or binge eating, are leading to various health-related problems in adolescents.

Self-harm is also very widespread among individuals, and according to W.H.O. and the Global burden of Disease study, as many as 800,000 individuals die wide world every year as a result of harming themselves. The matter of utmost consideration is that approximately 90% of these suicides that have resulted from self-harm are committed by the adolescents residing in low- to middle-income countries. At the base of these self-injurious behaviors are the risk-taking tendencies, which are at peak during adolescents. These risk-taking behaviors may include excessive drinking, drug abuse, unprotected sexual activities. As per the estimation of WHO, on the basis of data obtained from 130 countries in 2016, around 13.6% adolescents in the age range of 15–19 years had indulged in episodic drinking, and as many as 5.6% adolescents had consumed cannabis at least once in the previous year, which is a matter of concern.

In the Indian context, the researchers have focused upon the adolescents belonging to different states, socio-economic strata, as well as rural and urban areas and have found some common mental health issues among the Indian adolescents, irrespective of their financial or cultural background (Kharod & Kumar, 2015; Keyho et al., 2019; Nair et al., 2017; Seenivasan & Kumar, 2014) . In general, the mental disorders with onset in childhood or adolescence are more common in the northern states of India and less common in southern states of India, which are comparatively more developed; as reported in the Global Burden of Disease Study 1990–2017 (Sagar et al., 2020).

In a study conducted by Kharod and Kumar (2015) on 966 school-going adolescents in the age range of 10–19 years, residing in the rural areas of Gujarat, using strengths and difficulties questionnaire (SDQ), it was found that only 37% adolescents had normal SDQ scores, 30% has their scores falling on borderline range, and 33% of them had self-reported abnormal scores. The problems were majorly associated with the peer relationships. Additionally, it has also been found that in case of the adolescents residing in urban areas of India, the mental health issues are more prevalent among the adolescents having both of their parents employed compared to adolescents having non-working mothers (Seenivasan & Kumar, 2014).

In an epidemiological survey conducted on 693 adolescent school children of Gujarat, aged 13–17 years, using strengths and difficulties questionnaire (SDQ), it was found that one out of eight students was vulnerable to mental health problems, with rural children having more mental health issues. Also, girls were more likely to have emotional problems, whereas all the other issues were more prevalent among boys (Nair et al., 2017). In a similar study conducted by Keyho et al. (2019) on the private and government school-going adolescents (in the age range of 13–19 years) residing in Kohima district of Nagaland using SDQ, it has been found

that mental health issues are very prevalent among Indian adolescents. A considerable number of participants were suffering from emotional problems, hyperactivity, conduct problems, etc., which point toward the need for early intervention and care.

The substance abuse has emerged as yet another major issue of concern among adolescents and has still somehow remained under-researched in India. The substance abuse problem was previously considered to be an issue related to street children; however, some of the recent studies shed light on how the problem is prevalent among different sub-population of children and how children adolescents form a high-risk group vulnerable to abusing substances. In a nationwide survey conducted by National Commission for Protection of Child Rights (NCPCR) on around 4000 children and adolescents below the age of 18 years, covering over 100 cities and towns in different states, it was found that individuals were abusing drugs in both rural and urban areas. The tobacco was the most commonly abused drug, which initiated at the average age of 12.3 years, followed by alcohol, cannabis, and inhalants. They were also found to be using opioids, heroin, and sedatives, the consumption of which began around 14–15 years of age (Dhawan et al., 2017).

Succinctly put, the global burden of mental health issues amongst youth is around 20%, i.e., around 20% young individuals suffer from mental health problems worldwide, whereas only 7.3% of India's youth suffers from it. Yet, the stigma associated with mental health issues in India renders many help-seeking young people without any treatment (Gaiha et al., 2020). In a meta-analysis concerning the magnitude and manifestations of the stigma associated with mental health in India, it was found that there are notable conceptual gaps and mis-perceptions about mental health among Indian youth (Gaiha et al, 2020). Consequently, it becomes crucial to raise awareness and sensitize the young population about the risk factors, potential causes, symptoms as well as treatments available for mental health disorders.

In the recent times, the trepidation surrounding coronavirus outbreak that has been declared a pandemic by WHO has also emerged as a cause of concern as it can have repercussions for adolescents' mental health, who have been forced to confine in their homes owing to the nationwide lockdowns. Kumar, Eregowda and Giliyaru (2020), in their study on 10–19-year-old quarantined adolescents residing in Bangalore, India found that they had high levels of perceived psychological distress, which they attributed to uncertainty about future and academic delays. The parental anxieties, disruption in routine life, lack of physical activity, and home confinement with no access to peers or teachers could also be some of the perpetuating factors in maintaining the stress amongst adolescents (Patra and Patro, 2020). These unprecedented times have also put the adolescents at augmented risk of school dropouts, increased gender gap in education, child labour, early or forced marriages, and numerous other psychosocial issue (Kumar, Priya, Panigrahi, Raj and Pathak, 2020).

There also appears to be an intersection between mental health issues and juvenile delinquency among Indian adolescents. A juvenile is any individual below the age of 18 years, and juvenile delinquency refers to the juveniles indulging in the crimes that call for legal intervention. Statistics show that in the USA alone, as many as 50–75% juvenile delinquents across the globe suffer from some type of mental health disorder (Underwood & Washington, 2016). A study by Chaurasia and Ali (2019) in Bihar

state of India revealed that compared to normal adolescents, juvenile delinquents had significant difficulties on different dimensions of mental health and suffered from issues such as emotional instability, low self-concept, low sense of safety and security, and difficulties in adjustment.

The Juvenile Justice (Care and Prevention of Children) Act, which was enacted in the year 2015 by Government of India, targets the children that are in conflict with the law and aims to provide protection and care to them; focuses on their development, treatment, rehabilitation, and re-integration into the society, by adopting a child-friendly approach in the matters of adjudication with the provision of juvenile justice system. It is based on the assumption that children are tender and cannot be treated with the same laws as adults. Many young offenders are often indulged in crimes because of their background which speaks of their neglect, abuse, exploitation, etc., and they may also be dealing with mental health issues. As a result, dealing with them by relying on the same justice system as that of adults may further escalate their problems and victimize them even further. Therefore, the act seeks to provide a more comprehensive legislative framework for children that contravene the laws of the country.

In this way, the Government of India has taken several steps to ensure the well-being of the adolescent population of the country. At the policy level, the Government of India has also come up with National Mental Health Policy (2017), which is an initiative to prioritize the mental health of its citizens, as despite being of paramount importance, it has hitherto remained neglected in the parliament. With the introduction of the National Mental Health Policy, the Government of India seeks to provide an integrated, participatory, and evidence-based approach to address the mental health concerns of individuals. Adolescent population is also one of the stakeholders in this policy, as its goals aiming to increase the access to mental health services, reduce prevalence of mental health issues and the stigma associated with it, reduce rate of attempts to suicide, etc., are all directly affecting the adolescents as well.

Gap in research and policies in India

Despite the best of our efforts to identify and lay down the concerns of adolescents, who are the assets of the country, there still remains a gap between the theory and the policy in action. For instance, in a policy review, Roy et al. (2019) reviewed six policies and programs, including National Youth Policy (2014), National Mental Health Policy (2014), Rashtriya Kishor Swasthya Karyakram (2014) and interviewed 11 key stakeholders. One of the key findings of their review was that the young people are minimally involved in the development and implementation of these programs. The stakeholders also revealed some of the major challenges in the implementation of these policies, including the lack of coordination between different sectors, fragmented governance, i.e., poor coordination between state and central governments, inadequate human resources, and budget constraints.

Therefore, there is an immense need to increase the involvement of adolescents in the policies and programs that are meant for them, because target groups are one of the key stakeholders in any program or policy, and unless we include them in the formation of policies meant for them, we cannot fill the gaps between research and policy implementation. Also, different sectors of the society as well as state and central governments should be clear about their respective duties, and efforts should be made to increase the coordination between them. The need for coordination between different departments and ministries to cater to the mental health concerns of people has also been emphasized by the Mental Health Act, 2017. The focus should also be on capitalizing on existing human resources and increasing the budget allocation for these programs and policies meant for adolescents, who will ultimately help in generating revenue for the country later on.

Again, India needs a vigorous policy that specifically deals with the mental health of older children and adolescents, as it is a crucial transition phase where the individuals go through considerable physical and psychological changes. As of now, India does not have a comprehensive policy that specifically targets the adolescents' mental health. Adolescents have largely remained under-studied and have often been confused with older children or early adulthood, instead of being studied as a separate developmental stage. Even when they are studied as a separate developmental stage, their needs are hardly understood properly. Hence, by intervening at this stage and identifying their needs appropriately, the expenditure on health care that this population may yield in their adulthood can be avoided. At the psychological level, we need to have stakeholders that are highly motivated and enthusiastic so that the policies can be sustained and utilized for a longer duration of time (Hossain & Purohit, 2019).

In addition, merely formulating policies or implementing the programs appropriately is not sufficient, making them accessible to the target group for which it is meant is equally important. For instance, the researchers have found that most of the programs and policies aimed at improving the sexual and reproductive health of the adolescents serve the needs of school-going adolescents, as a result of which the out-of-school adolescents are left out. Also, female adolescents are less likely to be the recipient of these programs due to less freedom of mobility, compared to male adolescents (Santhya & Jejeebhoy, 2012). Hence, there is a dire need to address all the barriers that prevent the adolescent population from accessing the programs meant for them.

The WHO Mental Health Gap Action Program (mhGAP, launched in 2008), also aims to accelerate the efforts to make the treatment more approachable for the individuals in low- and middle-income countries, as it has been found that in spite of sharing the large burden of mental, neurological, and substance use disorders among its population, as many as 75% of the individuals in these countries do not have any access to proper care, assistance, or interventions. WHO has urged the member states to respond appositely to this growing challenge of mental health issues. The mhGAP program provides intervention guide and training manual in different languages, so as to guide the low- and middle-income countries on preventing and managing the mental, neurological, and substance use (MNS) disorders. At the base of mhGAP is the vision for collective action to deal with mental health concerns, i.e., joint efforts

of government, mental health professionals, family, society, along with the support of international community or organizations is needed to eradicate the MNS disorders.

Future Perspective

The traditional approaches have focused upon risk assessment for intervention and treatment of mental health concerns in adolescents. However, there is a need to shift from merely identifying their weaknesses to building upon their strengths, i.e., to rely on a strength-based approach for positive development in adolescents (Duncan, 2009). Grounding the developmental approaches to adolescents in their strengths requires the practitioners to understand what constitutes strengths in adolescents, helping the adolescents gain confidence in their strengths and relying on shared decision-making to bring about the behavioral change.

In addition, the future approaches and intervention strategies should make use of innovative technologies to deliver or implement the interventions. For instance, Wasil et al. (2020) designed single-session computerized interventions (computerized SSIs) and implemented them on high school students of Pune, India. The interventions were made in three domains—behavioral activation, gratitude, and growth mind-set exercises. The results indicate that computerized SSIs may serve as an effective way of implementing the intervention in a systematic manner and disseminating it to a widespread population in a time bound manner. They can serve as the effective replacement for traditional methods of delivering interventions that are not only time-consuming, but also very expensive.

The Positive Youth Development, which has been defined by the "Interagency Working Group on Youth Programs" as an intentional approach aimed at engaging the youth within their own communities, schools, organizations, etc., in a way that is conducive to their positive development, i.e., enhances their strengths, fosters positive relationships, promotes positive outcomes by providing opportunities, can also be utilized for promoting positive development in adolescents. In this way, positive youth development approach builds upon the strengths of youth to further promote their positive development. Positive youth development has its roots in prevention, i.e., preventing the youth from the problems that typically arise in adolescent years, such as teen pregnancy, substance abuse, juvenile delinquency. However, over the years, it has shifted its attention from prevention to the protective factors, such as family environment, which can improve youth's ability to cope with the adverse situations of life.

Hameed and Mehrotra (2017) carried out a rapid review to examine the relevance of positive youth development approach for mental health promotion among adolescents. For the purpose, they carried out keyword-driven search, jointly using "positive youth development" and "India" as keywords, using electronic databases (EBSCO, ProQuest, and MedIND). Surprisingly, the search identified only 24 articles in total, out of which nine studies (six non-intervention and three intervention studies) that met the criteria for inclusion were retained for the review. It indicates

that there is severe paucity of research in the field of positive youth development and its implication for mental health in India.

There are few mental health initiatives, for instance, "feeling good and doing well" that have made use of positive youth development approaches to improve mental health and well-being of adolescents. This intervention program was aimed at testing the efficacy of mental health efficacy program, for which the mental health intervention was implemented on 85 college youth residing in a metropolitan city, while 86 participants were placed in the waitlist control group. The results indicate significant improvement in well-being and self-efficacy, and significant reduction in psychological distress (Mehrotra, 2013). It indicates that PYD has consequences for improving the psychological well-being of adolescents, an approach that has remained underutilized in the arena of mental health.

Therefore, the dearth of literature in this area points toward the opportunity of using a positive youth development approach to promote mental health of adolescents. The youth themselves can work as the agents of change by participating in different positive youth development programs, which can incorporate the components of mental health in them. As the adolescents themselves would be engaged in the development of these programs, they will not only feel empowered, but it can also have consequences for their psychological well-being. In addition, the mental health awareness can also be raised among adolescents through positive youth development programs, which will further promote their holistic development.

Finally, the adults that are in direct contact with the adolescents, such as caregivers, parents, teachers, should also be made stakeholder in the development of these programs and policies. One of the major obstacles in the successful development and implementation of adolescent programs is the lack of manpower. Through inclusion of these adults in the process, we can not only ensure that the programs and policies are implemented appropriately, we can also ensure that they are actually helping us accomplish the objectives and reaching our target of a better present and future of adolescents in India.

Conclusion

Adolescent years are characterized by prominent physical, psychological, and socio-emotional changes. The stage is considered to be very crucial as the well-being in this phase determines how the individual will communicate with the world as an adult. During this stage, the individuals are faced with various challenges by virtue of being embedded in a socio-cultural context, which can be understood by drawing upon Bronfenbrenner's model. The interactions within the microsystem, such as family and peer relationships, or between different microsystems, i.e., mesosystem; the environments such as mass media or local politics that an individual is not directly in touch with, i.e., exosystem; the overarching beliefs or attitudes of the culture, i.e., macrosystem; and, the changes that take place over time, i.e., chronosystem, are all responsible to provide protective as well as risk factors that tend to influence

the adolescent development. Nevertheless, few researches in India have attempted to study these systems as well as processes that can help us discern the adolescents' needs. In view of the global efforts to ensure well-being of adolescents and to meet Sustainable Development Goals (SDGs), India has also prioritized the mental health and well-being of its adolescent population of around 373 million people, through introduction of various programs and policies, such as School Health Program, Rashtriya Kishor Swasthya Karyakram, Adolescent Reproductive Sexual Health Program, Integrated Child Development Scheme. However, despite several attempts by researchers, practitioners, and policymakers, there still remains a gap between research and policies, which can be attributed to the lack of participation of adolescent population in the policy formulation, lack of motivation and co-operation between different stakeholders, and lack of information among general population. The programs and policies specifically meant for adolescent population, in which the adolescents themselves are involved in the formulation, can be considered a step forward in this direction. There is also a need to shift the focus of interventions from merely rectifying the weaknesses of adolescents to capitalizing on their strengths, i.e., to rely on strength-based approaches for positive youth development. In addition, a multidisciplinary approach should be utilized, in which different stakeholders work in a collaborative manner to provide appropriate services to adolescents, in a timely and integrated manner. The health and well-being of adolescents should be considered a shared responsibility, as synergy between various stakeholders and not the isolated individual efforts is the need of the hour.

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Chapter 8
School Bullying and Violence: A Matter of Human Rights

Phillip T. Slee

Abstract In this chapter, consideration will be given to the matter of schools, schooling, and violence and bullying and its impact on mental and physical health in a global context. The UN Convention on the Rights of the Child clearly outlines a range of fundamental human rights for all young people. Underpinning the Convention is the right to pursue an education free from the threat of violence. The chapter will begin with a consideration of the issue of violence and bullying from a global perspective. Of necessity, this entails a systems wide view of the issue and to that end the chapter will turn to a consideration of the nature of systems. Argument is then made for a human rights perspective and for a consideration of the issue of violence and bullying from a human rights perspective. Joint Indian and Australian research will be used from schools in these two respective countries to illustrate the need to recognize the rights of young people to pursue an education in a safe and protected environment.

Keywords Students · School bullying · Violence · Human rights · Concern

Introduction

School Bullying and Human Rights!

> Action to combat bullying in schools is undoubtedly a major contributor to the achievement of child rights globally. (Richardson & Hiu, 2018, p. 3)

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_8

Violence and Bullying in Global Context

In a globally connected and culturally diverse world, addressing violence and bullying and successfully negotiating diversity and prejudice is critical. There are a number of historical figures whose names are associated with the concept of nonviolence as a way of addressing aggression and promoting peace in our society. Arguably, one of the most famous is M. K. Gandhi. Formative in the development of Gandhi's philosophy of nonviolence was his experience as a lawyer in South Africa and his defiance of the enactment of an Ordinance by the South African Government of the time that would have required Indians living in South Africa to take out a certificate of registration (Asiatic Registration Act). Gandhi had already experienced racial prejudice having been violently ejected from a train he was travelling on in Pietermaritzburg because his first class train ticket offended a white passenger arguing that colored people could only travel third class. The evolution of Gandhi's philosophy of "civil resistance" differed from Henry David Thoreau's concept of "civil disobedience." Because Gandhi believed that civil resistance was far from "passive." As Gandhi noted "Disobedience to be civil must be sincere. Respectful, restrained, never defiant, must be based upon some well understood principle, must not be capricious and above all, must have no ill-will or hatred behind it" (Kripalani & Meghani, 1969, p. 51).

In further developing his concept of nonviolence, Gandhi wrote "I object to violence when it appears to do good; the good is only temporary; the evil it does is permanent" (Kripalani & Meghani, 1969, p.49). Gandhi was insistent on differentiating passive resistance (the initial terminology) from the developing idea of "Satyagraha." Gandhi also objected to passive resistance because it did not disavow the use of physical force. However, Satyagraha incorporated "truth" (Satya) and "love and firmness" (Agraha). Satyagraha was used by Gandhi in India to oppose British rule. However, it was also seen as a universal solution incorporating moral force to address social injustices and harm. Inherent in Gandhian philosophy is a belief in the essential goodness of a person. As everyone has a conscience, if a person is made aware of their misbehavior, they are capable of seeing reason and behaving differently rendering unnecessary the use of violence to bring about change. A feature underlying the philosophy of Satyagraha is that it calls for the education of the other. Having considered the background to the thinking and philosophy of one of the most influential reformers of the last century, we move forward to consider more modern initiatives engaged with the peace movement generally with a particular focus on education and schooling. In doing so, the chapter will also consider the related issue of the need to address school bullying as a human rights issue.

Violence, Aggression and Bullying—Two Sides of a Coin!

Globally, there is now a significant focus on the issue of school violence as witnessed by the number of journal and book publications. A significant increase in conferences focused on the issue serves to highlight the policy and program focus of researchers and government agencies on addressing the issue of school violence. One view is that the concerns represent an overreaction or "moral panic." The alternative view which adds a heightened sense of urgency to the matter is that young people in our schools are becoming increasingly vulnerable to interpersonal violence particularly as it is manifested through social media. In turn, this has led to a significant emphasis on the development of policy and programs to address the issue.

Cohen and Espelage (2020) in an edited book have provided a comprehensive overview of research relating to violence and bullying prevention, highlighting global concerns regarding the matter. This latest summary echoes earlier reports such as that from the USA Mulvey & Cauffman (2001, p. 797) who note "school violence, having been dubbed a crisis, permeates the national consciousness and media outlets." Counterbalancing the heightened level of awareness of the issue is emerging evidence from a variety of sources concerning a declining level of school crime and violence. For example, researchers in the US report a decline in school crime (e.g., Hyman, et al., 1997). Interestingly, within the Australian context, researchers including Leigh and Ryan (2009) have noted that youth crime rates (e.g., violent and property crime rates) have remained relatively constant through the 1980s and 2000s (e.g., AIHW, 2007).

Vulnerability to Violence

Bullying in Australia and India

In Australia, estimates of the extent of bullying in schools have been made using interviews with students, teachers, and parents, and direct observations of students. A more complete description of these statistics and related research is found in Slee (2017).

Australia-wide surveys (Slee, 2017) involving over 9722 students from more than 36 schools (Catholic, independent and state) confirm that:

- Between one in five and one in seven students report being bullied "once a week or more."
- More bullying occurs in primary than secondary schools.
- In primary schools. bullying is highest in the lower years.
- In secondary schools, bullying is highest in years eight and nine.
- Males typically report being bullied more than females
- Cyberbullying is now a feature of students' online presence.

The matter of estimating the frequency of bullying in India is challenging given that India does not at present have a history of research into the topic. Certainly, it is noted that female Indians do report high levels of "eve teasing." This is defined by the Cambridge dictionary (2017) as the act of publicly annoying a young female person or woman. Common forms of eve teasing include stalking, groping, lewd gestures which may result in sexual assault. In the Australian context, this behavior toward a female would be identified as sexual harassment (not necessarily bullying). In a recent systematic review of bullying and victimization in India, Thakkar et al. (2020) concluded that estimates of the frequency of bullying among Indian school students were problematic in light of the different metrics used to measure bullying, the lack of a randomized sampling procedure and challenges to the data collection process.

Forms of Bullying

As Slee (2017) has noted in Australia, the forms of bullying vary widely in frequency and are also affected by age and gender. Generally, verbal forms (e.g., name calling) are the most common. Physical bullying is the least common and declines with age. Online or cyberbullying is now another form. In their review, Thakkar et al. (2020) noted that in India, the most common form of bullying was verbal.

Bullying and Mental Health Sequela

In both Australia (Slee, 2017) and India, Thakkar et al. (2020) stated that the reviews of research clearly indicate that school bullying is associated with poor mental health outcomes. Generally, recognized poor mental health outcomes include proneness to depression, anxiety, and in more extreme cases to suicidal ideation.

Bullying and Individual Factors

In Western countries as reviewed by Slee (2017), young people who are perceived by their peers to be "different" are more likely to experience bullying. For example, young people with special educational needs and disability (SEND) report higher levels of bullying. Gender nonconforming young people (lesbian, gay, bisexual or transgender) are at greater risk for bullying. In the Indian context as reviewed by Thakkar et al. (2020), one factor associated with higher levels of reported bullying is the caste system.

One particular group deemed at risk for being subject to violence and bullying is that of young people on the autism spectrum. The limited research highlights that students with ASC are a very high risk group for victimization, higher than students with other disabilities (e.g., Humphrey & Hebron, 2015), presenting a major concern for young people's well-being. Maïano et al. (2016) in their meta-analysis found that when compared to their typically developing peers, youth with ASC were just as likely to exhibit bullying behaviors, with similar rates of perpetration. However, in terms of bullying victimization, youth with ASC were highly vulnerable, being up to three times more at risk of being victimized generally, and twice as likely to be verbally victimized. Regarding children with ASC and bullying in Australia, a study reported in Bottroff et al. (2019) noted that 61.6% of the bullied ASC students (aged 12–14 years old) reported being bullied "*once a week or more often*" which is considerably higher than the 1:5–1:7 students reported by Slee (2017) for the general population of Australian students. What is relevant here is that bullying is a real and ongoing issue for many students, and that *"once a week or more often"* is generally identified as "serious" (Slee, 2017).

In terms of duration, all of the 45.5% of the victimized students with ASC in the South Australian study reported that the bullying lasted "*months or more.*" Contrast this with a separate analysis of 5,850 mainstream Australian school students who if they had been "seriously bullied" reported that for 17.8% it lasted "months or more" (Slee, 2017). That is, for the ASC students, the chronicity of the bullying is significantly greater. The most frequently reported types of victimization (multiple responses allowed) were: "name calling" (60.4%), "physical" (32%), being "left out" (29%), and being "threatened" (21.9%). Some 3% of students reported being bullied via social media, e.g., the internet.

However, in discussing violence against children and young people, the challenge is that there exists in research a confusing array of terms including "aggression," "violence," "anger," and "bullying" which are sometimes used interchangeably so a brief consideration of the terms is warranted before proceeding further. Defining 'aggression' has been challenging. The early definitions focused on physical harm, but it is now more broadly understood that it is important to distinguish between various types of aggression, e.g., proactive vs reactive aggression. The reason for this is that not all forms of aggression are associated with harm, e.g., being assertive in order to defend oneself would not necessarily be considered harmful.

In their book, Anderson and Bushman (2002, p. 29) report that five main theories of aggression guide research: (a) Cognitive neoassociation theory, (b) social learning theory, (c) script theory, (d) excitation transfer theory, and (e) social interaction theory. These various theories serve to highlight how aggression is understood ranging from frustration to learned behavior to negative cognitive responses to a breakdown in information and coding of an experience to explanations invoking a developmental phase.

In relation to violence, it was noted by Denmark et al., (2005, p.18) "that no acceptable comprehensive theory of violence has emerged ought not to be taken to mean that progress in understanding behavior that is violent has not been made." As broadly understood, violence is any aggressive act resulting in extreme physical

harm including on occasions injury and death. The puzzle is that while all violence is aggression, not all aggression is violence, e.g., a child pushes another to obtain a desired toy may be aggressive but it is not violence. Moreover, violence encompasses a gamut of acts including domestic violence, child and elder abuse, and common assault.

Bullying is another term that has of late become a common part of our everyday lexicon. To many, it has become a misunderstood and often misused term. This is curious because as reviewed by Slee (2017) bullying has been an identifiable feature of most if not all cultures. In the Australian context, Indigenous Australians representing one of the oldest cultural groups utilized a DreamTime story to explain how a flightless bird called the Emu actually lost their ability to fly as a result of their bullying behavior. The "dreaming" is a mechanism that the Aborigines used to establish their values and beliefs and explain their relationship to the country. The Wangkatha, otherwise written Wongatha, Wongi, or Wangai, is a language and represents the identity of a number of Aboriginal tribal groups in the south-eastern corner of Western Australia. Their DreamTime story recounts how Emu lost the ability to fly as a punishment for their bullying of smaller birds. As a result of their bullying behavior, the emus became loud and boastful and although the smaller bird tried to reason with them they would not listen leading to the smaller birds losing their will to sing. As a last resort, the small birds approached the elder of the tribe who cast a spell on the bullying emus resulting in them losing their ability to fly and bully the smaller birds.

Smith et al. noted that Heinemann (1973) discussed the issue of bullying using the Norwegian term "mobbning," drawing on ethological theory representing the action of a group against an individual. Dan Olweus (1978, 1993) subsequently extended the definition to include systematic one-on-one attacks of a stronger child against a weaker child.

> A student is being bullied or victimized when he or she is exposed, repeatedly and over time, to negative actions on the part of one or more other students. It is a negative action when someone intentionally inflicts, or attempts to inflict, injury or discomfort upon another. [And] In order to use the term bullying, there should also be an imbalance in strength (an asymmetric power relationship): The student who is exposed to the negative actions has difficulty in defending himself or herself and is somewhat helpless against the student or students who harass. (Olweus, 1997, p.496).

Hemphill et al. (2014, p.15) undertook to define bullying concluding:

> School-based bullying is a systematic abuse of power in a relationship formed at school characterised by: 1. aggressive acts directed (by one or more individuals) toward victims that a reasonable person would avoid; 2. acts which usually occur repeatedly over a period of time; and 3. acts in which there is an actual or perceived power imbalance between perpetrators and victims, with victims often being unable to defend themselves effectively from perpetrators.

Slee et al. (2003) reviewed the matter of definition in five countries in the Asia–Pacific region noting considerable differences as to whether countries had a word for "bullying" and how it was defined. Different cultures have different words (e.g.,

in Japan, it is "ijime," and in Korea, it is "wang ta") and that different meanings are attached to the word. For example, in Japan, the word "ijime" refers to the indirect and exclusionary features of the behavior rather than emphasizing the physical aspects. Other cultures do not have a word for bullying, at least as that understood in mainstream Western countries. As such, the matter of definition is a contested one. For example, it has been argued that a one off incident can also constitute bullying. For example, cyberbullying may involve a negative message or image posted on the internet once but it goes viral is it bullying? Generally agreed upon facets that distinguish bullying as a particular form of aggression include (i) a power imbalance, (ii) an intention to hurt, (iii) the point that the victim generally feels unable to stop the behavior and feels harmed by it, and (iv) repletion of one kind or another.

To reiterate then as argued in this chapter, the concern with school violence now extends across the globe. In the present chapter, a broad overview of the field of violence, aggression and bullying will be considered. The chapter will also focus on theories underpinning school bullying. There exists in research a confusing array of terms including "aggression," "violence," "anger," and "bullying" which are sometimes used interchangeably so the nature of these various terms will also be considered.

The World Health Organization (WHO) has defined violence as

> The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation. (WHO Global Consultation on Violence and Health, 1996)

The issue that arises when the concept of bullying is introduced into the equation as noted previously is what exactly the difference between violence and bullying. However, while the definition of bullying is subject to some debate, decades of research on bullying have enabled some broad consensus of what comprises bullying—at least in the Western world (Smith et al., 2012). Bullying is conceived as a subset of violence or aggressive behavior; that is, as behavior that is intentionally harmful, psychologically or physically, to another individual. As a special form of an aggressive act, bullying is defined as

> A student is being bullied or victimized when he or she is exposed, repeatedly and over time, to negative actions on the part of one or more other students. It is a negative action when someone intentionally inflicts, or attempts to inflict, injury or discomfort upon another. [And] In order to use the term bullying, there should also be an imbalance in strength (an asymmetric power relationship): The student who is exposed to the negative actions has difficulty in defending himself or herself and is somewhat helpless against the student or students who harass. (Olweus, 1997, p.496)

While bullying is an international issue, it is only just beginning to be researched in India. Research using the PhotoStory method published by Skrzypiec et al. (2015) consistent with the previously described meta-analytic study of Thakkar et al. (2020) notes the high frequency with which Indian females report that sexual harassment or "eve teasing" is a common occurrence. As broadly understood, the word "eve" originated from the name of the very first women according to the Biblical creation

story. According to Cambridge Dictionary (2017), "eve teasing" is the act of annoying a woman or women in a public place. According to Kuruvilla and Suhara (2014), "eve teasing" generally occurs in pre or early adolescence when girls are sexually maturing. It can take various forms as catcalling, lewd gestures, stalking, groping, and might lead to sexual assault as well.

The Convention on the Rights of the Child

The Convention on the Rights of the Child (CRC) is the most widely ratified human rights treaty in the world. The only country that has not ratified the CRC is the USA. The CRC statement encompassing human rights advocates that all individuals regardless of ethnicity, gender, language, or place of residence are entitled to basic human rights. The question which then arises concerns whether school bullying is a violation of human rights which raises the question of just what are human rights.

The Australian Human Rights Commission (2013, p.1) notes that "human rights recognize the inherent value of each person, regardless of background, where we live, what we look like, what we think or what we believe." In the same document, it is noted that such rights draw upon the significant principles relating to mutual respect encompassing and embracing of cultural, religious, and philosophical tolerance. Of particular note and relevance to the argument presented in this chapter is Article 19 of the CRC which addresses the rights of children who are at the receiving end of bullying and harassment: "Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child." As such, it would appear that school bullying is a human rights issue. The United Nations notes in very explicit terms that "human rights are rights that every human being has by virtue of his or her human dignity (1989, p. 19)".

Another question which then raises concern is what is controversial about human rights. Indeed, Molnar (1986, p.) has identified that "the topic of human rights in the context of schools has the potential to be extremely controversial." One possible reason reflected in mainstream media and popular culture is that the view that human rights were generally allowed some individuals to exploit "rights" to their own advantage, i.e., to escape punishment for some misdeed. Another view is that children, especially primary school children, were not developmentally able to understand some of the more "complex" matters associated with human rights. In not understanding the concept, children could use/abuse their "rights" arguing that there were responsibilities that accompanied human rights. Other teachers in the study believed that human rights were too dry and boring to engage students. Other teachers believed that young children in particular might be "frightened" or "scared" by the topics covered in discussing human rights, e.g., violence, poverty, or discrimination.

The question which then arises concerns whether school bullying is a violation of human rights. The Australian Commission for Human Rights (2013, p.1) for example, notes that "human rights recognize the inherent value of each person, regardless of background, where we live, what we look like, what we think, or what we believe." They are based on the principles of dignity, equality, and mutual respect, which are shared across cultures, religions and philosophies. They are about being treated fairly, treating others fairly and having the ability to make genuine choices in our daily lives.

In Australia, the National Safe Schools Framework (NSSF) launched in 2003 and reendorsed by Federal Parliamentary Ministers in 2010 and last in 2019 notes that its underlying premise is that "all Australian schools are safe, supportive and respectful teaching and learning communities that promote student well-being" (p. 1).

https://www.education.gov.au/national-safe-schools-framework-0.

In this chapter, it is argued that, consistent with the Convention of the Rights of the Child, the Australian Commission for Human Rights, and the National Safe Schools Framework, students have the right to expect that they will be able to undertake an education in a safe and respectful environment.

Now, it follows that if governments truly believed that the issue of bullying was a matter of human rights, it would follow that government policy would reflect this—in the following section, we examine this point of view. Consideration is given to the identification of factors that we currently understand contribute to the successful reduction of the incidence of school bullying. In doing so, the chapter calls upon the United Nations 2019 report "Behind the numbers: ending school violence and bullying" and the 2018 UNICEF report "Developing a Global Indicator on Bullying of School-aged Children" written by Dominic Richardson and Chii Fen Hiu. We will also refer to a landmark OECD 2018 report on school bullying. To illustrate the points made in these landmark reports, a case example will be provided from the Australian education sector.

The United Nations 2019 report is significant for a number of reasons. In outlining the factors contributing to a reduction in bullying and school violence, the report used case studies of seven countries where there had been a sustained reduction in bullying using data collected via the Global School-based Student Health Survey (GSHS) or the Health Behavior in School-aged Children (HBSC). There currently exist a number of significant publications documenting the issue of school bullying globally (e.g., Smith et al., 2018). However, in the UN (2019) report the seven sites selected also reflected different world regions and education systems thereby offering some new insight into creative and constructive responses to the issue of bullying. In the countries selected for the report informants were presented with quantitative data for that country and the task was to explain why the prevalence had decreased or remained low in their countries.

We will further examine the success and constraining factors identified in the UNESCO report later in this chapter. However, before doing so, we need some appreciation of why the issue of bullying and victimization has become an international focus in education systems and schools globally.

Part answer to these questions lies in the prevalence of school bullying and the harmful physical, social and psychological sequelae arising out of its extensive and widespread nature. The UNICEF report provides some very useful insight into the matter of prevalence. Utilizing data available data from all regions collected using the (Global School-based Student Health Survey (GSHS); and the Health Behavior in School-aged Children (HBSC) research showed that 32% of students have been bullied in some form by their peers at school on one or more days in the past month. Across GSHS countries, the prevalence of having been bullied ranged from 7.1 to 74%. Across HBSC countries, the prevalence ranged from 8.7 to 55.5%.

The 2019 Organization for Economic Cooperation and Development (OECD) report has provided some helpful clarification of matters pertaining to school bullying including its prevalence and relationship with academic performance and well-being. In providing an overview of the OECD (2019) report, it is noted that:

- On average, 23% of students reported being bullied at least a few times a month.
- Males and low-achieving students in reading were more likely to report being bullied at least a few times a month than girls and high-achieving students.
- Some (88%) of students (88%) agreed that it is a good thing to help students who cannot defend themselves.
- Students who report being frequently bullied also report compromised well-being and mental health in terms of depression and anxiety.
- In schools with a high prevalence of bullying, students reported feeling less engaged.

Effective Responses to School Bullying

An important question which then arises with relevance to Australia and India concerns just what constitutes an effective national response to school bullying? Some important insight into answering this question is provided by the United Nations 2019 report. Based on case studies of six countries that have succeeded in reducing school violence and bullying (viz., Eswatini, Italy, Jamaica, Lebanon, Republic of Korea, and Uruguay) and two countries that have maintained low levels over time—the Netherlands and Sweden it has identified a number of factors that contribute to effective national responses.

One such leading factor concerns political leadership and high-level commitment, together with a strong and visible legal and policy framework that addresses violence against children and school violence and bullying. It was highlighted in the 2019 report that most successful countries have an emphasis in their national policies on promoting a safe learning environment and a positive school and classroom climate and a strong commitment to child rights and empowerment.

In reading the 2019 report, it is clear that a contributing factor to low rates of school bullying includes the matter of partnerships. These countries recognize that at a national level, this includes partnerships between the education sector and other

sector departments such as that of health, community organizations, tertiary institution such as universities and the print and television media. At school level, it includes partnerships involving all stakeholders in the school community, including head teachers, teachers, other staff, parents and students, local authorities, and professionals in other sectors. More specifically, the involvement of all students, including bystanders, and the use of peer approaches have been a key factor in countries that have made the most progress.

A third factor identified in the 2019 report includes an emphasis on evidence-based approaches, which are informed and shaped by the systematic gathering and maintenance of comprehensive data bases. The gathering of such data facilitates the regular and systematic evaluation of the effectiveness of existing programs. Using these evidence-based approaches provides for regular and transparent reporting and monitoring of school violence and bullying. Independent and scientific evaluation of the impact of programs and interventions was also identified in the report.

A critical factor contributing to low levels of violence and bullying noted in the 2019 report concerns the provision of professional training and support for teachers to better care for and provide support for bullied students. In particular, training of teachers in successful countries has focused on developing skills to prevent and respond to school violence and bullying and to use strengths based approaches to classroom management.

In summary then, it is clear that the issue of school bullying has gained global attention. An argument has been presented in this chapter that it is incumbent on governments and education authorities around the world to address the issue. In part, this imperative arises because at its heart school bullying violates the rights of the child and young person to pursue an education in a safe environment. It is also apparent in reviewing the research that bullying is physically, socially, and psychologically harmful, impacting on the young person's academic attainment at school. Evidence has also been presented that it is becoming clearer what steps must be taken at a government and policy and program level to address bullying. To illustrate the steps required to address bullying, the chapter now turns to an example from the Indian subcontinent and Australia. These two countries were chosen because it will enable the discussion to encompass many of the points identified in the UNESCO 2019 report involving the use of case studies of countries to pinpoint guidelines for successfully addressing bullying. In particular, the focus will be on (i) leadership and high level commitment, (b) collaboration and partnerships, (c) evidence based approaches, (d) teacher training, and (e) student voice.

In 2012–15, the Indian–European Research Networking Program in the social sciences funded a program entitled "Bullying, Cyberbullying and Pupil Safety and well-being". The funding brought together two Indian teams (from Annamalai in Tamil Nadu and Patiala in the Punjab). The European team was from universities in London, UK; Nice, France, Munich, Germany and Amsterdam, Netherlands. The Australian team was from Flinders University and the University of South Australia, South Australia, and Queensland University of Technology, Queensland. The Indian, European, and Australian teams collaborated over a period of three years (2012–2015). An extensive program of work was undertaken as part of the international

collaboration and involved literature reviews, the development and application of research tools to undertake cross-cultural research, and a range of hosted international conferences in India, France, and Germany at which researchers reported the findings emerging from the international networking and research collaborations (Fig. 8.2).

Bullying in India and Australia

As noted earlier in this chapter, a recent systematic review of bullying and victimization in India (Thakkar et al. 2020) concluded that estimates of the frequency of bullying among Indian school students were problematic in light of the different metrics used to measure bullying, the lack of a randomized sampling procedure, and challenges to the data collection process. That said, it is important to recognize the findings from existing Indian research into the topic. In an early study by Ramya et al., some 500 students from five randomly selected schools in Maharashtra (a state in the Western peninsular region of India occupying a substantial portion of the Deccan Plateau). The students were aged from 8 to 14 years old. In reporting their findings, the researchers concluded that in India, "bullying is a major problem among school children" (p. 307). In summary, they noted that over 60% of their sample reported being bullied was most prevalent among the boys and typically involved verbal bullying with victims reporting a range of somatic symptoms including headaches and depression. Only, a minority of parents were aware that their child was being bullied.

In a more recent reported 2016 study conducted under the auspices of the United Nations International Children's Emergency Fund (UNICEF) "Experiences of Peer Bullying among Adolescents and Associated Effects on Young Adult Outcomes: Longitudinal Evidence from Ethiopia, India, Peru and Vietnam" data was reported from nearly 1000 young people in India (the states of Andhra Pradesh and Telangana). In reporting the findings for 15 year olds in the study across the three countries, indirect bullying was the most prevalent type of bullying affecting over a quarter of Indian children, and while physical bullying was the least prevalent across the three countries, the exception was India where it was almost as prevalent as other types of bullying. Physical bullying was the most common type reported by males in all three countries. In India, children from the "scheduled tribes in India were 18 percentage points more likely to report verbal bullying than the more advantaged 'other castes' reference group" (p. 30). For example, a 16-year-old boy from the scheduled tribes in Andhra Pradesh described being treated disrespectfully and bullied because he belonged to a caste group with low social status. He said: "They are from higher classes and we are from lower classes… We gave respect to them, but they didn't give it to us… We were six to seven people and we stayed in the queue in the hostel for food, but our higher-class students came in the middle of the queue. If we ask 'why do you do that?' they scold me" (Pells et al., 2013: 8–9). In fact, the issue of looking different either in terms of appearance or because of poverty and disadvantage was associated with the qualitative reports of the children of an increased level of

bullying. The report noted that structural associations with bullying, e.g., poverty, are generally overlooked in mainstream research but the UNICEF survey data found that economically disadvantaged children are consistently more likely to be bullied in India.

In Australia, the matter of school bullying has been the subject of research for nearly 30 years. In the first published large-scale Australian study of school bullying, Rigby and Slee (1991) surveyed the extent of bullying among Australian school students and attitudes toward victims of bullying involving students and their teachers. It was found that approximately 1 child in 10 was subjected to peer groups. In a further large-scale follow-up to this first research study in the first national evaluation of the incidence of bullying, Rigby and Slee (1999) collated data regarding the extent of being victimized in Australian schools based on research involving approximately 25,500 primary and secondary students from over 60 Catholic, independent, and public schools. The evaluation was made using the Peer Relations Questionnaire (PRQ), which was developed by Rigby and Slee (1993). In responding to an anonymous questionnaire, a definition of bullying was provided distinguishing between bullying and other aggressive acts such as fighting and quarreling between equals. Overall, in this, first (nonrepresentative) collated Australian database between one in five and one in seven students reported being bullied once a week or more. Males and females reported experiencing different types of bullying (e.g., males reported more physical bullying). In secondary school, the amount of bullying was highest in Years 8 and 9 (students aged approximately 12–14 years of age). The issue of school bullying has been the subject of considerable research in the last thirty years with the 2018 UNESCO report indicating that unfortunately, Australia still ranks as moderately high in terms of the frequency of bullying on a global scale. The discussion now turns to the outcomes from research conducted as part of the three-year Indian–European Research Networking Program in the social sciences in which Australian researchers were actively involved. One component of their research involved utilizing PhotoStory methodology which will be described later in this chapter.

By way of background to this research, it is important to appreciate as Shute and Slee have noted in their in their text "Child Development: Theories and Critical Perspectives" that the idea of "student voice" has more recently gained increased emphasis. There exists in research now a strong move away from viewing young people as passive and vulnerable individual to an outlook that values them as active agents in the research process. The history of research in mainstream Western countries shows that children and young people have not had a voice in either the research process or the outcomes of research. Children's and young people's role was primarily as objects for research with their participation consisting solely of responding to adult instructions or demands, e.g., providing subjects in observational research and was generally viewed as passive recipients or objects at the center of adult enquiry. However, the 1989 UN Convention on the Rights of the Child, ratified by Australia in January 1991, changed adults' perceptions of that role, stating that:

- "Children have the right to say what they think about anything that affects them, and … what they say must be listened to and given due consideration"(Article 12).
- "They have the right of freedom of expression, and freedom to seek and impart information through any media of the child's choice" (Article 13).

A significant issue then is *how* the voices of children may transcend the constraints placed upon them by historical perceptions of what constitutes childhood, its embeddedness in culture and the influence of the dominant positivist paradigm in mainstream Western research regarding the conduct of research. Shute and Slee have considered at some length the importance of capturing the voices of children and young people as part of developmental psychology's postmodern mandate. In support of this outlook, Spears et al. (2011) examined the role of young people as coresearchers in anticyberbullying initiatives. The researchers argued that giving youth voice to such initiatives acknowledges young people's understanding of the issue. Moreover, adopting such an outlook positions young people and identifies them as change agents and as allies in the research process.

Support for this outlook is found in Hart's (1992) publication of the "ladder of participation" by UNICEF "Children's Participation: From Tokenism to Citizenship" (UNICEF). The conceptual model he outlined is also consistent with Article 2.1 of the 1991 Convention on the Rights of the Child concerning the child's right to have a voice in decisions that affect them. At the nonparticipatory level, young people are manipulated or at best only involved in a token-like manner with matters that impact on them. For example, an education department or school in developing antibullying has typically relied on the policy being written by adult(s) for students. However, using Hart's model (Fig. 8.1) at the highest level of participation, young people would be responsible for initiating shared decisions with matters that concern them. Here, a school's antibullying policy would follow an initiative from students and the students would research, formulate, and launch the policy (Fig. 8.3).

As outlined in Shute and Slee, the philosophy of science, including the conception of knowledge, influences or shapes the way we conduct science. The dominant research paradigm is generally known as empiricism but outside this mainstream methodology exists other important but widely neglected methods for conducting research. While no agreed upon name exists to describe the methods, they are variously referred to in the literature as "new paradigm" research, "hermeneutic research," "a priori research" or "cooperative enquiry". As these authors note, new paradigm research is part of a new worldview which is emerging through systems thinking, and represents a break from the dominant mainstream empirical outlook. There are three components to the shift: (1) "a participatory and holistic knowing," (2) "critical subjectivity," and (3) "knowledge in action."

In relation to the idea of participatory and holistic knowing, it is argued that there is a move in the social sciences away from a natural science outlook that emphasizes cause and effect toward a more holistic outlook emphasizing the nature of behavior as it is considered in its context. The second feature of the new paradigm research involves a shift from objective enquiry to critical awareness. In this process,

Fig. 8.1 Notice regarding eve teasing in Patiala, India

Bullying in schools leads to dropout rate, suicides

A.V.Ragunathan

CHIDAMBARAM: According to a recent study undertaken under the "Indian-European Research Networking Programme in the social sciences, bullying in schools have led to disastrous consequences. It causes insidious damage to the student. Therefore there is a need to create awareness among parents, teachers and students about the detrimental effects of bullying, said Peter Smith, an emeritus professor of psychology at Goldsmith College, University of London. He took part in an international seminar on "Safe schools: Preventing bullying and harassment" organized by the psychology department of Annamalai University, at Chidambaram.

He told *The Hindu* that bullying was prevalent both in schools and colleges but the focus was now on the former because it was felt that early correction of such an objectionable behaviour would bring about positive changes among the individuals concerned. It would also help safeguard victims from taking any disastrous steps.

Mr Smith termed bullying as "a systematic abuse of power or repeated aggressive acts against someone who cannot easily defend himself or herself." He also clubbed the repeated misuse of Internet and mobile phones with the intent to hurt or intimidate, and, to spread rumours to bring disrepute to an individual within the ambit of bullying.

Peter K.Smith (left) at the seminar held at Annamalai University, Chidambaram.

He further said that the issue of bullying mattered because it would create a low self-esteem among the victims and this might lead to suicides. The victims would also be prone to physical and psychosomatic problems. It would have its repercussions on the bullies too. If they continued with the same traits they would end up as anti-social elements, creating problems to their families and the society, Mr Smith added.

Other resource persons attributed bullying to genetic factor, influence of the environment in which they were brought up, wrong parenting, callous emotional traits, lack of empathy and perceived popularity.

S.Suresh, Assistant Professor, Department of Psychology, Annamalai University, said that his university along with Punjab University had been involved in the Indian-European project. The study carrying out by the university indicated that bullying was one of the major causes forcing students to drop out of schools.

Even calling a student by his caste, creed or community, or making an unnecessary reference to his physical appearance and mocking at religious markings and so on were the various forms of bullying.

Mr Suresh said that corrective measures should be planned at the individual and classroom levels. Compared with other countries the awareness level in India was low. Therefore, it had become important to sensitise the students, parents, teachers and the institutions on the issue and on the ways and means of tackling it.

Fig. 8.2 Media report of the Indian–European–Australian three-year networking collaboration in Chidambaram, India

the researcher's own subjective experience is not suppressed but is seen in terms of second-order cybernetics and considered as part of the process of enquiry. The third and final feature of new paradigm research—knowledge in action—emphasizes the practical application of research. Reason (1988) argues that these three changes constitute a paradigm shift.

Fig. 8.3 Hart's ladder of participation

In terms of methodology, PhotoStory uses photography to illustrate a story that conveys the perspectives of individuals about a particular issue. The use of images and photographs is advocated by researchers as an alternative and effective means for exploring phenomena alongside other methods of data collection (Gabhainn & Sixsmith, 2006; Skrzypiec et al., 2013a, b). As Wang and Burris (1994) have noted, photographic data provided by participants is more likely to reflect their world. Such a methodology has "the unique ability to help individuals convey inner thoughts" (Bessell et al., 2007, p. 558) and offer insight into a reality that cannot otherwise be easily captured by words and language-centered approaches. With this in mind, the author has used the PhotoStory methodology for studying school bullying (Wang & Buris (1997). In a further example of the methodology in rural Australia, it has been employed to understand issues regarding water resource allocation and the emotions and values associated with this topic (Keremane & McKay, 2011). The use of a PhotoStory approach reduces cultural barriers as young people are given the opportunity to express their thoughts through a photograph that they take. Young people who may lack confidence or feel disempowered through a limited means of expression may be able to use an iPad to take a photo of something that triggers their memory about bullying. They may then use this photo to express their feelings and thoughts about bullying as well as how they cope with bullying.

PhotoStory Methodology

As Skrzypiec et al. 2013a, b have noted, the PhotoStory method is framed in feminist theory and utilizes a methodology following the principles of participatory research (Israel et al., 1998). It also reflects a holistic and participatory way of knowing. Finally, a significant feature of the use of PhotoStory methodology is the emphasis it places on providing the participants and community generally with the outcomes of the findings from the research. For example, the author has used the photographs as a display in schools to illustrate student perceptions of their experiences of school victimization. In turn, the practical application was to alert the wider school community including the parents to the issue encouraging individuals, e.g., parents to talk to their children about the issue of bullying. Importantly, it is also regarded as an effective way to bridge the power gap between researcher and participant (Keremane & McKay, 2011). In a PhotoStory study, the photographs taken by participants can be used to highlight issues and to promote change thereby facilitating individual empowerment.

The use of the PhotoStory methodology involves the researchers and the participants working in cocreating the understanding of the phenomenon that is the focus of the research, in this instance, school bullying. In adopting this participatory approach to research, the emphasis is given over to centering on the experiences of the individuals who are the focus of the research. The method involves engaging with the participants in the research, providing them with cameras/iPads and instructions concerning the task, and encouraging the telling of a "story" about the photograph they took and its personal meaning for them.

To briefly summarize the main characteristics of the PhotoStory approach:

- PhotoStory is used to allow the participants to tell conveying their perspectives about a particular issue.
- Emphasis is given to placing the child/young person at the center of the investigative process.
- The approach involves empowerment utilizing codesign and collaboration between the researcher(s) and participants.

Castleden and Garvin (2008) have noted that during decades of research with Indigenous people, researchers have "parachuted" into the communities, gathered their data and left, frequently contravening basic principles of ethical guidance including informed consent and communicating their findings back to the communities themselves. In this regard, Castleden and Garvin have argued strongly for community based participatory research highlighting the importance of engaging with participants as coresearchers in the endeavor in a mutually collaborative fashion.

As previously noted, Australian and Indian researchers participating in a three-year India-European Network project devised and assessed the use of PhotoStory procedures to better understand school students' experiences of bullying. Using iPads, the PhotoStory study involved students capturing visual images of situations related to a student's experience of school bullying and then using the picture to gain

an insight into the impact of school bullying and its relationship to school safety and well-being. The research was designed to give children a voice in understanding their perceptions of school safety, particularly in relation to their experiences of school bullying and how they coped. The data was collected from Indian schools in the Punjabi region and South Australian schools in Adelaide. In this chapter, consideration is given to the procedures used and the outcomes of this cross-cultural research project.

Using PhotoStory to Understand School Bullying Cross-Culturally

This research project sought to investigate different views on traditional and cyber-bullying using a PhotoStory procedure. We were working with schools to obtain a picture of what happens when bullying occurs, the types of bullying students reported and their feelings. The overall aim of the project was to use PhotoStory as a medium to understand young people's experiences of bullying and types of bullying in two different cultures, namely Australia and India. Ethics permission was obtained from the Flinders University Social and Behavioral Sciences Research Ethics Committee and in India from the Punjabi University Research Ethics Committee along with permission from the relevant education authorities in each country.

Participants

Overall 16 student volunteers from each of three schools in India and 18 students from Australia were engaged in the project. Students and their teachers were invited to participate in this research as it was important that the views of school students were heard and that the findings represented the student voice.

Participants were asked to attend an informal student briefing session conducted at the participating schools in India and Australia, where the researcher explained the project purpose and procedure. Students and teachers were instructed in the use of an iPad to take the picture and attach a story using Pic Collage. They were instructed in the use of the free downloadable Pic Collage to edit and add their "story" regarding the photo adding "stickers" if they wished to embellish their picture and story. No pictures of identifiable students, teachers, or family were allowed. Finally, instructions were provided regarding downloading the image and story and emailing it to one of the researchers ensuring their confidentiality.

Students were instructed to use a photograph or picture to illustrate something that they would like to tell the researchers about bullying and the types of bullying experienced. The instructions were as follows: "What you might like to tell us might just be an opinion that you have, or it may involve telling us about something that

Table 8.1 Types of bullying and feelings as reported by Indian and Australian students in the photo voice study

	India (%)	Australia (%)	India- Feelings	Australia- Feelings
Physical	56	22	Helpless- 38%	Scared- 57%
Verbal	31	50	Humiliated- 38%	Sad- 29%
Social	13	5	Scared- 15%	Angry- 14%
Cyber	0	22	Sad- 8%	

you have witnessed or experienced. If you tell us about a bullying incident try and tell us how it made you feel and about what you or others did or should have done, about it."

Students in the Australian classrooms booked out the iPad for 7–10 days during which time they took the photo and wrote a story about it and emailed it to the researchers. In the Indian schools, the conditions were altered to suit the needs of the school but essentially, the students had access to the iPad for a period of days. In both groups, the pictures and stories were emailed directly to the researcher to ensure the confidentiality of the picture and story.

The researchers then coded the pictures and the student stories in relation to (i) types of bullying and (ii) feelings associated with the bullying. Having coded the data, a second researcher also coded the data, and any differences in coding were resolved by discussion (Table 8.1).

As emerging research from India indicates, e.g., Ramya et al., the frequency of bullying appears to be relatively high in India although much caution is warranted in comparing countries in view of the different cultural understandings of the meaning and definition of bullying. In a more recent reported 2016 study conducted under the auspices of the United Nations International Children's Emergency Fund (UNICEF) "Experiences of Peer Bullying among Adolescents and Associated Effects on Young Adult Outcomes: Longitudinal Evidence from Ethiopia, India, Peru and Vietnam" data indicated that in India, physical bullying was almost as prevalent as other types of bullying. In Table 8.1, 56% of the Indian students who submitted a PhotoStory reported that it was physical in nature. An illustration of this is provided in Fig. 8.1.

In the PhotoStory (Fig. 8.4), a 14-year-old Indian student reported that he took this photo of the school ground because it reminded him of the experience of being physically bullied on various occasions when he was trying to play cricket at school. In his story, he told how "two boys in his class came into the ground and beat me without any cause."

In the Australian context, the most common types of bullying was verbal in nature—i.e., name calling. In Fig. 8.5a, student describes in her story the impact of being verbally bullied and described the feeling as like being "torn apart."

In relation to the feelings generated by the bullying, there were some interesting differences between Indian and Australian students that may warrant replication with a larger and more representative sample. The Indian students were evenly divided between feelings of "humiliation" and "helplessness" while Australian students

Fig. 8.4 PhotoStory illustrating an experience of physical bullying by a 14-year-old Indian student

Fig. 8.5 PhotoStory illustrating an experience of verbal bullying by a 14-year-old Australian student

predominantly reported feeling "scared." Possible explanations for these differences in the emotions evoked by the bullying could be cultural or relate to the types of bullying being reported. In the 2016 study conducted under the auspices of the United Nations International Children's Emergency Fund (UNICEF) "Experiences of Peer Bullying among Adolescents and Associated Effects on Young Adult Outcomes:

Fig. 8.6 International conference of the Indian–European–Australian networking project. University of Punjab, Patiala

Longitudinal Evidence from Ethiopia, India, Peru and Vietnam." In this study, the issue of economic disadvantage and that of caste were identified as being associated with students' feelings of shame and humiliation. Among the Australian students, the higher level of bullying associated with the internet could be associated with feeling alone and frightened given the anonymity provided by the internet in relation to cyberbullying. The findings from the research were reported back to the schools involved and at several international conferences including one hosted at Punjab University Patiala, India (Fig. 8.6).

Summary

In the present chapter, the global concern with the issue of school bullying has been framed within a human rights perspective. That is, from a human rights perspective, it is the right of all children and young people to pursue an education in a safe and protective environment. In this chapter, it has been argued that school bullying is significantly at odds with the United Nations Convention of the Rights of the Child (CRN). As such, it is the responsibility of governments and education authorities to recognize the harm that arises out of school bullying and to develop policies and

evidence-based programs that will provide protection and support for those students at risk of being bullied.

To illustrate the argument made in this chapter an innovative methodology called PhotoStory was used as part of a three years Indian–European–Australian Networking project. The present study has further reinforced the value of images and photographs to address particular research questions in a manner that compliments other research paradigms, However, as previously noted, such a methodology is generally under-used. It is argued in this chapter that photographic data provided by participants is a valid method for helping individuals convey inner thoughts and offer insight into a reality that cannot otherwise be easily captured by words and language-centered approaches as reflected in questionnaire data.

The researchers engaged with all of the schools involved providing professional development sessions for the teachers. Following these sessions, the participants used the iPad to illustrate their "story" by taking a photograph or a video recording, as well as write their "story."

These "stories" were used to produce a photo book, which was made available to the schools as a resource and in acknowledgment of the time and effort of the students and teachers in participating in this study. The data from the students was analyzed in relation to the types of bullying experienced by the students and the feelings associated with the school bullying. Some significant cross-cultural differences were identified in relation to types of bullying and the feelings identified. Given the small sample size involved, these suggested differences may warrant replication with a larger more representative sample of students.

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Chapter 9
School-Going Students of Border Conflict Zone in Jammu Region: In the Contours of Impact and Adjustment with Ceasefire Violations

Raveena Kousar and Subhasis Bhadra

Abstract Conflict in any form creates a huge chaos and tension for common people. Living under continuous uncertain threat on basic safety and security causes a sequel of trauma. The communities living in the conflict-hit zone of Jammu and Kashmir (J&K) are the silent survivors of the political unrest between India and Pakistan for at least the past three generations, since independence in 1947. With the drawing of the ceasefire line (1949) now known as Line of Control (1972), the phenomenon of "extended violence" came into existence, which has become a normal and inevitable part of their lives. The intermittent firing and shelling are a normal phenomenon in the border areas of the J&K region. Uncertainty, death, destruction, displacement, disturbances in daily routines, livelihood activities, restricted movement, frequent closure of schools, are inescapable parts of living for the communities. Indiscriminate firings affect every individual, but students at their developmental age become the worst victim of the situation that jeopardizes their psyche and learning environment, gravely impacting their aspirations and future prospects. Ceasefire violations have become an impediment for teachers to teach and for students to learn. The chapter has explored the issues in the life of the students due to ongoing conflict that frequently led to disturbance in academic activities, classroom learning, and also closure of the school. Mortar cell hitting at school, home, leading to injury, death of friends, family members, pets, or cattle is quite common. While teachers expressed their concern for safety in school, the students find multiple problems in daily routine, academic achievements, and in familial context. In such a situation, resiliency is a crucial component for achieving adjustment and maintaining well-being that is crippled in true sense. Thus, it requires strategic policies and programs for enhancing psychosocial resources, multi-stakeholders' engagement, and revamping the education system for the children living in conflict zone.

Keywords School · Students · Border conflict zone · Jammu region · Impact · Adjustment · Ceasefire

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_9

Introduction

Conflict in any form creates huge chaos and tension for common people. Armed conflict or war with compromising the basic safety and security generates an uncertain threat to the lives of the people and pushes many to struggle with the sequel of trauma. According to the Uppsala Conflict Data Program, 52 active state-based and 76 non-state-based armed conflicts were recorded in 2018 (Pettersson et al., 2019). Armed conflict created a huge loss of lives with almost 94,300 deaths (Pettersson et al., 2019) along with a massive loss of resources and infrastructure (Ali et al., 2015). Almost 70.8 million forcibly displaced people have been registered in 2018 due to conflict (United Nations High Commissioner for Refugees, 2019). Every member of society is affected by conflict, but students at their developmental age become the worst victims of the situation that jeopardizes their psyche, disrupts their learning environment, and gravely impacts their aspirations and future prospects. About 250 million children live in the countries affected by conflict, and more than 12,000 children have been killed and injured due to conflict in 2018 (Associated Press, 2020). According to Article 26 of the Universal Declaration of Human Rights, education is a basic human right and valid in every situation including emergencies, war, and armed conflict (Seitz, 2004). Yet, the children in conflict-affected areas are deprived of the right to education. In 2018, nearly 258 million children and youth were out of schools (UIS, 2019). All agents, viz., students, family, education team, infrastructure, the school environment, curriculum, and the pedagogy of the teachers are affected in these circumstances. It impairs the functioning of the education system, destroys educational infrastructure, and prevents the students from attending their schools (Seitz, 2004). Conflict not only impacted children physically but also psychologically as they dealt with the death of family members, separation or displacement from family, loss of home, loss of access to education, lack of access to proper health care, malnutrition and disability (Annan & Brier, 2010; Dimitry, 2012; Kadir et al., 2019; Rieder & Choonara, 2012; Toros, 2013). Children who experience traumatic events are more likely to develop behavioral, emotional, or psychiatric problems (Baweja et al., 2016).

During the conflict, support often shifts toward humanitarian aid and rarely focuses on education. In humanitarian response, education is considered as the fourth pillar in addition to food, shelter, and health care. It helps the students to give shape and structure to their lives, prepares them with skills to survive in conflict, and promotes justice, stability, and respect for human rights (Nicolai & Triplehorn, 2003). Education could provide a sense of stability and normalcy that gives children a hope for the future and can alleviate the impacts of toxic stress (Save the Children, 2016). Yet, the children in border areas of Jammu and Kashmir are deprived of their rights. People living in the conflict-hit zone of Jammu and Kashmir (J&K) are the silent survivors of the political unrest between India and Pakistan for at least the past three generations, since (the year 1947) independence. With the drawing of the ceasefire line in 1949, now known as Line of Control since 1972, people are experiencing firing and disturbances which have become a routine and unavoidable part of their lives. The intermittent firing and shelling are a “normal” phenomenon in the border

areas of the J&K. Uncertainty, death, destruction, displacement, disturbances in daily routines and livelihood activities, restricted movement, frequent closure of schools are inescapable parts of living for the communities. This chapter attempts to highlight the impact of border conflict on students' lives and their adjustments with the ceasefire violations.

International and National Guidelines for the Protection of Children

In the 1945 United Nations Charter, the international community stated its determination to "save succeeding generations from the scourge of war" (Shepherd, 2008). The continuous outbreak and spread of armed conflicts around the world make the promises of peace in the year 1945. The Convention on the Rights of the Child (CRC, 1989) was the first global commitment to incorporate the civil, cultural, political, and social rights of children on an equal footing within the Universal Declaration of Human Rights (UDHR, 1948). Article 26 of UDHR guarantees the right to education for all. The International Covenant on Economic, Social, and Cultural Rights (1967) included the right to education for the population affected by war, displacement, and calamities (Bensalah et al., 2000). Then, the World Conference on Education for All (EFA) held in Jomtien, Thailand (1990), triggered a new stimulus toward basic education especially with its vision and commitment in making it available for all (UNESCO, 1990). In 2000, a parallel session on Education for All: Meeting Our Collective Commitments was held at Dakar to take initiatives on account of the need for education of the children and adults affected by armed conflict. Subsequently, it incorporated the provisions to create safe, healthy, and inclusive educational environments with equitable resources which would be useful to learning (World Education Forum, 2000). Continuing the education for all movement, the Incheon Declaration (2015) represents the commitment of the education community to Education 2030 and the Agenda 2030 for Sustainable Development recognizing the vital role of education as a basic element of development. It intends to mobilize all countries and stakeholders around the Sustainable Development Goal (SDG) on education and its targets, as well as recommend ways to implement, coordinate, finance, and monitor Education 2030 in order to ensure that all people have access to high-quality education and lifelong learning opportunities (World Education Forum, 2015).

The Inter-agency Standing Committee's (IASC, 2007) Mental Health and Psychosocial Support (MHPSS) recommends guidelines to improve access to safe and supportive education. It included crucial actions such as promoting safe learning environments, making education more supportive and meaningful, and ensuring universal access to education.

The Inter-agency Network for Education in Emergencies (INEE, 2005) is a global network working together to ensure access to education during emergencies and post-crisis recovery. The Minimum Standards covered five domains, namely foundational

standards, access and learning environment, teaching and learning, teachers, and other Education personnel and Education Policy (Inter-agency Standing Committee, 2007). The Global Coalition to protect education from attack is formed in 2010 to address the problems of targeted attacks on education during armed conflicts. The agency highlights the incidences and impact of attacks and infused insecurity among key actors. Further, it focuses on cultivating public support for safe education, monitoring of the situation, reporting of the incidents, and strengthening preventive responses as per international law to ensure accountability of schools (GCPEA, 2018).

In 2006, the Ministry of Women and Child development was established as a separate Ministry. Since 1985, it has been a Department under the Ministry of Human Resources Development. The ministry's key responsibility is to achieve holistic development by resolving inequalities in state action for women and children by encouraging inter-ministerial and inter-sectoral convergence in order to establish gender-equitable and child-centered legislation, policies, and programs.

The act ensuring the free and compulsory education for every child named Right to Education (RTE) Act, 2009, represents the constitutional legislation envisaged under the Article 21 A of the Indian Constitution and guarantees that every child has a right to full-time elementary education. This Act guarantees free and compulsory education in a neighborhood school to all children aged six to fourteen (MHRD, 2009). As a positive fallout of the abrogation of Article 370 of the Indian Constitution by the Parliament of India on August 5, 2019, The Right of Children to Free and Compulsory Education Act (RTE), 2009, came into force in J&K that guaranteed free and compulsory elementary education for all the children till the age of 14 years. Previously, the Jammu and Kashmir School Education Act, 2002, was the only law that had the provisions for compulsory elementary education. However, it missed certain provisions of RTE Act, 2009, like reservation of 25% seats in private schools for the children from socially disadvantaged sections of the society. After the abrogation of Article 370, the RTE Act, 2009, became applicable in the state of J&K. MHRD (2018) is an integrated scheme for school education from preschool to senior secondary level. The main goals of this scheme are to provide high-quality education and improve students' learning outcomes, as well as to address social and gender gaps by ensuring equity, inclusion, and minimum standards at all stages of schooling (MHRD, 2018). The National Commission for the Protection of Child Rights (NCPCR) was established in 2007 as a statutory body under the Ministry of Women and Child Development under the National Commission for the Protection of Child Rights (NCPCR) Act, 2005, to protect, promote enquire into violation of child rights, and to defend child rights in the country (MoWCD, 2007). The National School Safety Policy (2016) guidelines aim to ensure the creation of a safe learning environment for children where all students, teachers, and other stakeholders in the school community are protected from natural disasters of any kind (National Disaster Management Authority, 2016).

Impact of Conflict on Education: A Review of the Global Situation

Conflict has led to the disruption or end of education for children (Ali et al., 2015; Attack, 2018). In few conflict-affected countries, children have never had the opportunity to attend school in their lifetimes (Jones & Naylor, 2014). As education does not seem like an immediate need compared to food, shelter, and safety, the right to education is diluted at the time of conflict. After the violence ends, the children face difficulty in education to compensate for the loss of time, study material, competent teachers, and educational infrastructure (Machel, 2002). The review of the literature on the impact of conflict on education is highlighted below.

Disturbed Schooling

Armed conflict adversely affects the quality of basic amenities and health care. Every child has a right to education in every situation including in emergencies. Schools help the students to learn the skills they need for life and protect their future (Save the Children, 2015). Armed conflict destroys education infrastructure including school buildings, all supporting learning facilities and ruins the educational systems. At the time of ongoing conflict, the basic functioning of education systems either be compromised or may make schools unsafe for children. In Yemen, about 500,000 children have dropped out of schools since the war started, and about 4.7 million children need educational assistance (GCPEA), 2020). As per the report of GCPEA (2018), about 3.7 million children between the ages of 7 and 17 remained out of schools in Afghanistan. Airstrikes, ground fighting, and cross-fire in Yemen aggravated the situation and caused a serious threat to students and teachers. Till 2019, it was estimated that 256 schools have been demolished and 1520 have been damaged by armed violence in Yemen (Global Coalition to Protect Education from Attack, 2019; Nicolai & Triplehorn, 2003; Save the Children, 2016). About four million children are out of schools, compared to 1.6 million before the war (OCHA, 2019). More than 11,000 attacks were reported on schools, and it harmed over 22,000 students and educators in 93 countries between 2015 and 2019 (GCPEA), 2020). Around 7300 direct attacks on schools were reported between 2015 and 2019. In both the Democratic Republic of Congo and Yemen, over 1500 school attacks have been recorded. In Afghanistan, Palestine, and Syria, between 500 and 999 attacks on schools were reported (Cappelaere, 2019; UNICEF, 2019). India, Ethiopia, Pakistan, Palestine, Sudan, and Turkey are the most heavily affected countries where attacks on students, instructors, and higher education institutes were reported (Global Coalition to Protect Education from Attack (GCPEA), 2020). Attacks on school and university kill and injure the students and teachers which lead to drop-out of students, the loss of infrastructure and diminishes the quality of education (GCPEA, 2018; Save the Children, 2015; (GCPEA), 2020; UN News, 2019). Syria is estimated to have one

of the lowest enrollment rates in the world. Before the war, almost all the children in Syria were enrolled in primary schools. At least a quarter of the schools have been damaged, abandoned, and used for military purposes. Syrian schools are under attack, and it is dangerous to get education (Save the Children, 2015; UN News, 2019). In conflict-affected countries, schools and universities have been occupied and used by the militaries as their bases, barracks, storage of weapons, detention and interrogation centers, and as temporary shelters (GCPEA, 2019; GCPEA, 2020; Save the Children, 2016). In Myanmar, about 30 schools were used for military purposes by the armed forces (UN Security Council, 2018). After the conflict, schools re-opened with more than a quarter of students in attendance (GCPEA, 2020). It made parents frightened to send their children to schools, and teachers were terrified to teach.

Armed conflict often leads to forced displacement and causes disturbances in the education of millions of children. As per the report of the United Nations High Commissioner for Refugees (2018), the global population of forcibly displaced people grew by 2.3 million people in 2018. By the end of the year, nearly 70.8 million people had been internally displaced around the world as a result of persecution, war, terror, or human right violations. According to the Education for All Global Monitoring Report (2011), 56% of people affected by the conflict had been displaced. It is also mentioned that the fear of displacement was the greatest fear among the conflict-affected communities, after the fear of losing a loved one and encountering economic adversity, respectively. Another report of the Internal Displacement Monitoring Center (2018) mentioned 6.1 million people are displaced in Syria till 2018. Conflicts not only contribute to the physical displacement of people from their communities but also disrupt the educational opportunities for the children. Separation from family is common at the time of displacement. Children often get separated from their parents (Fazel & Stein, 2002). Near 866,000 people from Bangladesh have crossed the border, and 55% of this population are children (Cox's Bazar Education Sector and Child Protection Sub-Sector, 2017). Conflict affects all children, whether they are displaced or not. Children who are not uprooted are equally subjected to be the victims of the ongoing conflict (UNICEF, 2016). In Somalia, the intensified conflict in the South Central Zone in 2009 has worsened the condition and reduced the enrollment rates up to 22% (UNICEF, 2016). Though the education system seems operational to some extent in conflict-affected areas, enrollment rate and quality of the school education suffer (Sinclair, 2001). In all such situations, most of the children were dropped-out and were further deprived of education (Akresh & Walque, 2008; Chamarbagwala & Moran, 2011; Moyi, 2012; Maio & Nandi, 2013; Shemyakina, 2011; Wessells, 1998). Mostly, people fled without their belongings, making it difficult for classes to begin without external help. In the report of Machel (1996), the UN agencies, international organizations, and governments of many countries urged to make education accessible to every child affected by armed conflict.

Problems Faced by the Students

During a conflict, it may be dangerous to leave the household and attend schools (Azam & Hoeffler, 2002). According to the report of GCPEA (2020), over 11,000 attacks were reported that harmed approximately 22,000 students and teachers between 2015 and 2019. In armed conflict-affected areas, there were cases where schools have remained opened, and teachers being threatened or killed (Bragin & Opiro, 2012). Between 2015 and 2019, about 8300 students, teachers, and other institutional staff were assaulted. Teachers and students were often affected by armed conflicts in Palestine, Afghanistan, Cameroon, and the Philippines (GCPEA, 2020). In Palestine, about 12% of the injured children are suffering from a permanent disability (Qouta, 2004). Insecurity arises at, or on the way to or from school by the attacks on teachers, students, and other staff which includes assassinations, assaults, torture, forced displacement, and threats of abuse (Cappelaere, 2019). Such kinds of attacks jeopardize the safety of students and teachers, compelling schools to close for a longer period and impede student attendance and enrollment, obstruct learning, and diminish the quality of education. Insecurity and threat to the life of the students and teachers make it difficult for students to learn and for teachers to teach. The report of Human Rights Watch (2013) highlighted the impact of conflict on the students who had left the schools became child laborers, child soldiers, or helpers for the armed opposition. In Syria, more than 52,500 teaching staff have lost their ranks since the beginning of the conflict (Save the Children, 2014).

The impact of damaged infrastructure and the displacement makes it difficult to sustain education in conflict-affected areas. The classes are being forced to be conducted in basement shelters, open areas, garages often without proper infrastructure and facilities which makes it unsafe for children to get education. Moreover, the uncertain frequency and unpredictable intensity of shelling and sniper fire make it difficult to organize classes as it truncates the school year by making class schedule irregular (Burde et al., 2017; Sinclair, 2001). Akresh and Walque (2008) and a similar study by Shemyakina (2011) found that parents were unable to bear the schooling expenditure as their livelihoods were taken away and merely could afford the necessities. Similar problems have been found in the conflict-affected areas of Syria where parents are pulling their children out of schools so that they can work to improve the family income due to financial constraints by the rising costs of basic services, food, rent, and with the high rates of unemployment (Save the Children, 2014). In Syria, increased poverty, loss of livelihood, unemployment, and inadequate access to food, water, sanitation, housing, health care, and education have all had a dreadful impact on the people placing them at risk of further exploitation. Increased levels of poverty, loss of livelihood, increasing unemployment and limited access to food, water, sanitation, housing, health care, and education have all had a dreadful impact on the people putting them at further risk of exploitation (Hassan et al., 2016).

Children residing in conflict-affected areas have much lower access to quality educational services than in other comparable situations (UNICEF, 2016). As more attention is paid on security and to meet the necessities of life, so education is less

likely to be available in the emergency phase of displacement. Access to quality education in conflicted areas is important for providing the children with physical, psychosocial, and cognitive protection that can be both life-sustaining and lifesaving (UNICEF, 2018). Safe and free education helps in mitigating the impact of conflict by providing children a sense of normalcy, stability, and hope for the future (UNICEF, 2017). Scholars have mentioned that children in conflict often confront severe living conditions and have inadequate ways to improve their future. Lack of teachers and teaching aids, non-availability of books, and other stationery impedes access to education in the conflicted areas. School enables children to cope with challenges in their life and to find reasons to hope for a better future (Winthrop & Kirk, 2008).

Psychosocial Issues Among the Students

Conflict not only impacts children physically but also affects them psychologically as they deal with the death of family members, separation or displacement from family, loss of home, loss of education, lack of access to adequate health care, malnutrition, and disability (Annan & Brier, 2010; Dimitry, 2012; Kadir et al., 2019; Rieder & Choonara, 2012; Toros, 2013). Conflict-affected communities have been linked to a wide range of adverse impacts on mental health and psychosocial well-being, ranging from temporary psychological distress and behavioral issues to elevated prevalence rates of mental illnesses such as mood, anxiety, and behavioral disorders (Bragin & Opiro, 2012). In armed conflict situations, loss and sorrow, whether for missing or deceased family members or for other social, relational, and material losses, are the core issues (Hassan et al., 2016). Disturbances and insecurity due to uncertainty and displacement can harm physical, intellectual, psychological, cultural, and social development of the children. It may also serve as a foundation for another generation to indulge in vengeance, conflict, and displacement (UNHCR, 1994). When conflicts are beyond the normal, the ability of a child to make mental use is strained. Extremely violent disputes are interpreted in the brain in a different way. Children's potential for symbol formation and analytical thinking is diminished as a result of ongoing conflict. Inattention and low school results are short-term effects, while long-term effects impair concrete thought and diminish the ability of a child to solve difficult interpersonal situations (Bragin & Opiro, 2012). Children who live in armed conflict face constant loss, risk, and threat to their lives, resulting in psychological distress. Psychological and social distress among the conflict-affected children manifests a wide range of emotional, cognitive, physical, and behavioral and social problems. Sadness, sorrow, fear, frustration, anxiety, rage, and despair are examples of emotional manifestations. Physical symptoms include exhaustion, sleep disturbances, lack of appetite, and medically unexplained physical complaints, along with cognitive signs such as helplessness, worry, ruminations, boredom, and hopelessness. Symptoms associated with post-traumatic events have been well-documented

such as nightmares, intrusive memories, flashbacks, avoidance behavior, and hyperarousal (Ventevogel et al., 2015). Social and behavioral manifestations include withdrawal, aggression, and interpersonal problems. Children and adolescents in conflict-affected areas have been shown to have high levels of anxiety, mental and behavioral symptoms, and post-traumatic stress disorder (PTSD) (Punamaki et al., 2001).

Studies have revealed a strong association between children's exposure to violence and mental health symptoms (Malla et al., 2019; Paul & Khan, 2019). In conflict, the population is at greater risk of psychological distress due to a combination of traumatic events, economic constraints, and the collapse of conventional social support systems. (Gorst-Unsworth & Goldenberg, 1998; Housen et al., 2017). In order to measure the effect of armed conflict on mental health, several prevalence studies have been conducted in various parts of the world. Yasan et al. (2008) reported a prevalence rate of 15% for current PTSD in a population affected by protracted conflict in Turkey. Nearly, half of Syrian refugee children in Turkey met the clinical requirements for post-traumatic stress disorder, and about 200,000 children were diagnosed who needed counseling support (Sinclair, 2001). According to UNICEF (1996), more than two-thirds of Rwandan children had witnessed someone being killed or wounded, suggesting that the psychological well-being of war-affected children was put at risk (UNICEF, 1996). Children who have been impacted by armed conflict have struggled to sit in a classroom, concentrate, and understand (Macksoud, 1993). Families facing acute financial hardships and the absence of learning opportunities in conflict-affected areas have harmed the well-being of children and put them in an epidemic of child labor. Half of the refugee children were working in Lebanon and Turkey. Children were being drawn into agricultural labor and forced into street hawking (Save the Children, 2013; UNHCR, 2013).

The Situation of Different Stakeholders of the Education System

A safe home provides a basic need and makes it possible to establish secure and adaptive human relationships. Unfortunately, the protective shield that is essential for the mental health of the children is intensely destroyed when their families witness the shelling and demolition of their homes (Qouta, 2004). Findings of the children's support networks suggested that parents, teachers, friends, and communities are important sources of emotional support. Children with strong support social networks are more expected to cope well with life stressors than children without such support networks (Prinstein et al., 1996; Ventevogel et al., 2015). Parents, teachers, and peer groups would be most helpful to engage children in their normal family, student, or friendship roles. These support systems also provide distractions by encouraging children to engage in activities that distract them from trauma-related worries or concerns (Duarte & Cano, 2016; Prinstein et al., 1996).

Armed conflicts have an effect on the social determinants of mental health and well-being of family, teachers, and community care networks, as well as the access to basic needs and education, morality, and spirituality. In their study, it is found that in collective centers, many refugee children were unable to play, and their parents were unable to provide normal parenting. Parents faced difficulties in protecting their children from sights of destruction, violence, and abuse (Qouta, 2004). Parents or other relatives would be stressed and unable to meet the emotional needs of their children. Parents resisted sending their children to school because of continuous conflict and lack of security or the fear of attack at school or on the way to and from school.

Apart from the family, school is a child's most natural support system. Teachers play an important role in the lives of children and are seen as trustworthy by children and parents (Wolmer et al., 2005). The school environment is generally seen as safe, supportive, and secure, and the importance of teachers in children's lives significantly increases in situations of armed conflict. The expectations from teachers have widened beyond instruction in academic skills and knowledge and in addition to ensuring a safe learning environment, supporting children's emotional needs to foster social cohesion (Baum et al., 2009; Pfefferbaum et al., 2004). In the conflict zones of Northern Uganda, teachers faced the same hardships as the rest of the population. Teachers and their families were at risk of being kidnapped, raided, destruction of their homes, and losing loved ones due to war and disaster. In Rwanda, more than two-thirds of primary and secondary schools' teachers were either killed or fled. Teachers had 100 students in their classes, and each of them had a heart-breaking story to tell (Bragin & Opiro, 2012). They faced huge pressure due to large numbers of traumatized children and limited resources which makes the learning more chaotic and inconsistent for all (Save the Children, 2014). In the book of Naidoo (2015), it has been mentioned that low aspirations were particularly prevailing among the children affected by the conflicts which created a significant barrier toward future achievement and success.

Historical Past to Present—Problems of Border Conflict in J&K

J&K was a princely state at the time of the independence of India in 1947. On October 22, 1947, armed tribesmen and troops from Pakistan's Northwest Frontier Province crossed the border into Kashmir with the aim of capturing Srinagar (summer Capital of J&K). In order to deal with the invasion, Maharaja Hari Singh signed an Instrument of Accession with India on October 26, 1947. Thereby, J&K became a state of India (Zutshi, 2010). Article 370 of the Indian Constitution governed the J&K state's relationship with the Indian Union. This allowed the state of J&K to have certain autonomy with the power to have its flag and constitution and exempt the state from the entire applicability of the constitution of India. The Indian government

repealed Article 370 of the Indian Constitution on August 5, 2019, which granted "special status" to J&K and split the state of J&K into two union territories—Jammu and Kashmir and Ladakh.

The origin of the ceasefire line as well as the international border (IB) in J&K is traced during the first India–Pakistan war of 1947–1948. In January 1948, India took the matter to the United Nations Security Council (UNSC), which constituted the United Nations Commission for India and Pakistan (UNCIP) to examine the conflict situation between the two countries. The United Nations Military Observer Group in India and Pakistan (UNMOGIP) was set up on the recommendation of the UNCIP. The prime function of the UNMOGIP was to observe, report, and investigate complaints of ceasefire violations and submit its results to each party as well as the Secretary of state (Jacob, 2019). After the end of this war, both the countries signed the UN-mediated Karachi Agreement in 1949 and defined the ceasefire line (CFL) and considered it to be a temporary measure at the time. In 1972, both the countries delineated the J&K border and renamed the CFL to Line of Control (LoC) under the Shimla agreement. This delineation was done only on the map, not on the ground and created confusion when it was applied on the ground. After the Shimla agreement, there was no mechanism to control and limit the hostilities between the two countries. Hence, the firing rose between the two sides in the 1980s and 1990s. In November 2003, India and Pakistan signed a Ceasefire Agreement (CFA) along the Line of Control (LoC) and international border in J&K. The Ceasefire Agreement was accepted by both countries to bring peace and stability to the tense border between the two countries. The CFA of 2003 was the fourth ceasefire that India and Pakistan agreed to since 1947: The first was signed at the end of the 1947 war; second agreement resulted in the 1965 war; the third one in December 1971; and, at last, the Ceasefire Agreement of 2003. The first three were war termination ceasefires, although the 2003 CFA was to end a particularly tense period in India–Pakistan relations that witnessed several ceasefire violations on an annual basis on the LoC and IB/WB (Working Boundary) in India and Pakistan (Jacob, 2017). It was successful only for a few years. There were hardly any cases of CFVs on the border until 2008 and resumed in 2009 and continued to this day (Jacob, 2019). Around 590 villages were located between 0 and 5 km from the IB/LoC, of which 448 villages are vulnerable due to CFVs (Jacob, 2017). Ceasefire violations are becoming more common every year (1368 in 2017 and 2442 in 2018). In J&K, 3,200 ceasefire violations were reported in 2019, the highest number in the previous 16 years (Times Now Digital, 2020) (Table 9.1).

Issues and Concerns of the Students in Bordering Areas of J&K

Living in conflict zones is not easy for survival. The situation at the border in J&K is extremely unpredictable and firing could start at any point of time. People always

live in the turmoil of firing. Children have a distinctive psychological feature and their personalities and coping skills develop almost every day. Children's physical, intellectual, psychological, cultural, and social growth may be harmed by disturbance and insecurity. Education leads to an immense advancement in society. It is an important institution through which knowledge, job skills, cultural norms, and values imparted to its members. It also helps to improve personal lives and prepare them for their citizenship roles. The institutions of education are often paralyzed in the border conflict-affected areas of J&K. The eruption of conflict in the border areas is uncertain with incidences of fire exchanges between the militaries of two countries. In such instances, shifting to safer places for their protection becomes a basic survival requirement. Frequently, natives shift to relief camps organized by administration or to their relative's homes in the nearby areas. Even though, one adult member of the family often stays back at home to take care of the cattle and to ensure the security of the household goods. When the situation pretends to have the low intensity of threat, the residents return to their home and strive to get back to a routine. The whole process of shifting and relocation creates a huge disturbance in the education system which has been discussed under four heading, viz., severe disruption of the education system and schooling, concerns of the students, psychosocial problems faced by the student, and stakeholders of the education system experience incapacitated situation.

Severe Disruption of the Education System and Schooling

Education is the backbone and an integral part of any progressive society. Students not only learn from the academic curriculum but also learn social rules and expectations from interactions with others. School is an integral part of imparting education to the children. School is considered as the second home for the children as the children spend most of their time and utilize it in the form of learning. School fosters all-round development of personality, i.e., physical, mental, emotional, and social. During the phase of firing, the students in the border areas are deprived of their right to education and other basic amenities. In case of any disturbance, schools in Jammu and Kashmir border areas remained closed for a few days to weeks and in some incidents more than a month (Amar Ujala, 2017; Deccan Chronicle, 2018; Parveen, 2018; Yasir, 2018). Even authorities also put the notice to close the schools located near to the border. In the year 2018, more than seven times the authorities passed orders for closure of schools due to cross-border firing (Deccan Chronicle 2018; IANS, 2018; Parveen, 2018; Yasir, 2018). Due to uncertain exchange of fire, schools are considered dangerous and life threatening. Parents are frightened to send their children to school. By listening to the sounds of firing, parents prefer not to send their children to school. After the Pulwama attack in February 2019, the schools were closed for three to five weeks at a stretch. After the repeal of Article 370 of Indian Constitution (provided special status to J&K), schools remained closed for seven months in the Kashmir region (Press Trust of India, 2020). In March, it was planned to re-open the schools, but due to COVID-19, again all the educational institutions remain shut till the date

(Navneet, 2020). Children in Kashmir have been unable to attend school or college for almost a year, with the exception when they went on holiday assignments and received instructions for online exams in November (Hindustan Times, 2020; Zargar, 2020). The ceasefire violations directly affect education. Masoodi (2017) reported that such ceasefire violations during the period of examinations cause severe strain on the school system.

Displacement became a part of the life of the people living in border villages of J&K. Families had to move to safer places due to sudden ceasefire violations or war-like situations (Jacob, 2019; Kousar & Bhadra, 2019; Parveen, 2018; Yasir, 2018). Displacement creates chaos among the people in general and to the children. The people were not able to manage their daily affairs and livelihood activities. Agriculture is the main occupation in the border areas, and there would be no assurance that farmers could safely go ahead with their routine work in the fields. Often, the exchange of fire between the forces on both sides of the border would impede their farming activities. During ceasefire violation when people move to safer places, often their crops remain in the field and cattle in the sheds are left unprotected (Banerjee, 2010; Chowdhary, 2012).

Frequently, when the firing was going on continuously and no sign of relief could be foreseen, people started shifting in safer places. Authorities also released an order to displace the people to relief camps. About 1500 people have been shifted from border conflict-affected areas of the Nowshera sector to relief camps (Yasir, 2018). As the firing continued at regular intervals, people from the villages of Silikote, Balkote, Tilawari, Churanda, and Batgarh shifted to the relief camps organized by the administration in the safer place (Firstpost, 2018). At that instant, classes were arranged in the relief camps. Teachers came to teach the students there (Amar Ujala, 2017). Mostly, the relief camps were arranged in the school building (Firstpost, 2018). It was difficult for them to teach the children systematically as families were residing there, and the environment was not peaceful for the study. When the situation became normal, people returned to their places. It takes time to re-adjust. It took a few days to weeks to maintain the regular attendance of the students. The time was less for the teachers to complete their syllabus. Teachers gave priorities to the academic curriculum instead of other co-curricular activities.

As per policy, the J&K government provides that schools should work for a minimum of 180 days in a year. However, in border areas, students were constrained to attend the schools due to frequent occurrence of firing and attacks. The working days of schools dramatically reduced when the conflict was at its peak to just 39–40 days per year. Due to the closure of schools, the academic session was badly affected, and it caused irreversible loss of studies to the students (Futehally & Bhatt, 2004; Shah, 2016). Many classes had learned less than 50% of the curriculum for the year. Since schools were closed, the academic session was affected severely and caused irreversible loss of studies and tuition to the students. In the year 2016 and 2017, forty to fifty percent of the total syllabus of the classes tenth to twelfth of the J&K Secondary Education Board (JKBOSE) (The Indian Express, 2017).

Concerns of the Students

Frequent cross-border firing makes the lives of the students unpredictable. No one knows whether they will be able to attend the school on the next day or not. Regular firing, displacement, closure of schools, non-availability of education facilities lead to the various problems in the life of a student. When the schools were closed, no students bothered about the loss in their studies, and they were only concerned about the safety issues. When the schools re-opened after the conflict, students were scared to attend in the beginning as the thoughts of the insecurity of their family members and scenes of destruction caused by the firing—disturbed them to focus on their studies. Lack of concentration and problems of adjustment were seen among the children (Kousar & Bhadra, 2019). Often, the students forget what they have learned in the last classes. Teachers tried to make efforts to recall the previous lessons. As the conflict already disturbed the regular phase of learning, so teachers had less time to complete the syllabus (Kousar & Bhadra, 2021a). They touched upon the important concepts, and rest was left for the children to learn new things by self-study. Disruptions in learning create a burden on the shoulders of the student to complete their syllabus. In this whole process, students were kept away from other co-curricular activities in their schools due to shortage of time.

Education cannot be sustained during the period of ceasefire violation. Movements are often restricted, and there was no way to impart education. Students are not safe neither in the schools nor in their homes. The infrastructural conditions and facilities in the schools were not sufficiently secured to protect the students from any incident of firing or mortar shelling. The mark of the bullet on the wall of the school was quite prominent. Though in a few cases, repairing was done but the imprints of firing were still visible. When firing starts, there are no safe rooms in the schools' buildings to hide in during the school hours. Although the provisions for the construction of bunkers are there, still it is not available in all schools' premises (The Economics Times, 2018). There were cases when the classes were going on and suddenly the firing started. It created huge fear and tension among the students. About 217 students and 15 teachers were trapped in the schools located near the LoC due to deadly cross-border firing in 2017. On the same day, a school building was directly hit by the mortar shell where 55 students were present in the school building. Fortunately, they all were safe (Khajuria, 2017). These students have seen a direct threat to their lives. Is it easy for them to live a peaceful life? The fear of losing their own lives and threat to the lives of their closed ones keeps them away from focusing on their studies. Similarly, in 2018, hundreds of students remained trapped in the school building. As there has been heavy shelling, so teachers asked the students to go to their homes only when firing stops (Times Now, 2018). There were cases where the school building was directly hit by the mortar shells. In Rajouri sector, two school buildings got damaged by the mortar shells located near the LoC (Masoodi, 2017).

Psychosocial Problems Faced by the Students

Machel (1996) in her report stated that armed conflict has an impact on all aspects of child's development including physical, mental, and emotional, and effective assistance must be given to the children. There is no stability in the life of the people in the border conflicted areas. They are not sure whether they will sleep in a peaceful night or not. People are concerned about their safety and are forced to live in constant fear and tension. Uncertain firing incidents cause restlessness and stress among the people. Consequently, people were not able to manage their daily affairs and livelihood activities. Their crops remained in the field, and cattle in the sheds were kept unprotected. In certain cases, parents send their children to their relatives' homes for their safety. Other members of the family assume the risk of life and stay back at home caring for the cattle. But, children were worried about their parent's safety and unable to live calmly at the places of their relatives (Kousar & Bhadra, 2019).

Children have witnessed the incidences of cross-border firing since childhood. They are witnessing mortar shells hitting at school, home, leading to injury, deaths of friends, family members, pets, or cattle is quite common (State Nayak, 2020; Outlook, 2019; Ranjan, 2019; Times, 2019; Times of India, 2019). Violence becomes a reality which appears normal and continuous, mainly for these children who were born into conflict. Mortar shells have fallen on their houses, schools, fields, and other infrastructures. A recent incident of firing in the Poonch area caused on the spot death of three family members (father, mother, and son), and another family member was injured when a mortar shell had fallen on their house (Zee News, 2020). Another incident of ceasefire violation resulted in the death of three innocent civilians including one woman and a child (Nayak, 2020). In the starting year of 2018, 12 people have lost their lives, and 50 others were injured in indiscriminate cross-border firing along the IB and LoC (The New Indian Express, 2018). Not only is human life affected with firing and shelling but also the cattle, crops, houses, and other infrastructure are damaged. In one incidence of cross-border firing in 2019, two houses were fully damaged, and four partially damaged and four domestic animals were killed (Press Trust of India, 2019). In another incidence of firing, 20 domestic animals were killed, and many houses were damaged (The Tribune, 2019). Mostly people are dependent on agriculture and their livestock.

During ceasefire violations, children had witnessed somebody being killed or injured. Those who had lost their family members, siblings, friends, and other loved ones in the cross-border firing developed the feeling of hatred toward the enemy. Most of the students want to join military services to take the revenge of their loss (Kousar & Bhadra, 2019). Similarly, Chowdhary (2012) in the study found that a large number of people joined military forces in the border areas of Jammu region.

Their mind is captivated with the memories of a loved one and with an apprehension of losing more. Impacts of such experience include withdrawal from social interaction and from activities such as playing, laughing and sharing feelings, grief, guilt, anger, sleeping troubles, nightmares, and bedwetting flashbacks, and inability to concentrate in studies (Kousar & Bhadra, 2019; Ranjan, 2019).

These incidents of violation have wreaked havoc on residents' lives and livelihoods, as well as disrupted the education of children living in conflict-affected areas. Moreover, the educational infrastructure has also been destroyed so many times, and the existing condition of schools in these areas and other associated facilities is not up to the mark, which eventually directly or indirectly is hampering the educational process of children (Gupta, 2017). The prevailing condition often instills fear, insecurity, and lack of confidence among the children.

When the incidence of ceasefire violation is comparatively less volatile, people with their families preferred to stay at their homes. Everyone stays in one room which has a hard roof. They cook, have meals, and sleep in that room. There is often no distinct space for children to play and study. Everyone has lived in tension, and no one paid attention to the education of the children.

Stakeholders of the Education System Experience Incapacitated Situation

Family, teachers, and community played a crucial role in the learning process of the school children. The development of the personality of the students is the outcome of the complex interaction of several categories of factors like biological, physical, environmental, cultural, peer group, and personal experiences. Communities can provide services such as out-of-school-hours care and social systems that provide information about the school and educational expectations.

The support systems of the children are equally vulnerable during the turmoil of firing. They also live in constant fear during the phase of firing. As it starts without any prior information and at any point of time, there could be an exchange of firing. Mostly, the caregivers are not prepared with all the amenities. When the firing started, the movement had been restricted and created huge chaos among the people. Sometimes, due to the non-availability of foodstuff in the home, they had to live without food. The sound of firing has created fear among people as the mortar shell could fall at any place (Chowdhary, 2012). There is an equal possibility that anyone can become the victim of the firing. This makes everyone in the locality live under the shed of firing. Everyone does pray and hope for the well-being of all the members of the community as well as their cattle. Parents worry about the safety of their children and also have to pay attention to arrange other basic amenities. During this whole process, they paid no care toward the education of their children. Even, their basic needs are also neglected, and there is no option left for them other than surrendering themselves and compromising with the situation (Kousar & Bhadra, 2021b). When the moment comes to help the children to re-integrate into the social environment, school is the best place to make them normalized by spending time with other children and bringing routine to their lives (Bragin, 2012). Teachers played an important role to systematically observe the children and identify the special needs of them (Alisic, 2012). During conflict time, the possibility of positive interaction between the teacher

and the children is reduced. Teachers are also equally vulnerable to become the victims of the firing. Sometimes, the classes were going on and suddenly firing started amid such adverse circumstances, and teachers have to look after the safety of the children and of their own. The building of the schools is not much compatible with bare mortar shells and firing. When the situation becomes normal after a few days or weeks, teachers have to pay attention to their academic progress in order to complete their curriculum in the shortest time possible. Therefore, teachers are unable to provide any sort of psychosocial support to children in order to deal with their problems.

Field Reflections from the Border Region of Jammu

The author has carried out interviews with the children and their parents during field visits in the villages located within the range of 0–5 km of the international border of the Jammu region in January and February (2020). Through the interaction with the parents and children, following issues were emerged and guided through their statements: uncertainty and predictability, the threat to the security of their own life and closed ones, lack of basic amenities, frequent displacement, crops destroyed, death of the nearest ones and cattle, loss of livelihood, closure of schools, and tensed about the future of the children.

Whenever incidents of ceasefire violence happened, consistently the schools in the border region were shut by the government orders or by the local administration. Parents resisted sending their children to schools. One of the parents stated, "*Mostly the schools remained closed during firing even when the situation became normal. I am frightened to send my child back to school.*" Parents have expressed that there is always uncertainty. Sometimes, the situation is peaceful, and all the activities are normal, but suddenly firing and shelling disrupts the peaceful atmosphere. The uncertainty shatters the real happiness of the people of border areas, especially causing huge chaos in the lives of the school-going children. Firing could be started at any time without any prior information. During such volatile situations, people are not safe even in their homes. One of the parents stated, "*Last year, a mortar shell fell on my house. I got some injuries due to it. All family members were tense and not able to sleep for many days due to fear. We are not safe at our home.*" As the firing started at sudden, parents were not ready with all the essential commodities. Sometimes, there was nothing in the kitchen to cook. They all had to wait until the situation was normal. One of the parents responded, "*We all were busy with our work. I was working in the field. Suddenly firing started. We did not have anything in our home to cook. We stayed without any food for one day. Children were asking for food, but we had nothing except rice. The next day we shifted to a relief camp. There we got some food to eat.*" In such a tensed and worrisome situation, it is obvious no one paid any heed toward the education of the children.

When the situation became worse, people had to shift to safer places. They were displaced and relocated either to the camps organized by the administration or to

their relative's homes. Most people preferred to stay at their relative's homes. One of the respondents shared, "*As firing became an inescapable part of our lives similarly displacement has also become a part of our lives. Whenever the situation becomes worse, we have to shift to a safer place. How many times can we go to our relatives' homes? We are tired of this kind of situation. God knows when things will be normal.*" During the process of displacement, in a hurry and tension, people only took necessary belongings and forgot to carry books along with them. "*At that time, we were concerned about our lives and carried only the essential things in a hurry*", one of the parents stated. The eighth, ninth, and tenth standard students were quite tense with the increased incidences of firing at the border. The school board examinations are very crucial for their further academic career, so the children and their parents were highly concerned about their future prospects. A student aged 15 (F) stated, "*I have never seen an academic year without any disturbances. From the last two years, the incidents have increased, and the school remained closed for many days. How can we be able to secure good marks in such circumstances.*" Due to frequent unrest, the schools are irregular, and the syllabus becomes a burden for the children living in the border areas. They are expected to study on their own and be at par with others. After re-opening of the schools, teachers have less time to cover the entire syllabus. Often, the topics are not adequately explained, and some portions of the syllabus are untouched in classroom teaching. Therefore, students experience a lot of problems to understand those topics. A student aged 14 (M) said, "*In every academic session, our syllabus has not been covered completely due to disturbances. We have to put more effort into completing our syllabus. I find it difficult to understand certain topics. I asked my elder brother to teach me. He is also engaged with his studies and could not help in my studies.*" The situation is never conducive to focus on studies as both the school and home environment are equally in turmoil. The educational requirements like additional coaching, books, or other materials were never prioritized due to financial problems, lack of additional support, and loss of income during ceasefire violations. Children witnessed the firing, violent events, death or injury of nearby ones or their pet/cattle, loss of houses, and damage of crops which affect their mental and emotional health and make them frustrated and aggressive. A student aged 14 (M) stated, "*I lost my friend during firing. He was my best friend. We played and studied together. I was shocked to know about his death. I will take revenge for killing my sister by joining the army.*" Not only the people have a threat to their lives but also cattle or pets are equally vulnerable in the shattered firing. A cross-border firing victim shared his pain, "*I lost five cattle when a mortar shell fell on their shed. My child's favourite calf also died in the firing. That was the only source of my income. It became difficult for me to run home.*"

Education System After the Abrogation of Article 370 and During COVID-19 in Jammu and Kashmir

On August 5, 2019, the Government of India abrogated Article 370 of the Indian Constitution which granted "special status" to J&K and splits the state of J&K into two union territories—Jammu and Kashmir and Ladakh. As a safety measure to prevent civil disobedience, all internet and communication services including land-line phones were blocked after the abrogation of Article 370. All leading local newspapers started publishing fewer print copies and avoided publishing editorials on the emerging situation for months. It had little or no coverage of how people lived through the emerging situation. Most of the local dailies suspended online editions for more than three months as the internet services were snapped (Maqbool, 2019).

The world is suffering from the pandemic of COVID-19, and governments all over the world are doing everything they can to combat it. The most efficient action known against it is social distancing, and consequently, countries have imposed lockdown to protect human lives. Lockdown has had economic, social, and psychological effects on people. Unfortunately, people in border conflict-affected areas of J&K have already faced a form of lockdown many times in their lives, but they were not debarred during this difficult period. Amid this pandemic, people living along the border are constantly facing heavy shelling and live in constant fear of death and fear. Many heart-breaking events have occurred in these areas during this difficult period, in which several people have lost their lives, their homes, and their livestock. The most terrible incident occurred when an image on social media of an injured mother holding her dead son in the cuddle went viral. On the same day, the news was also reported of severe mortar shelling and firing at the LoC in several district areas of Poonch causing injuries to two civilians and damage to a number of houses (The Wire, 2020).

When we analyze the situation of people who live in areas impacted by cross-border firing, their challenge is twofold. COVID-19 may give some hope of survival, but the indiscriminate shelling takes a second to kill an individual or ruin everything he or she has. Heavy shelling and firing have created chaos and uncertainty in their lives. Individuals are confined in their homes, but no one knows who the next victim of the conflict will be. This phenomenon is not new to them. They have been living in a condition like that for a long time. But, shelling has created yet another issue for them in this virus (COVID-19) when everybody is expected to maintain a social distance from each other. Prior, they had an option to shift to the relief camps or to their relatives' homes. At this time, they cannot go to the relief camps because of the fear of being affected by coronavirus after coming in close proximity to other people.

The classroom teaching has been suspended during the disrupting COVID-19 pandemic. It is important to note that educational establishments are not merely instruments of learning set up to conduct examinations. Instead, they provide a space where creative energy and scholarly ideas can flourish in a group setting and provide a forum to learn the basic life skills which are necessary for the development of human

beings. The outbreak has significantly enhanced the need to switch to online learning mechanisms and activities for the students. With the annual calendars facing a vast roadblock and pandemic ambiguities, it is critical to acknowledge online education as the new "standard." In a short period of time, platforms like "Zoom" and "Google Classrooms," which most people had never heard of before, had become commonplace. While students and teachers everywhere try to access online learning, the students in Jammu and Kashmir are facing the problem of internet restrictions and lack of connectivity. After the repeal of Article 370 in August 2019, Kashmir has experienced an "educational paralysis," with educational institutions closed and the internet blockade firmly in place. Section 144 of the Criminal Procedure Code (CrPC) imposed in the state and curbs on movement imposed in Jammu and Kashmir by imposing an unprecedented high-security grid and a communications blackout across the entire area (Qadr, 2020; Rautray, 2020). Schools, colleges, and other educational institutions were closed. However, the schools were opened in the areas where the situation was normal, but most of the schools in the state remained closed. The government has made necessary arrangements to open primary schools in the valley, but classrooms stayed empty with most students staying away. Parents were worried about the security situation and resisted sending their children to the schools. After a few months post-Article 370 abrogation, the two-and-a-half-month-long winter holidays in Kashmir were declared until mid-February. On February 24, schools reopened in Kashmir after a gap of seven months (Press Trust of India, 2020). The UT administration released an order on March 11, 2020, ordering the closing of all educational institutions due to the COVID-19 pandemic. Children in Kashmir have been unable to attend schools and colleges for almost a year, with the exception of November when they went in to take assignments for the holidays and seek instructions for online exams. The reasons were enough for students' learning and development to make it difficult for them to re-adjust themselves in a systematic school routine. During a pandemic situation, access to education has been shifted from classroom teaching to remote learning through a smartphone application, holding virtual classes through Zoom application and Google meet and conducting examinations through different applications, sending notes, and recorded lectures on emails and WhatsApp class groups. This approach appears to be more difficult for students in Jammu and Kashmir, where internet access has been restricted for security reasons, and only 2G internet service is accessible. The internet ban in the region is considered to be the longest communications blackout in the history of any democratic nation. On January 25, governments restored 2G internet and put a ban on social media and limited the access to whitelisted Web sites. On March 4, authorities announced access to social media and other Web sites but continued the ban on high-speed internet in the state (Wani, 2020). In the current pandemic, it is extremely difficult to get new internet connections, and some places do not have access to adequate network infrastructure, making it extremely difficult for teachers and students to overcome educational obstacles. Not every student has a smartphone, but those who have are not able to access the education due to low connectivity and network problems in far-flung areas in Jammu and Kashmir. The university projects, assignments, placements, and online interviews for higher studies are at a halt. The students of the

region lag behind comparatively to their counterparts in the other states. Low-speed connectivity makes it difficult for the students to learn from online videos as they stream with many disruptions, low clarity and keep buffering for a longer time. The recorded lectures and downloading class notes that were sent by the teachers through groups or emails are usually taking longer time without better internet facilities. Loss of learning opportunities and restrictions on daily activities are the immediate effects on the students. Some of the immediate consequences include a lack of schooling and limited social development opportunities for students in the UT J&K. For many students, the opportunities provided by the "Right to Education" are a far-fetched dream at this point of time.

Conclusion

Education is the pillar and an integral part of any progressive society. Without making appropriate steps for imparting quality and standard education to its members, no society can prosper. Conflict damages school buildings, all supporting learning facilities and ruins the educational systems. Education can provide a structure for children's life, foster solidarity among peers, and facilitate other important interventions in the field of health and security in conflict-affected areas. In such areas, priority should be given to the education of the children. It cannot be compromised in any situation. Education combined with skills enhancement can be extremely important for the development of the students. It leads to the well-being of students and could offer hope for a better future life. In the long run, it is the next generation that will determine a country's pain or gain.

Recommendations

The prevailing situation often instilled fear, instability, and a lack of confidence among students and community members. There is a crucial need to promptly facilitate the positive changes in the lives of the students living in border conflict-affected areas. The families are unable to ensure enough care and protection of the students due to ongoing tension. They are also the victims of the ongoing conflict. Three generations have seen the conflict and developed a different kind of mind-set. They have a sense of victimization because of the conflict. Every citizen of the country has a right to life, but these people are living under a direct threat to their lives. Many of them have become victims of the conflict. Still, nothing substantial has been done to improve the condition of these people. Facilities such as establishing relief camps, bunker building, and a huge military presence are all set up to deal with emergencies. Yet, these steps are insufficient to ensure the safety of children. As in relief camps, there is no separate facility for the children to play or study. Likewise, bunkers are to keep people secure from the incidences of firing. In such conditions,

childhood is caged with many barriers due to conflict situations and added factors of living near to the international border. The prevailing situations include poverty, lack of infrastructural facilities, lack of quality education and limited opportunities for the children. Living near the international border added additional stressors such as anxiety, hostile environment, mobility restrictions, and the constant presence of unpredictable volatile conditions. In such a situation, the government is supposed to be highly proactive in order to accelerate welfare initiatives and conducive educational environment and necessary arrangements of uninterrupted learning opportunities for the school-going children. Underpinning the need for protection, safeguarding children's rights, including promoting education, is critical for their healthy development. Consequently, strengthening public infrastructure, house safety features, community living, and community resilience building are important steps to be considered in addition to extending peace agreement with neighboring nations.

India is a democratic welfare nation committed to guarantee equality and justice. Every child has a right to education as enshrined in the constitution of India. It is the responsibility of the state to ensure an unimpeded accessibility of education in every situation including in time of emergency. The safe school declaration should be properly implemented in the UT so that the children can have a safe and secure environment to access education in any circumstances.

The psychological turmoil is quite well-evident in this region, and the nurturing environment is jeopardized both at school and at home. The persistent incidences of conflict shattered the caring and protective environment in the community as well as in the family. Maintaining a living without fear and threat is almost utopian that continuously hampers the psychological and social development of the children living in the areas affected by border conflict. Children experience distress are scared, experiencing concentration difficulties, flashbacks of incidences, and lose interest in social activities disturbing them mentally. So, psychosocial interventions and resiliency building should be promoted by engaging the children in activities that inspire them to express their views, overcome stress responses, develop abilities to deal with challenges, encourage group participation, and strengthen social networks and relationships. These can help them to deal with their feelings and to concentrate on their studies. As the students have faced psychological turmoil, so there is a need to add training courses for the teachers to deal with the situation and the children. There is a need to include guidelines or protocols in the schools to deal with emotional distress among the children. Studies have shown that the schools play an important role in helping students to regain a sense of security and reduce stress reaction and give the students a supportive peer group with whom they can learn and practice coping skills from the program delivered (Pfefferbaum et al., 2004; Punamaki et al., 2001; Rolfsnes & Idsoe, 2011).

Uncertainty, disturbances, displacement, and direct threat to life are always there, and it is not possible to sustain education without any conflict in an academic year. Hostel facilities in safer places can be the alternative to make access to education to the students of border conflict-affected areas.

Table 9.1 Casualties and injuries due to ceasefire violation

Period	Ceasefire violations incidents	Civilian death	Civilian injured
2014	583	14	101
2015	405	16	70
2016	449	13	66
2017[a]	971	12	99
2018[a]	2936	61	250

Jacob (2019) [a]The Economics Time (2020)

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Chapter 10
Mental Health and the Working Professional

Bishakha Majumdar

Abstract Next to one's family environment, the part of life that is most influenced by mental health concerns is the work. Work is a key part of the identity of individuals, causing most working adults to spend the largest number of hours in a day in various professional concerns. The pressure to stay professionally relevant in an uncertain environment, competition to stay ahead of colleagues, and increased complexity of the nature of work, expose the average worker to work–family conflict, workplace bullying, and other professional stressors—leading to debilitating impact on mental health of the individual. Again, challenges to psychological well-being, arising out of personal disposition or life situations outside the workplace, have detrimental effects on the productivity and the efficacy of employees. Work stress exacerbates these preexisting dispositions, resulting in loss of valuable resources in terms of employee work hours, firm profitability, and even reputation of the organization in the eyes of customers, suppliers, and other stakeholders. The importance of putting up a balanced, rational, and controlled demeanor at work is the chief challenge to assist professional mental health concerns—as the early signs of disturbances tend to be brushed under the carpet, both by the employee and by the employer. The stigma associated with mental illness and relative scarcity of insurance/healthcare packages to address psychological symptoms further discourages health-seeking behavior among professionals. Another serious challenge is the normalization of maladaptive work practices, such as workaholism, so that individuals fail to notice the first signs of deterioration. This chapter explores the critical nuances of professional mental health concerns, the mental health situation at work in the twenty-first century, and ways to build a healthy and empathetic workplace.

Keywords Workplace · Mental health · Professional · Work stress · Work–life conflict

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_10

Introduction

With the growing awareness about mental health issues and challenges, the necessity for psychological well-being is gradually gaining prominence across the globe. Recent times have seen several public policy interventions in the field of mental health, including those focused on assisting vulnerable groups—such as migrants, survivors of trauma and challenging circumstances, children, and the youth, and senior citizens (e.g., Priebe et al., 2016). The conceptualization of mental health has also moved from an absence-of-illness to a wellness perspective (Keyes, 2002). Psychological well-being is no longer seen as an absence of disorders but a state of personal, social, and occupational fulfillment that leads an individual to a state of holistic enhancement of potential and harmonious living in one's broader context (Enns et al., 2016; Keyes, 2002).

Work and mental health share a connection that is intimate and complex. Work forms a critical part of a person's self-identity. It gives a person a sense of being productive, feeling of autonomy, and status and respect in the society (Fossey & Harvey, 2010) and reduces distress and morbidity caused by the stress of unemployment (e.g., Klumb & Lampert, 2004). Mental stability and health are viewed as necessary conditions to be effective in the professional domain. The ability to be engaged productively in a vocation, particularly one that generates revenue or is economically viable, is considered as one of the critical signs of mental health (McKee-Ryan et al., 2005). Such a perception stems from the fact that professional effectiveness depends heavily on the ability to think rationally and critically, to function in harmony with social and legal norms, and to act in empathy with other actors in one's surroundings (Modini et al., 2016; Paul & Moser, 2009). Irrespective of the complexity of the work, self-awareness and self-control are crucial for any person in the professional domain (Caldwell & Hayes, 2016). This, ironically, often contributes to the perception of a workplace as ideally divorced from mental health aberrations. The professional, in this perspective, is one who is a fully functioning individual living in the realm of subjective well-being, if not quite at the zenith of fulfillment.

Lofty ideals about the subjective well-being of a professional often silence conversations about mental health at the place of work. However, the stressors and consequent mental health issues that a person faces in other walks of life spill over at work and impact his or her functioning at the workplace. Unemployment often correlates with a poor mental constitution, and being gainfully employed is seen as a sign of psychological health. At the same time, work itself is one of the most significant sources of stress for individuals (World Health Organization (WHO, 2019). Fear of failure at the workplace amounts to a threat to the self-identity of a person, causing the individual to stretch beyond one's means to stay at the desired spot. This is exacerbated by uncertainties, role overload, workplace bullying, and discrimination or unfair treatment (Carnes, 2017; Dhanani et al., 2018)—things that aggravate any predisposition in a person toward psychological stress.

A look at the statistics of workplace mental health shows one a scary picture. About one in every four people globally has suffered from mental disorders (World Health

Organization, 2004). According to the World Health Organization Information Sheet on Mental Health in the Workplace (2019), the cost of lost productivity owing to mental disorders amounts to USD 1 trillion annually. Harvey (2018) observed that the impact of mental health at work in the UK went way beyond the "1 in 4" adage (McManus et al., 2009). Psychological distress and disorders at work not only affect the individual, but also affect productivity and health of the workers around him or her, the experience of other stakeholders such as customers, value chain partners such as suppliers and distributions, and other competitors, and the brand image of the organization. It also leads to job loss, causing distress to the family of the affected person, mainly if he/she is the sole earning member.

In India, the mental health scenario is far from satisfactory, a reflection of which is seen in the work environment as well. India houses more than 15% of all the global cases of mental disorders, neurological issues, and substance abuse problems—which affects more than 20% of the Indian population by 2020 (Birla, 2019). As per 2015–16 National Mental Health Survey, more than 150 million Indians need help concerning mental health, and less than 20% of them can access mental healthcare (NIMHANS, 2016). A substantial number of these people are part of the workforce. As per a 2016 survey by Optum, 46% of Indian workers suffer from extreme stress at work, and more than one-third of them report stress-related disorders such as diabetes, hypertension, and even suicidal ideations (Bhattacharya & Vijayaraghaban, 2016). Another 2016 survey by 1to1Help on 6000 workers across India found alarming trends of depression (55%), anxiety (80%), and suicidal ideations (8.1 out of every ten employees) among the respondents (Moses, 2018). Way before the COVID-19 pandemic had hit India, WHO estimated the economic cost of mental disorders in India to amount to USD 1.03 trillion over two decades between 2012 and 2030 (WHO, 2020).

Mental health issues at work are one of the most worrying challenges facing the employers of the twenty-first century. The following sections provide an overview of mental health issues surfacing in the workplace of the new millennium and its impact on the individual employee, the organization, and society. They also explore the interventions that may contribute to subjective well-being in the place of work and future steps that may be taken to make workplaces healthy and productive.

The Changing Nature of Work: The Context of the Twenty-First Century

Mental health concerns at work are not an entirely new phenomenon. The interaction between work and mental health has surfaced numerous times in clinical case studies over the past centuries, recording the impact of mental illnesses on productivity and social functioning. However, there is little historical data showing trends of prevalence of mental illnesses across professional groups. Workplace health impacts, therefore, was primarily limited to physical hazards at the workplace—owing to

poor work conditions, exposure to physical danger, and prolonged stress. It is only in the latter half of the twentieth century that psychological stress faced at work came to be associated conclusively with physiological symptoms such as diabetes, hypertension, migraine, ulcers, or blood pressure, thanks to the large-scale surveys scanning preponderance of mental health issues among different sections of the society. The second major emphasis on mental health in the context of work came with the growing awareness about the post-traumatic stress disorders faced by soldiers returning homes from combat roles in the World Wars (Matson, 2016). With the inflow of data on the general well-being of citizens and its socioeconomic impact, the study of workplace health gained momentum.

Workplaces have changed significantly since the early days of industrialization or corporatization of vocations. With the advent of digital connectivity and globalization, the average professional in the new millennium is characterized by the availability of more professional choices in more varied settings than his/her predecessors could have imagined. Corporate offices, as well as industrial settings today, are characterized by increased digitalization and mechanization—automatizing tasks that were previously human run (David, 2015). While this has simplified work significantly and reduced physical strain, it is also leading to rapid redundancies in existing skill sets of employees. With artificial intelligence-powered processes rapidly replacing human components at work, the modern worker has to constantly upskill oneself to stay relevant and valuable in a workplace dominated by augmented reality and robotics and, at the same time, learn to operate the AI-driven machines and digital contrivances. The physical strain of yesteryears is thus replaced with heightened cognitive tension, with increased emphasis on higher-order mental processes such as critical thinking, problem solving, and decision making in a volatile environment. Secondly, the rapid changes in the workplace are leading to uncertainty and anxiety about one's career development, as well as a constant feeling of inadequacies. Workplaces are becoming multigenerational and diverse, with increased openness among cultures, and expansion of the age of work. However, this, too, comes with its own set of subjective strains, as the professional has to adjust to demands of interpersonal interactions in contexts that often may be unfamiliar to him or her. Data-driven workplaces also subject the employees to a state of continuous surveillance, as well as algorithm-driven management decisions that, while precise, are sometimes found wanting in human moral imagination and empathy. The result may be feelings of isolation and anxiety, which can quickly accelerate to mental illness.

A dramatic change in modern workplaces is the eroding boundaries of the place of work. With growing digital connectivity, workstations are no longer limited to physical office spaces. This affords organizational features such as virtual teams spread across the globe, which, while gaining one exposure to work cultures and knowledge from across the world, brings the pressure of adjusting to varying time zones, increased screen time, and reduced opportunity for face-to-face human interactions. Connectivity and digitalization of the corporate space have also lent momentum to the gig economy, where increasingly workers are opting to stay away from a full-time commitment to one organization, choosing instead to work in a flexible, project-based model. While gig work provides the professional autonomy over his or

her life and work patterns, it denies the gig worker the support of the social network formed in a traditional workplace with peers and the mentoring and leadership of seniors. Gig work has been associated with feelings of instability and loneliness, in addition to leaving the workers without the safety net of institutional health care that comes as part of full-time employment benefits. Virtual workspaces have also blurred the boundary between home and work. Professionals now have to perform and deliver even when physically away from the office. The COVID-19 pandemic saw workplaces remain functional thanks to virtual networking platforms such as Zoom, Google Meet, WhatsApp, Slack, and Webex. However, while keeping vocations alive and functional, virtual workplaces have contributed to work–family overlaps like never before, where an employee needs to be available round the clock for their deliverables.

The most prominent influence of virtual technology on the millennial professional comes from social media. While they are not directly connected to work, social media is one of the commonest engagements among working professionals—where individuals search for jobs and applicants, advertise professional and personal successes, and seek mentorship and peer learning. Social media presents to the millennial worker extraordinary opportunities to craft one's professional image and career, beyond the boundaries of one's current workplace. However, at the same time, social media exposes the individual to the constant scrutiny of his or her social circles and feels pressure to keep up with the professional and personal successes of peers and acquaintances. Social media usage correlates with dissatisfaction, lowered self-esteem, and feelings of anxiety owing to underperformance in professionals, all of which add up to workplace stress.

Stressors in the Millennial Professional Space

One of the most captivating things about workplace stressors is their pervasiveness. Work stressors may relate to the nature of the work, the organizational setup, the human players at work, and the broader professional context in which a person operates. Based on their systematic review, Harvey et al., (2017, p. 1) identified eight workplace features that predict mental issues in the workplace—"high job demands, low job control, high effort-reward imbalance, low relational justice, low procedural justice, role stress, bullying and low social support in the workplace." However, the perception of stressors significantly depends on the expectations that the person brings to work and the discrepancy between the real workplace and the ideal one envisages. A significant difference makes stressors particularly damaging, enhancing the impact of any other strain that the person combats outside the work context. Working professionals reporting two or more adverse conditions at work showed a sharper decline in the mental health status than did their counterparts who are not in the labor force (Milner, Krnjacki & LaMontagne, 2017).

Nature of Work

Specific jobs, by their very nature, involve strain that, with prolonged exposure, may cause significant damage to the employees. Poor physical conditions, excessive and irregular workload, and solitary work, and characteristic of male-dominated industries (where the percentage of male employees is above 70) contribute to mental illness such as depression (WHO, 2005). Again, workers in frontline and first-responder roles such as soldiers and police, healthcare workers, firefighters, and those in essential services are particularly prone to severe stress and consequent effects such as post-traumatic stress disorder, burnout, and psychotic reaction.

The COVID-19 pandemic has renewed concerns about the mental health of workers owing to uncertainties, risks at work, and overload. Pandemics relate to the rise in mental illnesses among frontline workers, such as PTSD, anxiety, and depression (Huremović, 2019). Galbraith et al. (2020) reported heightened stress among doctors during the COVID-19 pandemic owing to prolonged hours of emergency work, lack of adequate protective gear, and increased risk of infection to self. The ethical dilemma of prioritizing between professional duty and risk to family members is likely to cause severe moral injury among healthcare professionals (Litz et al., 2009). Similar findings were reported in a review conducted by Kontoangelos et al. (2020). Further, frontline workers are less likely to prioritize their health over professional duties and seek help when needed—leading to a higher likelihood of depression and suicidal tendencies as a result of work stress (Gerada, 2018; Hassan et al., 2013). Work strain at times makes such workers resort to unhealthy habits such as substance abuse that, in turn, further escalates the problem (WHO, 2019).

Role Overload, Role Ambiguity, and Role Conflict

Mismatch of one's real and ideal work content may arise during hiring itself where both the individual and the organization operate under information asymmetry. Failure to disclose sufficient information about oneself and ambiguity in terms of the required work demands and returns may lead to what is called role strain—a struggle between the work roles as it is expected to be in contrast with what is. Role strains may manifest out of role ambiguity (when an individual finds the work scope and requirements unclear), role overload (when a person lacks the resources to fulfill the demands of a role), and role conflict (when the work role comes in the way of fulfilling the responsibilities that the individual may have in some other role inside or outside the organization). Role strains arising out of overload, ambiguity, or conflicts are significant sources of work–family conflicts and their harmful effects on mental health (Creary & Gordon, 2016).

Role overload may manifest through overwork as well as obsolescence of skills. A 2016 ManpowerGroup survey showed that Indian millennial workers spend about 52 hours a week at the office, which was the highest among the 25 countries studied

(Bhattacharya, 2016). At the same time, rapidly evolving technology keeps workers under the constant stress of obsolescence and upskilling (REF), leading to anxiety, burnout, and other maladaptive work patterns. Melchior et al., (2007) reported that high workload as much as doubled the risk of anxiety and depression in young workers.

Role ambiguity and role conflict, too, have been linked to maladaptive outcomes. In their meta-analysis on 32 research papers, Schmidt et al. (2014) found a consistent positive relationship between role conflict, role ambiguity, and depression.

Virtual Work and Work–Life Conflict

Virtual work environments and consequent non-traditional working hours have been widely associated with disruptions in the life patterns of workers and their health statuses. In their review of research on shift work, Brown et al. (2020) found a consistent relation between non-traditional flexible work hours and sleep disturbances, leading to lowered productivity, cognitive impairment, anxiety, depressed mood, and even suicidal ideations. Shift work and inconsistent hours have also been linked to various psychophysiological outcomes such as hypertension, stroke, diabetes, and blood pressure (e.g., Caruso, 2014; Mahoney, 2010) as well as poor quality of life (Nena et al., 2018).

Gig Work and Gig Economy

In a systematic review of 27 researches, Virtanen et al. (2005) found that temporary workers and those working on seasonal projects are far more likely to report psychological disorders than permanent workers. This trend could be attributed to job instability. Yoon and Kim (2013) too reported high job insecurity to be related to depressive symptoms.

Inequity

Perceived inequity or an effort-reward imbalance has been consistently linked with mental distress and mental illness at work. Buddeberg-Fischer et al. (2008) reported that long hours at work caused stress when accompanied by a perception of being under-compensated for efforts, leading to low job satisfaction, anxiety, and depression. Law et al. (2020) identified a lack of equity marked by the discrepancy between efforts and rewards as a potent cause for mental distress among young workers, along with a lack of job control and high insecurity.

Workplace Bullying and Violence

The act of bullying, commonly associated with adolescent maladaptive patterns, is ironically, more common in the workplace than one would like to believe. Workplace bullying can take various forms, from passive–aggressive acts such as spreading rumors behind one's back, being consistently overcritical of a peer to actively sabotaging a peer's efforts and opportunities, generating false implications against the victim, and even workplace violence (Einarsen, Hoel, Zapf, & Cooper, 2011). Bullying can happen between peers in a team or colleagues belonging to different demographic groups. Still, it may also involve individuals in situations of power asymmetry, such as in a superior–subordinate relationship. Mobbing or workplace bullying, pronounced or subtle, is a significant source of strain at work (WHO, 2019), leading to mental health problems (Schütte et al., 2014). Verkuil et al. (2015), in their review of research on workplace bullying, found a consistent relationship between bullying and stress, anxiety, and depression among workers. Similar findings were reported by Theorell et al., (2015). Nielsen et al. (2020) reported a link between workplace bullying and sleep problems—leading to decreased productivity at work. There are also links between workplace bullying and post-traumatic stress disorder, reduced productivity, and absenteeism at work (Nielsen et al., 2015, 2016).

Workplace aggression can also take the form of discrimination—based on race, gender, social class, or cultural identity (Vargas et al., 2020)—leading to mental illness (Lewis & Neville, 2015) such as depression and PTSD (Reisner et al., 2016). Harnois and Bastos (2018) reported a higher propensity to depression among both men and women employees facing discrimination at the workplace.

Sexual harassment is one of the most pervasive forms of workplace violence—leading to career disruptions, anxiety, frustration, and feelings of distrust and loneliness. Sexual harassment at work predominantly affects women, though men are also subject to such harassment from time to time. Frone (2000) found that young workers are far more likely to be subjected to unwanted sexual advances and consequent mental health strains than older workers.

Trends in Workplace Mental Health Issues

While work stressors tend to be pervasive, research shows intriguing patterns in risks and vulnerabilities of particular demographics when it comes to mental health issues. While women tend to suffer more than men from depression, Roche et al., (2016), in their systematic review of research on workplace depression in the last three decades, found the majority of research showing that male workers in male-dominated industries have a significantly higher likelihood of being affected by depression than the comparable national averages—trends that may be attributed to lower willingness to seek mental health assistance among men than among women (Schofield et al., 2000) and less knowledge about mental health (Cotton et al., 2006).

Milner et al. (2019) found both mental health in both genders to be equally affected by traditional job stressors, unemployment, and retirement. However, a long hour of work was found to affect the mental health of women workers more than it changed men at work. Law et al. (2020), on the other hand, found the mental health of men to be more adversely affected than that of women due to a perceived lack of support at work.

A 2018 Accenture Research survey showed that millennials reported more mental health issues than older workers; almost 93% of millennials were affected by mental health issues, although they were also more likely than their older counterparts to engage in wellness initiatives (Harvey, 2018). Research shows that young workers are more likely to experience inequity, bullying, and lower control at work than older workers—making them more vulnerable to mental illness (Frone, 2000; LaMontagne & Keegel, 2012).

Predisposition to mental illnesses is also a significant predictor of workplace mental health issues. People with a history of psychiatric diseases are more prone to fall prey to work stressors than those without a previous history of psychological distress (Gupta & Sahoo, 2020). Stress at home accentuates work stress, which in turn contributes to mental illness. Professionals acting as caregivers to mentally ill patients are likely to show symptoms of mental illness themselves.

Impact of Mental Health Issues in the Workplace

Combating mental health issues has profound effects on the working life of a professional—that go beyond the immediate symptoms. More than half (57%) of the people surveyed in the UK reported a loss of confidence, loneliness, loss of cognitive performance, and lack of productivity when combating mental illness (Harvey, 2018; Lerner & Henke, 2008). According to the 2019 Mind the Workplace Report (MHA, 2019), workplace issues were found leading to sleeplessness (66%), drinking, drug abuse, and other maladaptive behavior patterns (51%). Mental health disorders have been correlated with physiological outcomes such as heart diseases, blood pressure, and diabetes (e.g., Scott et al., 2016).

When it comes to organizational outcomes, productivity is one outcome that is severely affected by mental health. In the UK alone, companies face an annual loss of almost 42 billion pounds owing to mental health issues among employees, much of it rising from absenteeism (Hanebuth et al., 2006) as well as presenteeism—when the employee is present at work but not productive (Stevenson & Farmer, 2017).

Mental illness leads to job loss and layoffs (Andrews & Wan, 2009) as the employee gradually loses the ability to be socially functional and productive. 11% of employees who have disclosed a mental health issue reported facing dismissal, demotion, or disciplinary action subsequently (YouGov, 2018).

The debilitating impact of mental health issues, coupled with continued work stress, results in self-harm and suicide.

Interventions

Chisholm et al. (2016) reported a return of USD 4 worth of productivity for every dollar spent on the treatment of mental disorders at work. In the words of LaMontagne et al. (2014),

> To realise the greatest population mental health benefits, workplace mental health intervention needs to comprehensively 1) protect mental health by reducing work–related risk factors for mental health problems; 2) promote mental health by developing the positive aspects of work as well as worker strengths and positive capacities; and 3) address mental health problems among working people regardless of cause.

Policy-Level Interventions

In 2007, WHO laid down a Global Plan of Action on Workers Health (2008–2017) (WHO, 2007) in which it recognized the importance of healthy conditions at work and access to occupational mental health services for promoting mental health among professionals. The Mental Health Action Plan (2013–2020) by WHO further reinforced these values (WHO, 2013). In addition, in 2010, WHO laid down courses of action and best practices for firms to mitigate the presence and effects of stressors such as bullying, and creating healthy workplaces (WHO, 2010).

In India, mental health care remains a perennial challenge owing to the lack of an adequate number of trained professionals, lack of healthcare facilities, and stigma about mental illnesses. The Mental Healthcare Act of 2017 sought to address several of these problems by decriminalizing attempts to suicide and providing clear guidelines for treatment and care of mental illness, insurance cover for mental health care, and qualifications of professionals in mental health care. This act provided for the creation of the Mental Health Review Boards by the State Mental Health Authority (SMHA), led by the Central Mental Health Authority (CMHA). Apart from the government interventions, several private mental healthcare providers and NGOs are providing psychiatric and psychological support through trained personnel as well as lay counselors to spread awareness, provide support for day-to-day problems, and to flag severe cases for more intensive care and attention (Kulkarni & Gaiha, 2017).

Organizational Interventions

Organizational support services seem to work wonders toward providing immediate relief in psychological distresses. In India, a 2018 ASSOCHAM survey showed that as much as 93% of the employees surveyed felt motivated by company-sponsored wellness programs to take care of their health and to seek redressal for health problems (ASSOCHAM, 2018). In the UK, while only 5% of the people surveyed reported accessing organizational support services for mental health, 81% of the

people who had sought help at work through formal or informal channels reported positive emotions of empathy, solidarity, and return of confidence (Harvey, 2018).

When it comes to frontline workers, organizational support has been found to be highly beneficial to mitigate the effects of stress and moral dilemmas (Greenberg & Tracy, 2020). Galbraith et al. (2020) stated that recognition for service, adequacy of infrastructure, support for self and family members in case health contingencies arise, and clear communication and leadership helped mitigate the adverse effects of a pandemic on frontline healthcare workers (Devnani, 2012). Gupta and Sahoo (2020) too reported that clear communication and tangible support from the administration helped in reducing stress among frontline workers during the COVID-19 pandemic. This is, however, offset by the fact that only 10% of registered Indian and multinational firms in India offer formal mental health support programs (Moses, 2018). A few of the others opt for temporary measures such as intermittent psychological counseling or wellness sessions for teams and departments (Saraswathy & Pilla, 2020).

Organizational interventions in combating mental health issues may be in multiple areas.

Access to Professional Psychiatric and Psychological Care at the Workplace

Several organizations are ensuring the availability of mental health care to employees. Awa et al. (2010) reported psychotherapy and counseling as interventions adopted by organizations to prevent burnout at the workplace. Many Indian firms have stepped forward in this area. For instance, Tata Consultancy Services provide a 24/7 mental health helpline for its employees and family members under the program TCS Cares. Similar initiatives include a professional counseling network at Infosys and the employee assistance program Umang at Tata Steel (Saraswathy & Pilla, 2020). Globally, industry leaders such as EY, Cigna, Johnson & Johnson, and Cigna, as well as smaller players, are increasingly investing in mental health initiatives at the workplace, such as confidential counseling services (Agovino, 2019).

Access to health care needs to be supplemented by initiatives of insurance for mental health services. While some firms are making mental health support a part of employee insurance schemes, an effort is needed to take the burden of mental health expenses off the shoulders of employees.

Non-professional Support Services

With almost every country in the world suffering from a shortage of psychiatric professionals, there has been an increased impetus on the adoption of support systems of a non-medical and non-technical nature to fill in the treatment gaps at the workplace. Some such interventions include peer-to-peer counseling networks where employees are provided assistance and screening by their peers specially selected

for this role (Saraswathy & Pilla, 2020), such as the Mental Health Allies program in Accenture. This is supplemented by training for leaders and supervisors to detect early signs of mental disturbances in the employees. Regular surveys monitoring the mental health of the employees are an additional critical intervention for organizations to stay updated and intervene before problematic trends get out of the hand (Deodhar, 2018). Organizations also employ psychological debriefing to help employees cope with trauma at the workplace, particularly in the case of frontline employees (Joyce et al., 2016).

Attempts are made to address the lack of mental health personnel through self-assessment and the use of technology-driven interventions—such as online assistance for counseling. Martin et al. (2009) reported the use of computerized cognitive–behavior therapy as effective in reducing depression and anxiety in employees. Chandler et al. (2020) report the use of machine learning to develop a speech-based app for diagnosis and prognosis of mental disorders such as schizophrenia. Another interesting intervention is the mental health AI chatbot Wysa (Sharma, 2020) that simulates the counseling experience in an AI–human service encounter. Digital assistance for mental health care has been found to be effective in providing rapid and accessible services while maintaining anonymity and combating the problem of stigma faced in psychological help seeking (Naslund et al., 2017; The Medical Futurist, 2019). For instance, Accenture provides to its employees the Big White Wall, an anonymous chat environment to seek help on mental health issues.

Organizations are increasingly emphasizing awareness drives about mental health, available support services, and stigmas. The 2018 Mental Health in the Workplace survey revealed that while 88% of the management was aware of the organizational mental health support services, less than 50% of the non-management staff reported knowledge of such facilities (Accenture, 2018). Therefore, effort needs to be made to involve employees across levels in the conversation about mental health. Again, specific drives for dispelling stigma against psychological disorders help in encouraging open discussions about mental health in the workplace, especially among frontline workers in helping professions (Hanisch et al., 2016). Knifton, Walker & Quinn (2008) and Quinn et al. (2011) reported the effectiveness of antistigma workshops. Other researchers reported applications of various measures such as the use of role plays (Krameddine et al., 2013), psychoeducation (Nishiuchi et al., 2007), and group discussion.

Effective Work Practices and Culture of Well-Being at the Workplace

While curative measures need to be emphasized, researchers also stress the importance of preventive measures through work practices that are healthy and sustainable. Bhui et al. (2012) list job redesign initiatives as a critical intervention that allows workers to have a sense of autonomy at work and engage in activities that truly motivate them. They also reported quality supervision as beneficial in promoting mental health at work. Other research has found regular training and reskilling as useful in helping employees to cope with changing workplace demands and role overloads.

Culture of well-being refers to processes of work that encourage healthy habits, nurtures a supportive culture and interactions, and discourages the build-up of stress through role strains and uncertainties. Only 60% of employees in the UK see their line managers as "genuinely concerned for their well-being" (YouGov, 2018, p. 4). Reporting that as low as 10% of the surveyed employees in UK have a supportive culture, Harvey (2018) stated that a supportive work culture entails practices that ensure work–life balance and encourage employees to openly seek help about mental health issues, and without worrying if it may impact their careers or promotion opportunities within the organization.

To promote a culture of well-being, organizations also engage in health-promoting activities—such as sessions on relaxation techniques and physical exercises. Tan et al. (2014) reported team-based cognitive–behavior therapy sessions, relaxation training, and training sessions to promote resilience effective in preventing depression among employees. LaMontagne et al. (2007) reported the use of stress management workshops, counseling, and meditation sessions for employees for modifying responses to workplace stressors.

Rehabilitation of Workers and Re-entry into the Workplace

With the pervasiveness of mental illness among working professionals, it is likely that, despite their best efforts, organizations are going to have repeated instances of psychological distress and ill health among employees. Firms, therefore, need to have concrete policies for the rehabilitation of such employees and reabsorption into the workforce once they have undergone treatment. At present, only 45% of people feel that the organization is adequately supporting people with mental health problems (YouGov, 2018). Joyce et al. (2016) reported the effectiveness of problem-focused return-to-work programs and cognitive–behavior therapy as effective in aiding the recovery of employees suffering from depression or anxiety.

Individual Interventions

The promotion of self-care is a valuable solution to combat mental health problems. WHO brings out a series of self-assessment tools for early detection of maladaptive tendencies and self-care for affected people.

Mindfulness has been identified as one of the most potent tools to combat automatic negative thoughts and distressing ideations. Mindfulness-based interventions such as courses, apps, and reminders help in checking maladaptive thoughts and reducing stress (Spijkerman et al., 2016). Accenture provides to its employees apps on mindfulness for self-regulation and development (Harvey, 2018).

One critical perspective that has gained momentum in recent times is that of workplace spirituality—fostered through training and workshops as well as individual pursuits in the area (Honiball, Geldenhuys & Mayer, 2014). Workplace spirituality relates to seeing work as a means to achieve transcendence and a vehicle of connecting the self to others for holistic fulfillment that extends beyond economic gains (Houghton et al., 2016; Petchsawang & McLean, 2017). Work spirituality enables the employee to go beyond the mundane when making meaning of work and thus rise over minor negativities. A strong sense of workplace spirituality has been related to employee engagement and mental health benefits (Sharma & Kumra, 2020).

Future Directions: How Human Resource Management Can Contribute to Workplace Mental Health

At the core of mental health challenges in organizations lie person-environment fit (Cable & DeRue, 2002)—which postulates that an employee is useful in the organization to the extent his or her needs are satisfied by the organization (need-supplies fit) and the extent he or she can fulfill the organizational demands (demand-abilities fit). A third parameter also matters—to what extent the values revered by the individual matches with the core and espoused values of the organization (person-organization value fit). Need-supplies fit is indicated when the job is able to match a person's career goals, life demands, and changing aspirations. Demand-abilities fit, on the other hand, comes when the individual has the competency and potential to carry out the organizational tasks effectively. When the fit is disrupted, the individual is at incongruence with the organization and its functioning. Lack of need-supplies fit leads to lowered job satisfaction, engagement, and frustration, which may accumulate to result in mental disorders. Again, feelings of inadequacy concerning demands of work lead to role overload and role ambiguities, resulting in psychological distress and subsequent disorders.

The close connection of person organization fit with mental health outcomes at work makes it imperative that mental health at work is viewed through the lens of strategic human resource management. Human resource management is the processes through which the organization acquires and trains human resources, aids them to become productive in the organization, and motivates them to grow and develop with the organization while achieving organizational goals. Human resource management, when driven by strategic vision, ensures that the HR practices of an organization achieve specific purposes of value for the organization and the employee and are sustainable in the long run.

Human resource being the most critical resource that an organization may possess to turn resources into value, mental health needs to be seen as a strategic choice for organizations of the twenty-first century. Employees endowed with subjective well-being are productive and loyal and contribute to organizational progress and

stakeholder satisfaction. Thus, it is essential that the steps that organizations take to manage their people are geared toward ensuring well-being and fulfillment of the internal stakeholders.

Job Analysis and Human Resource Planning

Even before people are acquired in an organization, jobs are designed for them—in terms of the tasks to be done, the goals to be achieved, the skills, competencies, qualifications, and attitudes that are needed to do the job at the desired level, conditions of work—such as time, environment, tools, and hazards, and the compensations at work. Mental health challenges can be addressed at this fundamental level by designing work in a manner that does not lead to overload and continuous strain for the workers and by ensuring that potential physical and mental health hazards are eliminated or sufficiently addressed. Further, by looking into critical incidents that can make or break a professional's performance, organizations can identify potential disruptors and stressors that may be mental health threats going ahead. Human resource planning, or accurate estimation of how many people need to be acquired by a firm, ensures that role overload, owing to overwork, long hours, and strain, is avoided. Finally, identifying appropriate knowledge, skills, and attitudes for a role helps organizations hire people who are good fit for the task and prevent misfits and its consequences.

Recruitment

The process that contributes the most to person organization fit is recruitment. Organizations need to screen employees not suitable for a role—not only in terms of the work qualifications and skills but also in terms of whether they display mental stability to deal with the stressors that the work and the organization may place in their way from time to time. Mental health screening is gradually emerging as a crucial addition to recruitment processes and is being adopted by organizations to shortlist candidates who are the right fit for the role. Organizations also contribute to fit during the hiring process by providing what is called a realistic job preview—letting the potential employee know what the job and its demands entail. This enables the candidate to decide if he or she is suited to the role or if the values of the organization tally with what the employee values for him or herself.

Training and Development

The core purpose of training and development in the organization is to familiarize the employee with the organization and its practices and fill any skill, knowledge, and attitude gaps that may exist between the new hire and the requirements of the organization. Organizations may contribute to mental health through training by skilling employees in positive work attitudes such as resilience, mindfulness, and optimism, as well as helping them acquire the best practices in stress management, conflict management, and communication skills. In addition, assisting new employees in filling their skill and competency gaps ensures that role overload and the ensuing stress and anxiety do not happen. Training also needs to be provided to leaders to develop sensitivity towards mental health issues and preparation for addressing any mental health crisis. The Mental Health at Work Summary Report (YouGov, 2018) report states that around 30% of line managers receive mental health training, a rise from 22% in 2016. CDC (2018) recommends the distribution of self-assessment tools among employees to assess their mental health status, free clinical screenings, and lifestyle coaching to address mental health issues.

Performance Appraisal and Compensation

The absence of perceived organizational justice and inequitable treatment at work has been found to be one of the most potent contributors to mental illnesses and disorders. 54% of employees surveyed in the USA reported that they feel uncomfortable reporting dishonest practices at work (MHA, 2019). Through transparent performance appraisals and commensurate compensation, organizations can ensure that feelings of organizational injustice and inequity do not arise among employees. Further, by providing career development opportunities, organizations can ensure that workers do not feel stagnated, out of control, and frustrated in the organizations.

Employee Engagement Measures

Engagement and motivation measures go a long way to ensure happiness and positivity in the organization. Management needs to invest in active efforts to install gratitude, motivation, and workplace camaraderie through training, workshops, and seminars. In addition, efforts need to be invested in addressing issues such as workplace bullying, abuse, and harassment, so that these do not accumulate to cause distress at work. HR managers should also make efforts to build a company culture that is open, transparent, and as free from negative politics as possible. The Thriving at Work Report (Mind, 2018) lays down six measures as essential components of a plan for mental health at work: (1) having senior leaders participate in the process and

demonstrate healthy behavior and openness about mental health, (2) create awareness by appointing mental health champions and holing awareness events, workshops, and training, (3) involving employees in planning and implementing a wellness culture by soliciting ideas, and appointing steering groups. (4) promoting work–life balance through limited work hours, adequate rests, and mandatory leaves, (5) offering opportunities for finding meaning at work through training and coaching, and (6) building positive work connections by encouraging teamwork and managing conflict (Mind, 2018).

Monitoring the impact of change is critical in the workplace. Prudential financial, for instance, surveys the effects of the change of supervisors on employees' well-being and encourages stigmatization of mental illness by having senior leadership to share stories about their mental health journeys (American Psychological Association, 2017).

Employee Welfare

Employee Welfare is the area that is most directly connected to the subjective well-being of workers. According to the 2019 Mind the Workplace Report (MHA, 2019), 69% of people felt safe staying silent about workplace stress, and 55% of people reported had apprehensions in taking even a day off to attend to their mental health issues. The welfare measure of the organization should encompass assistance for mental health treatment measures as well as insurance for mental health treatment (CDC, 2018). Further, measures for employee rehabilitation post-recovery and support for family members need to be ensured so that mental health issues are destigmatized in the workplace. For instance, American Psychiatric Association cites the case study of Houston Texans that provides comprehensive employee assistance program not only to employees but also to any other person staying in an employee's house, particularly those in caregiving roles (American Psychiatric Association, 2018).

Conclusion

Brock Chisholm, the first Director-General of the World Health Organization (WHO) observed that "without mental health, there can be no true physical health" (Kolappa et al., 2013). The importance of mental health for humanity in all walks of life is that it is social, professional, and personal, which cannot be overemphasized. Work forms probably the most significant part of an adult's identity, aspirations, and values. The professional identity of a person is critical for his or her well-being, life satisfaction, and social efficacy. However, the same professional identity can be a source of perennial strain for an individual, leading to work–life conflicts, frustration, and debilitating stress culminating in anxiety, depression, and mental breakdowns.

To ensure that individuals remain productive as professionals and do so sustainably, organizations, policymakers, and the society as a whole need to take concerted steps to address mental health issues at work—by ensuring fit, removing avoidable stressors, and building resilience, professional care, and social support. A healthy workforce forms the backbone of the global economy and contributes to the future of humankind by being productive, generating value, and ensuring sustainable progress.

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Chapter 11
Post-millennials: Psychosocial Characteristics, Determinants of Health and Well-Being, Preventive and Promotive Strategies

K. Alphonsa Jose, Shinto Thomas, P. Aneesh Kumar, and S. Syama

Abstract The post-millennial generation plays a significant role in the progress and development of every nation. The health and well-being of this generation needs critical focus. Post-millennial are unique, possesses an egalitarian worldview, global and open mind-set, commitment to the environment, society, and others. They are called digital natives due to their familiarity with social media and technology. They are also called snowflake generation due to their characteristics of being gentle and unique. Double income households and well-educated parents and their assistance make them a distinguished population. However, these characteristics are less explored while addressing the health and wellness concerns of this cohort. The present chapter discusses the psychosocial characteristics of the post-millennials and their implications exclusively in the mental health realm. It also presents the strength-based strategies to address the concerns of post-millennials and the significance of evidence-based practices in mental health and sensitizing mental health practitioners about the changing scenario.

Keywords Post-millennial · Mental health · Wellbeing · Gen-Z · Hustle culture · Strength-based approach

Introduction

Post-millennials are called Gen-Z, or iGen or Neo-digital natives (Prensky, 2001), and snowflake generation (Rumbelow, 2016). The term post-millennial was suggested by Pew Research Centre to address the individuals born between 1996 and 2012, but with an open chance of recalibration regarding the same (Dimock, 2019). According to the given definition, the oldest member of this cohort would be 25 years old, and the youngest would be nine in 2021. Though there is significant consensus (Thomas, 2011; Takahashi, 2016; Solman, 2019; Serjeant, 2019) in this generation's definition,

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https://doi.org/10.1007/978-981-16-8263-6_11

there are certain non-consenting voices too. BBC defines this cohort as anyone born after 1995; Business Insider and Forbes recalibrate the cohort as anyone born between 1996 and 2010 (Elsey, 2019; Stahl, 2019). Researchers are yet to reach a consensus regarding the ending birth years (Dimock, 2019). The global workforce will soon be dominated by millennials and post-millennials, whose worldview, attitude, psychosocial characteristics, life experiences, and needs are significantly different from the previous generations. The formative experiences of this group varied widely from that of millennials or any previous generations. Prensky (2001) coined the term digital natives to describe the characteristics of people born and raised in the digital period, speaking the language of computers. The previous generations—the digital immigrants were not born in the digital world but have familiarized or have adopted the digital culture, unlike the digital natives (Prensky, 2001; Repique, 2013).

The health and wellness concerns of the post-millennials cannot be understood using the same yardsticks used for millennials and previous generations. Understanding the psychosocial attributes of post-millennials and the implications of these characteristics in the contexts of work, education, and well-being are vital to address the issues they face and in providing professional support.

Psychosocial Characteristics of Post-millennial

The formative experiences of post-millennials are different from that of millennials or any previous generations. These experiences resulted in a varied value system and psychosocial characteristics which are unique to them.

Post-millennials as gentle, Unique Snowflakes. Post-millennial possess the best-educated parents, compared to any other generation. In most cases, they specialized in one area or career and income (Fry & Parker, 2018). Both the parents will be sharing the financial responsibilities, as they are earning members in the family (Sladek & Grabinger, 2014). Parents spend less time with their children (Sladek & Grabinger, 2014). So, in most cases, the parents try to substitute their non-availability to children with the material rewards. The family's financial security provides post-millennials better opportunities in terms of education, quality resources, and better support, which gives them an edge compared to any other cohorts. As children, post-millennials grew up with parents who were focused on giving their children an ideal life, protecting them from harm, and encouraging them to seek out their passions from an early age (Rainer & Rainer, 2011). The relative wealth of the parents, the reduction in the number of children in the family, parental desire to provide the best to their child, and the sense of importance to the parents provided an opportunity to service providers to create pseudo-significance to this unique cohort (Fry & Parker, 2018).

Families were identified to be the most significant factor in the life of Gen-Z (Seemiller, 2016). This cohort is also called the snowflake generation. As Rumbelow (2016) points out, each member of the snowflake generation was cherished by their

parents as precious little snowflakes, each special and unique. Children often experience "overprotective" or "helicopter parenting" (Schiffrin et al., 2014). Each parent considers their child as unique compared to others. They guide them to be unique by providing special care to protect them from all possible hardships and harm, which devoid them from experiencing the harder side of life and developing resilience (Fox, 2016; Schiffrin et al., 2014). Collins dictionary (2016) defines the term "snowflake generation" as "*the young adults of the 2010s, viewed as being less resilient and more prone to taking offence than previous generations*".

Post-millennials as Digital Natives. As we already mentioned, this cohort is familiar with and consumes technology from a very young age. Hence, they are called digital natives or iGen (Rickes, 2016; Sriprom et al., 2019; Strauss & Howe, 1991; Turner, 2015; Yadav & Rai, 2017). Cohort shows a strong affinity toward online communication and remains connected via technology (JWT, 2012), utilizing technology for distraction and affective and interpersonal connections. (Toronto, 2009). Gen Z uses social networking and other sites to stay connected with friends and make new connections with or without real-world interactions and live in a world of continuous updates (Beal, 2016; Ernst & Young, 2016; Schwieger & Ladwig, 2018). Beal (2016) survey reports the increasing concern of digital device addiction. The outcomes of social media usage among Gen Z include content contribution, information sharing, information usage, searching for facts and data, online participation and entertainment (Yadav & Rai, 2017). It is evident that the cohort is highly familiar with technology and uses it for academic, entertainment purposes, and rapid delivery of limitless information (Salleh et al., 2017). The situation is such that it calls for critical thinking skills among the generation to handle the endless info at their fingertip wisely (Bejtkovský, 2016; Salleh et al., 2017).

Egalitarian Worldview and Values. Generation Z is reported as highly compassionate, fair, and highly concerned about marginalized people, nature (Merriman, 2015), and animals, i.e., they are other-oriented (Dupont, 2015), socially aware and change-oriented (Collisson et al., 2021). Their choice of career is highly purpose-driven (Collisson et al., 2021). For example, a group of Gen Z psychology majors said they desire to improve society, enhance mental health, and understand people's behavior. Concern toward climate change, inequalities, and egalitarian worldviews keep them apart from the previous cohorts (Generation Z, 2020). According to Gen-Z, climate change is considered real, and it requires macro-level—national and global level—governmental attention. They widely accept sociocultural diversities (Generation Z, 2020). A shocking incident took place in India where a 16-year-old girl committed suicide leaving behind a letter addressing to Prime Minister urging severe action to curb climate crisis and environmental degradation (Mirror Now Digital, 2020). *Greta Thunberg* and many assembled behind her are prime examples of Gen-Z concerned about the climate crisis. The Varkey Foundation and populous international survey study among 20,000 Gen Zers from different countries across the globe revealed that the post-millennials primarily value helping themselves and their families to get ahead in life, honesty. Their parents majorly influence them than any others (Broadbent et al., 2017).

They are reported to be highly appreciative of their peer's capacities. They consider peers as competitive, spontaneous, curious, and adventurous, but at times fail to see themselves as competent enough (Dupont, 2015). Post-millennial possesses a different value system. Post-millennials have a high sense of meaningfulness and accomplishment. So, they are the boss of their actions. Unlike the other generations, they look for more meaningful and challenging aspects in work than monetary benefits (Broadbent et al., 2017). Compared to the previous generation, they are less responsible, more carefree, and less concerned about the consequences (Twenge, 2017). They are more focused on the present rather than the future. When it comes to careers, they always seek the balance between work and life, hence lessening the chances of taking up a full-time job (Identifying What Matters Most to the Next Generation, 2018). Goldman Sachs identified Gen-Z as more conservative, money-oriented, and entrepreneurial than the previous generation, and many institutions consider entrepreneurial courses part of the curriculum than ever before (Millennials and Gen Z Picking Their Wardrobes Online, 2018).

Skill development and Side-hustle. As the cohort belongs to the world of continuous updates, they are believed to be efficient multitaskers (Beal, 2016). Cassandra study Tenacious reported that Gen Zers are pragmatic, viewing failure as an opportunity to try again (Deep Focus, 2015). This cohort realized the need for skill development and utilized their free time to upskill themselves from a young age. Preference toward app development, content development, and start-ups are few distinguishing characteristics of this cohort (Deep Focus, 2015). These upskilling and multitasking possibilities mainly stem from the availability of the internet and technology. Online learning (Beal, 2016; Schwieger & Ladwig, 2018) and internships are integral to their learning and development. Online multitasking possibilities resulted in the group's side hustling behavior (Deep Focus, 2015). The current pandemic has pushed many of them to side hustle to make money through online retailing or freelancing, to outlet creativity and entrepreneurial skills amid the social distancing (Williams, 2021).

In addition to the psychosocial characteristics of post-millennials, it is also essential to understand their immediate environments. Educational institutions and workplaces are crucial in shaping the cohort's future and wellness. Hence, the following segment will discuss the cohorts' experiences, expectations, and challenges in their workplace and educational setting.

Gen Z in Educational Setting

The post-millennial cohort prefers flexible and entrepreneurial learning opportunities. Hence, online learning has gained greater acceptance (Schwieger & Ladwig, 2018). The parents of post-millennials are educated, which influences generation z in seeking higher education. Hence, they are the best-educated generation yet (Beck & Wright, 2019). Educational institutions require better readiness to deal with this unique, particular, and zealous group of individuals (Beck & Wright, 2019). The

post-millennials prioritize gaining skills over knowledge. Generation z brings generational shifts and technological trends to their educational choices. This shift brings challenges, opportunities, and tests to the educational setting as well.

Traditional educational institutions faces increased challenges in as the students seek entrepreneurial education and training. The students' values contradict the educational institution's. The differences in expectation, value system, and lack of understanding about the characteristics of post-millennial can lead to multiple issues, which will hamper the development of students as fully functional beings. The change of the education system to fit the requirements of this generation is the need of the hour.

Gen Z at Workplace

Post-millennials at the workplace are more likely to find cultural conflict around the structures that control work, organizational culture, and career employment model (Okros, 2019). The possible cultural conflict with the millennial and Gen X supervisors in the workplace requires additional attention. Post-millennials carry specific values to the organizations. American management association's communicating across generation seminar (2019) points out that Gen Z looks for impactful work, appreciate and valueeffective feedback, and recognition of their work (Communicating Across Generations, 2019; Dwivedula et al., 2019). They prefer one-to-one communication and customized feedback in the workplace; seek honest leaders (Half, 2015) who will seek their ideas and value them without being prejudicial about their age, title, or experience (Francis & Hoefel, 2018). The ideal workplace for this cohort ensures greater flexibility, work–life balance, adequate technological support, enough independence and opportunities to prove oneself and providing the recognition one deserves. They also consider organizations with progressive values, friendly co-workers, and a fun environment as they do strive to make the world a better place. The disparity in values between the Gen Z employees and managers is a severe concern at many workplaces that pose a serious threat to the organization's existence. Opportunity for fair compensation, promotion, professional development, ethical and respectful behavior toward all employees, society (Agarwal & Vaghela, 2018), and wise decision-making skills are also highly appreciated by the cohort in their workplace (Merriman & Valerio, 2016).

These characteristics provide them with an edge over other generations in multiple ways. Are these characteristics helping them to wade off the evil or making them vulnerable to mental health issues?

The Mental Health of Post-millennials

There is a significant increase in reported mental health issues among this cohort compared to previous generations (e.g. Schroth, 2019; Twenge, 2017). Millennials and post-millennials are more anxious than any other generation. They are more concerned about their mental health, and seeking professional help to deal with it.

Are Gen-Z a generation with higher mental health issues? Or are they a generation with better awareness about mental health? Are they less stigmatized to mental health and professional help-seeking?.

Gen Z cohorts are diagnosed with high rates of depression, anxiety, and difficulty in managing stress (Schroth, 2019). Post-millennials understand the role of job and job environment in mental health and well-being. Research published by Harvard business review states that around 75% of the post-millennial left their job for mental health reasons (McMaster, 2020; ACHA NCHA II, 2016). Many post-millennials experience isolation and loneliness and start to seek emotional support from an external environment. Post-millennials experienced more out of home child care than any other previous generations due to the shifts in the family structures and roles. The change in the family structure resulted in newer emotional issues and challenges. The rate of depression, suicidal thoughts and behaviors, and psychological distress are reported to be higher (Gillihan, n.d.). Snowflake's thesis tries to explain why post-millennials experience more anxiety and depression. It states that parents of the post-millennials are more protective. They make their children more dependent on them and do not like to share any responsibility. This cocoon environment prevents the child from developing mental resilience (Twenge, 2017). Lifestyle and cultural trends, poor sleep quality, and increased social media use of post-millennials result in increased mental health concerns (Scott, 2018; Children and young people, n.d.). They are comparatively more stressed than any other generation (Bethune, 2019; Twenge, 2014, 2017). Sources of stress vary from personal to social causes. Personal reasons include low income, interpersonal friction, marital discord, and divorce of parents. Social causes stem from the egalitarian worldview the group possesses; it has, instances of assault and abuse, and the suffering of the marginalized and the poor environmental condition increases the vulnerability to stress (Bethune, 2019).

Social Media and Mental Health

Social media and increased use of the internet and technology also acts as a stressor to the post-millennials. Though the primary objective of social media is to connect with others, many find it challenging to manage multiple accounts, which results in stress (Hampton et al., 2015). Some research supports that post-millennials are more vulnerable to emotional and related mental health issues (Bethune, 2019; Twenge, 2014, 2017).

Being a socially disconnected generation has significantly enhanced the chances of addiction and substance use. Mohan and Ravindran (2020) report the significant relationship between loneliness and problematic usage of the internet. Similarly, a significant relationship between loneliness, alcohol abuse, and tobacco use is reported (Mohan & Ravindran, 2020). Increased availability, consumption, and dependence on technology contribute to depressive disorders (Generation Z, 2020). Young Indians also report stress due to social media usage (Generation Z, 2020). Mobile phones and technology have transformed the present and future of mental health. People use them to sustain relationships, social status, and income generation (Amankwaa et al., 2020). The resultant hustle culture among Gen Z adds to the existing mental health concerns. Hustling has implications for mental health and well-being (Gupta, 2021; Absher, 2020; Balkeran, 2020).

The COVID-19 pandemic and the new normal started changing the scenario as education, and almost all social interactions are online. Everyone is highly dependent on electronic gadgets and the internet, even for their formal education. It has profound implications for mental health professionals as the risk of mental health concerns associated with the prolonged use of technology will be more than any time before in history. In the new normal, physical distancing is beaten through social media participation, and most services have gone online. However, the matter of concern is the lack of control over social media participation and the FOMO.

Unfavorable social comparison in social media platforms may add to the mental health concerns. Research conducted on social media platforms like Instagram reveals its impacts on mental health. Carlyle et al. (2018) reported an increased rate of Instagram posts that mentioning self-harm and suicide ideation elicited more engagement among followers, leading to suicide contagion among followers. Lup et al. (2015) also reported a positive association among frequent Instagram usage, depressive symptoms, and social comparison. Researchers have also identified maladaptive behaviors and glorified portrayal of mental illnesses such as depression, eating disorders, and suicidal ideation on social media (Lachmar et al., 2017; Tanner, 2015; Alderton, 2018) can, in turn, increase mental health concerns.

The current situations with the global pandemic have significantly reduced the social connections of post-millennials to social media platforms. Most of their mobility and real-time socialization is currently restricted. Though most of them live with their parents and family, they still experience a severe lack of social support due to the inter-generational conflict in values, expectations, and perceptions. Pushy parents familiar with technology identify this to be an ideal time to increase the surveillance overtheir children. This increases inter-generational conflict and dissatisfaction. Parental interruption and control of internet use may cause stress among this cohort. The parental overcontrol in social media and technology may adversely impact the parent–child relationship (Generation Z, 2020).

Parental involvement is crucial in their well-being, as the cohort is looking for practical parenting and balance. Parenting styles focusing on collaborative and understanding methods are desirable while dealing with this generation. The reduced peer and perceived social support significantly contribute to varied mental health issues, mainly suicidal thoughts, depression, anxiety, loss of hope, and fear of

missing. The chronosystem remains the same for everyone. The pandemic and associated uncertainties add to the already existing mental health concerns of the post-millennials.

The romanticization of Mental Illnesses. Information is on the tip of their finger—the greater access to the internet results in safe and unsafe information consumption. In mental health, it is noted that there is a trend to self-evaluate and derive a conclusion based on rather than professional assessment. The trend of romanticizing mental illness is rising among Gen Z (Vidamaly, & Lee, 2021). Social media provides immense opportunities to express, discuss, and seek support to deal with mental illnesses (Naslund et al., 2017; Naslund, & Aschbrenner, 2019; De Choudhury & De, 2014. Romanticism aims at increasing the acceptance of mental illness among the audience by portraying mental illnesses as attractive and desirable (Dunn, 2017; Shrestha, 2018). Pictures, GIFs, and memes are used on social networking sites for representing mental illnesses. The trend of portraying mental illnesses as beautiful suffering or as one's display of quirky personality in their social media feeds increased. These trends contribute to a culture of alternative self-expression through mental illnesses among the younger generations. The social media romanticization of mental illness provides a chance for self-expression (De Choudhury & De, 2014), acceptance, and a sense of community. It also risks stigmatization, spreading misinformation, and misusing disclosed information (Blair & Abdullah, 2018). The aesthetic presentation of severe mental health concerns (e.g., Cute but psycho) and adopting the persona of sad and mad is trending (Thelandersson, 2018). The phenomenon of romanticizing mental illnesses trivializes the significance of mental illness by presenting it as a personal struggle and expression of quirky personality (Dunn, 2017). It results in the trivialization of severe concerns like depression and suicide (Shrestha, 2018).

Risk Behaviors Among Post-millennial

Research findings reveal that the rate of substance abuse, alcoholism, teen pregnancy, and school dropouts are low compared to the previous generation among this cohort (Generation Z Is Stressed, Depressed and Exam-Obsessed, 2019; Patalay & Gage, 2019; Thompson, 2017). The group is considered as risk-aware than risk aversive (Generation Z, n.d.). These trends are not universal. The sociocultural environment is responsible for the variation in developing and developed countries (McMaster, 2020). In developing and under developing countries, there is massive competition for resources and opportunities. Very few succeed in their attempts, and others fail. There is also immense pressure on them to be successful. As a result of this, competition and failure create a large unsatisfied group that wants to survive and prove. This group can quickly get into risky behavior and other illegal activities. The Crime Bureau of India reports analysis also supports the same (Vaccaro, 2014). Social media usage is identified to cue the teens to drug usage.

Along with these cues, social media might influence this generation through other means as well. On a neurological level, the likes, comments, and followers enhance the dopamine surge in the brain (Macït et al., 2018). Constant use of social media predisposes the millennial generation to *actual* substance abuse for an even bigger dopamine release.

The pop culture and legalization of marijuana and few other drugs made substance use and dependence less taboo among the post-millennials (Calandrillo & Fulton, 2019). The traditional discussion on substance abuse focusing on the different health consequences fails to hold ground in the case of post-millennial experiences and understanding related to most of these drugs (Fratila & Berdychevsky, 2020). However, the group also fails to identify or consider the other severe consequences such as drug dependence, tolerance, and withdrawal. Social and mass media narratives normalize booze and drug parties. The lack of efficient laws increases the hazards associated with drug use among post-millennials.

The Well-Being of Post-millennials—A Positive Strength-Based Approach

WHO (1948) defines health as "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*" (WHO, 2006) and mental health as "*a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community* (WHO, 2004). National Wellness Institute defines *wellness as an active process through which people become aware of, and make choices toward, a more successful existence* (National Wellness Institute, n.d.). Six dimensions of wellness model by Bill Hettler and National Wellness Institute (1976) deliberately discuss wellness from all the different realms of one's life, ranging from occupational wellness to physical and affective wellness (Fig. 11.1).

Occupational dimension of wellness points to the importance of satisfaction and enrichment in one's occupation. An ideal career would be aligned to one's value and interests and provide scope for developing functional, transferable skills through involvement. The physical dimension of wellness recognizes the need for regular physical activity, healthy diet, and nutrition while forgoing health-compromising behaviors such as smoking or alcohol consumption. Physical wellness necessitates the personal responsibility to take physical health seriously. The social dimension urges the individuals to consider and accept the interdependence of an individual with community and nature. Common welfare and harmonious living with others and the environment contribute to social wellness. The intellectual wellness of the individual lies in creative, stimulating mental activities. The spiritual wellness dimension points out the meaning and purpose of human life. A purpose-driven, meaningful life with

Fig. 11.1 Six dimensions of wellness

a deep appreciation of spiritual values adds to wellness. Emotional wellness emphasizes the awareness, expression, and acceptance of one's and others feelings and being enthusiastic about one's life (Hettler, 1976).

This holistic model points out the importance of various dimensions in experiencing wellness. A person achieves wellness through physical, mental, social, intellectual and spiritual activity, and by being a valued member of the community by contributing to the community and the environment.

The PERMA theory of well-being, like the six-dimensional model and many other well-being models, conceptualizes wellness from a multidimensional perspective. The PERMA model by Seligman (2012) presents the five building blocks of well-being (Seligman, 2011, 2018). They are positive emotions, engagement, relationships, meaning, and accomplishment. Different people will derive well-being through these building blocks to varying degrees.

There are a multitude of models and theories available which explains and predicts well-being. When it comes to addressing post-millennials' wellness, which of the models is the best suiting? Is there any single model which guarantees cent percentage effectiveness in the case of post-millennials? Mental health professionals experience various challenges while dealing with the post-millennials. What are the strategies they can adopt to help this cohort?

Strategies to Enhance Well-Being

Post-millennials are unique from the preceding cohorts in their characteristics, living conditions, physical, and psychological environments, and therefore, addressing their health and wellness concerns requires special attention and tailor-made approaches that suit their unique features. When addressing the prevalent mental health concerns, it is crucial to consider their characteristics.

Internet-based Interventions. Post-millennials have less taboo toward mental health and help-seeking behavior. The heavy use of hashtags on social networking sites on mental health (McCosker & Gerrard, 2020)-related aspects support the same. Digital natives utilize social media as a powerful platform to seek social support, share mental health information, and openly discuss mental illness issues to promote a sense of community (De Choudhury & De, 2014). This characteristic provides a scope for the service providers to utilize social networking sites for increasing mental health awareness and accessibility to professional support. The effectiveness and quality of services offered or promised through online platforms need to be ensured and assessed. Social media-based practices and interventions need to be designed (Naslund & Aschbrenner, 2019). Reece and Danforth's study (2017) shows that human ratings of photo attributes posted on Instagram were moderately predictive of depression. The study revealed that posting frequency and specific characteristics of posts such as increased hue, reduced brightness, and saturation were mild predictors of depression. Social media usage analysis among digital natives would yield significant outcomes in predicting mental health issues. It will help in identifying mental health concerns and providing better services among digital natives. McCosker and Gerrard (2020) proposed the hashtag practice approach, which is ideal for the present generation, advocates better mental health engagement among people through aesthetic, memetic, and cautious mental health posts on Instagram. This careful usage of social media in spreading awareness about mental health should replace romanticizing mental illnesses.

The COVID-19 conditions restricted access to in-person mental health services. However, there is professional help offered in online mode. Gen Z is tech natives, and they use social media platforms effectively, which puts Gen Z in an advantageous position. Their technological skill drives them to seek professional support online, which benefits both the profession and support seekers alike.

Instagram can be a potential platform for mental health interventions as it is a widely used social networking site among the post-millennials. Existing literature points out the significant mental health impact of the same platform (Carlyle et al., 2018). It also provides immense opportunities for mental health professionals and public health professionals to intervene, apply, formulate, and spread awareness about mental health and policies regarding healthy online mental health conversations.

Strength-based Approach. Strength-based approaches will yield desirable mental health benefits among post-millennials, focusing more on internal strengths and resourcefulness. It also gives a more balanced understanding of the person, situation, and concern (Rashid, 2015). This approach would yield more success in post-millennials because they are the actors or agents of change. The characteristics of the post-millennials, specifically, accomplishment and meaningfulness, would compel them to adhere to this approach (Strength-Based Therapy, n.d.).

The six standards proposed by Rapp et al. (2008) can be used to assess the strength-based approach. The standards include goal orientation, strengths assessment, and resources from the environment. Adopting a strength-based approach as the background, the mental health professionals can design the specific individual or client-based practices. Some of the evidence-based practices are discussed here.

Positive Youth Development Model. To promote the healthy development and flourishing of the group, research, policy and service providers should follow a system-based approach. It is crucial to consider the target group part of larger ecologies and consider these when dealing with them. Bronfenbrenner's bioecological developmental model (2005) offers a framework for the intervention, primarily focusing on preventive and promotive measures. The framework looks at one's development within the system of relationships that forms their environment, where the child's biology becomes the primary and essential of all domains. Individuals' biology, immediate family, community, and social background determine their development. Complex layers of the environment and their complex interactions become a point of concern and a tool of change.

Positive youth development, a strength-based approach rooted in the interactive system, provides an appropriate framework for intervention among the given population. The positive youth development associated with developmental systems theory offers a practical framework to enhance the well-being of post-millennials. The PYD perspective provides a scope to intervene to reduce problem behaviors and promote desired wellness outcomes, alongside curbing the undesirable behaviors. Positive youth development (PYD) considers youth as "resources to be developed rather than problems to be solved". It is a resilience-based approach. Positive youth development is an intentional, pro-social approach that engages youth within their communities, schools, organizations, peer groups, and families productively and constructively. It recognizes, utilizes, and enhances youths' strengths and promotes positive outcomes for young people by providing opportunities, fostering positive relationships, and furnishing the support needed to build on their leadership strengths ("Positive Youth Development", n.d.) (Fig. 11.2).

PYD emphasizes strengthening protective factors in one's developmental systems to promote desirable outcomes and curb undesirable ones. As suggested by Lerner (2004), primary outcomes include connection, confidence, character, competence, contribution, and caring. After school programs, community-based activities capitalizing on individuals' skills, characteristics, providing opportunities for community engagement, and leadership easily foster positive youth development (Blum, 2003; Pittman, 2017; Roth & Brooks-Gunn, 2003).

This framework is applicable for the group as the model leverages and capitalizes on the earlier discussed characteristics of the cohort including; egalitarian worldview, technological competencies, academic accolades, skills, and increased awareness toward well-being. The desire for meaning, purpose, and being change agents can be met while utilizing this framework, making it a practical approach to foster this generation's wellness.

DITTO Model. The DITTO model is developed initially to enhance the effectiveness of post-millennials in the workplace (Pichler et al., 2021). DITTO is an acronym for diversity, individualism and teamwork, technology, and organizational support. The model leverages these specific characteristics of post-millennials to enhance their productivity and participation in the workplace. Though initially and exclusively developed for the workplace, in foresight, it appears suitable for improving

Fig. 11.2 Positive youth development outcomes as suggested by Lerner (2004), Silbereisen and Lerner (2007) and Pedersen (2018)

the individual effectiveness and wellness among the digital natives, as it is capitalizing on the unique characteristics of Gen Z.

Diversity. Gen Z has shown acceptance and an inclusive attitude toward diversity (Yello, 2019). Capitalizing on these characteristics, wellness initiatives for Gen Z should incorporate their diverse backgrounds, ideologies, perspectives, and preferences effectively. Chances to interact and work with diverse communities (Newman & Lyon, 2009) and standing up for inclusivity would help the group achieve meaning, purpose, and relationships, which is identified as important in promoting their well-being proposed by the PERMA model.

Individualism & teamwork. Gen Z is individualistic, who prefers to learn and work in a highly customized, flexible manner. When it comes to mental health, this increased preference for individuality may isolate the Gen Z from seeking social

support. The literature points out that the Gen Z are lonely and prefer online communication to real-life social interactions. Providing them with the chances for teamwork would be ideal as it will enhance the social ties and allow them to work with and for others as well, not just themselves.

Technology. The wellness of iGen can be facilitated by incorporating it into the workplace, social connections, and teamwork possibilities. Facilitating more virtual interactions, flexible, remote working opportunities, and utilizing technology for enhanced social interaction can improve wellness through technology. Mental health services available through online platforms and social media will strengthen the possibility of Gen Z using them for their mental health.

Organizational support. Unlike the original model, in Gen Z's wellness promotion, the organizations can be varied. It can be educational institutions, social institutions, and the workplace. Designing the organizations inclusive of Gen Zs and their services customized for Gen Z is essential. With their desire for financial security, balance, and flexibility, educational institutions need to provide skill-based, flexible opportunities to the group. The group increasingly seeks out inclusivity policies, professional skill development, and economic decision-making skills. Increased opportunity for online and offline internships, liberal arts like graduate degrees, and application-oriented curriculum, etc., will be beneficial for the cohort. Organizations should also provide increased support and opportunities to this cohort to explore their possibilities and enhance their wellness.

Conclusion

The discussions identified post-millennials as a unique group with unique characteristics. They are significantly different from any existing cohorts. The present and future of the world depend on them since they are the primary customers and workforce. As their characteristics are unique, the challenges and the problems they face are unique. Hence, the service providers, including educational institutions, workplaces, mental health practitioners, and policymakers, should focus on providing tailor-made services to post-millennials. To make the place inclusive of Gen Z, the service providers need to familiarize themselves with this current generation of employees. They need to adopt newer practices that ensure meaningful work, better work–life balance, transparent norms and policies of work evaluation, and regular feedback. Evidence-based practices in the organizational setting moderate engagement, satisfaction, and performance hence become the norm.

Recommendations and Implications

While addressing their challenges, professionals need to focus on their increased need for meaning and values. The strength-based approach, which puts them in the

role of change agents, is ideal for the group. Their technological competencies are identified to be both a boon and curse to them. The current situation provides the right time to work with this particular group harnessing their technical competencies. However, this can be a potential cause of concern as well. It gives room for many non-professionals and inept service providers ending up providing services. This calls for immediate attention from service providers and policymakers as poor netiquette and lack of professionalism would destroy the credibility and quality of offered professional support. The mindful use of online platforms for delivering mental health services would ensure wider acceptance and better accessibility.

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Chapter 12
University Students' Mental Health: A Concern for All

Jace Pillay

Abstract Mental health conditions, disorders, diseases, and well-being of university students are rarely on the frontline of health regulations and global and local health agendas even though the World Health Organization (WHO, World Health Organization. (2019, October, 23). Adolescent mental health. World Health Organization (WHO). Retrieved from https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health) estimates that worldwide about 10–20% of young people experience mental disorders. Research has shown that student mental health (SMH) and well-being impacts all aspects of student life. They are a crucial group in society in terms of human capital who contribute to future economic growth and development in a country. Hence it makes sense that student mental health is a global concern and that it should get the attention it deserves. Taking this into consideration this chapter is based on a theoretical discussion on the identification and prevalence of common mental health problems experienced by university students across the globe, the causes of their mental health problems and what universities should do to support and prevent students who experience mental health difficulties. The findings clearly articulate the need for a multidimensional and multidisciplinary approach to address the mental health challenges and well-being of university students promulgating a concern for all stakeholders.

Keywords Student · University · Mental Health · Well-being

Introduction

According to the World Health Organization (WHO) mental health is "a state of well-being in which an individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2014, p. 12). Often mental health is seen as the foundation for emotions, self-esteem, thinking, communication, learning,

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_12

and resilience (Parekh, 2018). Taking these views into consideration a definition of mental health of university students would inevitably take into consideration their state of well-being, their ability to deal with stresses of personal and student life, their potential to succeed in their studies, and their ability to use their knowledge and skills to make a meaningful contribution to society. Inadvertently, this will include students having positive emotions, self-esteem, and resilience to thrive under adverse conditions.

Although global studies on mental health have evolved over the past decades (Joshi, 2018) there is still a serious crisis in the mental health care of young people in most countries (Lawrence et al., 2015; Perou et al., 2013; Sartorius, 2015). Increasingly, research is showing that poor mental health has a negative effect on the emotional and psychological health of university students resulting in long-term effects and consequences, such as anger, social isolation, risk of substance abuse, weakened immune system and may ultimately drive a person to suicide (Hawton et al., 2012; WHO, 2012). This is why WHO (2007) has encouraged countries across the globe to improve mental health policies and practices in order to effectively plan, monitor, and implement the delivery of mental health services. WHO (2019) has highlighted the burgeoning need for mental health support in light of the COVID-19 pandemic that is most likely to escalate a significant disease burden that will face the health systems currently and in the future. Several studies suggest that childhood and adolescence are critical periods to promote mental health and that more than half of mental health problems start at these stages, and many of these persist throughout student and adult life (Collishaw et al., 2019; Kessler et al., 2005; Patel et al., 2007). Kessler et al. (2005) postulate that about half of all mental disorders and substance-related problems start at the age of 14 years.

The concerns about the mental health of university students have become an international phenomenon. As noted above, mental health problems commence in childhood and persist into early adulthood if not treated. University students fall within the early adulthood stage of development so monitoring, assessing, and implementing mental health support interventions from the childhood stages of development would be paramount. The international evidence for child and youth mental health disorders have been steadily escalating in the last decade. For example, a study in the UK by Sadler et al. (2018) found one in eight children between the ages of 5–19 had a mental health disorder which was a significant increase in previous surveys conducted. The British Child and Adolescent Mental Health Surveys and Millennium Cohort Study further corroborated the increase in child and youth mental health disorders in the last decade (Collishaw et al., 2019). Similar trends have been observed in most European Union countries where it has been found that one in every 5 children and adolescents suffer from developmental, emotional, or behavioral problems and approximately one in every 8 have a clinically diagnosed mental disorder (Braddick et al., 2009). The situation in the USA was found to be no different from the upward global trend in increasing child and youth mental health problems as noted in the study by Perou et al. (2013) who found an increase between 13 and 20% in a given year during the period 1994–2011. According to Cree et al. (2018) one in 6 children in the USA

between the age of two to 8 (17.4%) had a diagnosed mental, behavioral, or developmental disorder. In the last decade the percentage of young Americans experiencing certain types of mental health disorders has risen significantly with larger effects on mood disorders and suicide-related outcomes (Twenge et al., 2019). In Canada The Child and Mental Health Ontario Report (2018) found that child and youth emergency departments and hospital visits for mental health disorders had risen by 54 and 60% over the last decade. The Australian Child and Adolescent Survey of Mental Health found that 1 in seven, 4–17 year olds experienced a mental disorder which is equivalent to 13.9% of Australian children and adolescents (Lawrence et al., 2015). In New Zealand it was estimated that more than 1 in four youth (29%) experienced a mental health disorder over a 1-year period, and 7.2% were estimated to have had a serious disorder (Oakley Browne et al., 2006). Frith (2016) reported a significant rise in mental health difficulties over the last five years. India has the highest number of suicide among university students with one student committing suicide every hour (Venkatesh, 2018). According to Bhuyan (2019) the negative mental health of university students in India is largely due to harassment based on caste, class, gender, and sexuality. Deb and et al., (2016) found that Indian university students experienced serious episodes of depression when they had negative perceptions of the university academic environment, poor living arrangements, and personal issues.

The focus on the mental health of university students in Africa has been very sporadic in the last decade. This is not surprising as the statistics on child and youth mental health in African countries are generally unavailable. In many African countries there is a serious lack of research on child and youth mental health and this impedes policy development as well as the implementation of evidence-based practices on child and youth mental health (Omigbodun & Belfer, 2016). In a study conducted by Omar et al. (2010) it was found that many African countries did not have a mental health policy and in the few countries that did have such a policy the implementation was very poor. A systematic review of the mental health of children and adolescents in sub-Saharan Africa by Cortina et al. (2012) showed that there were difficulties identified in one in seven children and adolescents, and, when using narrower diagnostic criteria, one in ten children (9.5%) had an identified psychiatric disorder. Africa fails at a fundamental policy level to deal with the mental health challenges in children and adolescents. The lack of focus on mental health in African countries can also be attributed to the belief that mental health problems are actually more of a spiritual and ancestral orientation rather than a psychological problem. The ability to communicate with ancestors in African culture is often seen as a gift (Van Rooyen et al., 2015).

In the last decade the South African government has made great strides in promulgating mental healthcare policies that are intended to regulate the establishment of child and adolescent facilities to promote mental health status, admission, care, treatment and rehabilitation of children and youth at local health clinics (Mokitimi et al., 2018). However, the policies are good on paper but are far from effective implementation throughout the nine provinces of South Africa (Mokitimi et al., 2018). Another conspicuous observation is that when there is a focus on mental health it is predominantly on adult mental health and not children and youth (Flisher et al., 2012). The

omission of mental health concerns about children and youth is clearly evident in the large scale, population-based study of common mental health disorders by the South African Stress and Health Survey (SASH) (Herman et al., 2009a, 2009b) which did not include young people (Jacob & Coetzee, 2018).

The above discussion on child and youth mental health in both developed and developing countries shows that an increasing number of children and adolescents experience mental health difficulties that may result in mental health disorders. However, the situation appears to be worse in developing African countries and this is most likely to have a negative impact on the mental health of university students. Several writers have highlighted the point that the issue of child and youth mental health has to be taken seriously if there is going to be a reduction of mental health problems among young adults and university students in particular (Flisher et al., 2012; Das-Munshi et al., 2016). Countries that are confronted with issues of inequalities, various forms of oppression and discrimination, the scourge of HIV/AIDS, gender-based violence, substance abuse, etc., are more prone to mental health problems among students (Coovadia et al., 2009). Research has shown that students from historically disadvantaged groups experience a significant prevalence of depression, anxiety, and post-traumatic stress disorders (Das-Munshi et al., 2016).

Common Student Mental Health Problems

A rigorous review of literature led to the identification of the top five mental health problems experienced by university students, namely depression, anxiety, suicide, eating disorders, and addiction to substances which are discussed below.

Depression

Studies in various part of the world show that depression is the number one reason that results in student dropouts at universities (Bantjes et al., 2020; Auerbach et al., 2018). Depression is defined as "a mental state characterized by feelings of sadness, loneliness, despair, low self-esteem and self-reproach. Accompanying signs include psychomotor retardation, agitation and withdrawal from interpersonal contact" (Austin et al., 2014: p. 530). Depression is caused by a combination of genetics, biological, psychological, and environmental factors which often leaves students feeling helpless, hopeless, and detached from reality. It affects their life, makes it difficult for them to focus on their studies, and negatively impacts on their sleep and eating patterns (South African Depression and Anxiety Group, 2020). Some of the common causes for depression among university students are related to homesickness (Conley et al., 2014), loneliness, financial stress (Ibrahim et al., 2013), academic stress (Bruffaerts et al., 2018), poor body image and self-esteem, alcohol and drug use (Peltzer & Pengpid, 2016, 2017), unresolved childhood trauma

(McLaughlin & Lambert, 2017), exposure to violence (Mfidi, 2017; Stansfeld et al., 2017), and social media which are discussed in more detail below.

Anxiety

Moderate levels of stress and anxiety are experienced by all people during the course of their lives. However, anxiety disorders arise when anxiety negatively impacts on the daily life of students affecting their ability to function and focus on their studies resulting in great stress and fear. In the context of this chapter anxiety can be described as persistent feelings of worry that interferes with students' state of mood affecting their thoughts patterns. It is also a normal state that can be functional within certain limits. It has psychological components that negatively affect emotions and cognitions. The negative affect is experienced in feelings of fear, distress, apprehension, and uneasiness related to both the student's university and personal life. Anxiety has a compounding self-aggravating effect with somatic symptoms that include "adrenalin secretion, and perspiration, increased heart rate, muscle tension and decreased salivation and stomach acid" (Austin et al., 2014, p. 94).

The Anxiety and Depression Association of America (ADAA, 2020) report that approximately 40 million adults present with anxiety disorders but only a third of them seek professional treatment. A significant finding is that approximately 75% of people experience the first anxiety disorder before the age of 22. This is significant because most young adults in the age cohort of 19–22 are probably university students. Anxiety disorders include generalized anxiety disorders (severe anxiety that affects daily activities); obsessive–compulsive disorder (irrational thoughts, fears, and obsessions that result in repetitive behaviors or compulsions); panic disorder (sudden attacks of panic and fear); post-traumatic stress disorder (onset by a terrifying event); and social anxiety disorder (social interactions that cause irrational anxiety, fear, and embarrassment). Anxiety and depression are comorbid mental health problems (Barlow & Durand, 2015; Boyes & Cluver, 2013) so the factors that cause depression in students, mentioned earlier, are the same ones that cause anxiety in them.

Suicide

Suicide is a deliberate act of taking one's own life (Andriessen, 2006) and this appears to be common among university students (Mortier et al., 2015). Statistics show that 10% of university students thought or attempted suicide and that approximately 1000 suicidal deaths occurred on university campuses in the USA yearly (Center for Disease Control & Prevention, 2020). Besides the stress of being at university most students who are suicidal suffer from depression and other comorbid mental illnesses (Auerbach et al., 2018). Bantjes et al. (2019) in their study of 1402 first year students

found 650 (46.4%) had suicidal ideations, 375 (26.5%) planned suicide, and 120 (8.6%) attempted suicide. Also they found that multiple temporal primary mental disorders predicted the onset of suicidal tendencies. Specifically, among university students' severe depression, anxiety, broken relationships, loss of loved ones, family mental health history and feelings of failure and hopelessness contribute to suicidal thoughts and behaviors (SADAG, 2020; Wilson & Deane, 2010).

Eating Disorders

Eating disorders are extreme behaviors, emotions, and attitudes that focus on food and weight issues. Research has indicated that millions of university students experience eating disorders during their college years (Lipson & Sonneville, 2017; Tseng et al., 2014). Many of them do not seek professional help and do not realize the seriousness of their issues. According to the National Association of Anorexia and Associated Disorders (ANAD) 91% of female university students experience issues around weight while 25% of them binge and purge to control their weight. There is suspicion that male students also experience eating disorders but they do not seek treatment due to cultural views on this being a problem associated with women. Common eating disorders are anorexia nervosa (unhealthy fixation on thinness); bulimia nervosa (binge eating followed by purging, fasting or over-exercising); and binge eating disorder (BED-persistent cravings that occur any time during the day that result in binge eating).

Addiction to Substances

Alcohol and drug use is common among university students who enjoy partying and socializing. However, addiction emerges when over dependency and repeated abuse of alcohol or drugs become part of the students' lifestyle. According to the National Institute of Alcohol Abuse and Alcoholism (2020), about 80% of university students drink alcohol, 50% of them are binge drinkers, over 1500 students die annually due to alcohol-related injuries, and 25% of them who drink have academic problems. Studies have found correlations between addiction and mental illnesses, such as anxiety and depression (Pedersen, 2013). Alcohol and drug abuse have been linked to physical violence and sexual abuse (Rich et al., 2016). The increase of stimulants such as Ritalin among university students has been noted in some studies (Bell et al., 2013) while other studies have highlighted the use of psychotherapeutic drugs for non-medical purposes (McCauley et al., 2011). Bantjes et al. (2020) found that 28.1% of South African students in their study sample of 1402 first year students used medication for ADHD, 64.3% for Bipolar depression, and 52% used psychotropic medication.

Causes of Student Mental Problems

In the review of literature, the following factors were identified as common causes for mental health problems among university students: stressful transition between high school and university, academic pressure to succeed, increasing study costs, student accessibility to universities, rapid evolution in technology and social and systemic issues, which are discussed below.

Going to university for the first time can be an extremely *stressful transition* for many individuals. Such a transition from high school to university can be both dramatic and traumatic if it is not managed well (Henriques, 2014). It can be stressful for students who were raised in very protective environments and often depended on adults for support. Stress could be further exacerbated if they are not adequately prepared for the demands of academic life and if they are not fully aware of their own abilities and performance (Cole, 2019). Going to university often means leaving home and adjusting to a new social environment which they may not be ready for (Alonso et al., 2018). Stressful experiences can be more compounded when anxiety and depression creep in. Hence, it comes as no surprise that research has shown that university students experience higher rates of psychopathology in comparison with the general population (Bantjes et al., 2019; Ibrahim et al., 2013; Stallman, 2010) and usually this occurs within the first year of study (Auerbach et al., 2016; Bruffaerts et al., 2018). Studies have shown that the mental health of first year university students is often challenged by initiation rituals, for example, in India ragging is identified as a serious cause of anxiety and depression among students which in some instances result in suicide (Bhuyan, 2019).

Intense *academic pressure to succeed* also contributes to the mental health problems of university students (Eisenberg et al., 2009a, 2009b). There are a variety of factors that place pressure on students to succeed, such as obtaining good results so that they could get bursaries, learning new study skills to cope at university, job markets becoming more competitive, and lesser career guarantees than in the past (Cole, 2019). However, *increasing study costs*, such as tuition fees and student loans are putting intense pressure on students to succeed. The financial pressure is so great that the number of students seeking counseling support at universities has escalated (Gani, 2016). In certain parts of the world, with South Africa being a popular example, the campaign for student fees to fall has been a forcible form of protest (Calitz & Fourie, 2016; Hodes, 2017). Not having funds to buy books, stationery, necessary equipment and transport costs to attend lectures place undue academic pressure on students. Social inequalities and injustices are still prevalent in many countries where students often do not have sufficient food to eat. This is most likely to contribute to them having concentration problems and distract them from their studies since the primary focus is to be fed.

Over the years' *student accessibility* to universities has increased globally which is certainly a move in the right direction. However, the capacity of different universities to address issues around increased numbers have not been adequately addressed in many countries. Some of these issues relate to increased student accommodation

needs, insufficient academic support programs, and a shortage of medical and mental health facilities on campuses. Another significant issue around increased accessibility of students to universities is the escalating diversity of students in terms of race, ethnicity, gender, socioeconomic classes, disabilities, and sexual orientations. Often many universities lack the capacity to address many of these diversities which often compromise the mental health of students, for example, lack of wheel chair facilities for the physically challenged and braille facilities for students who are blind leaves many of them anxious, stressed, and depressed (Engelbrecht & De Beer, 2014; Goode, 2007). Increased accessibility has resulted in more females attending universities but again the mental health support may be limited since research has shown that females are more prone to stress, anxiety, and depression in comparison with males who tend to have more externalizing problems related to violence and substance abuse (Henriques, 2014). Another significant setback in addressing the mental health concerns of students is that many of them do not seek help because of social stigma and fears about the lack of privacy and anonymity in seeking counseling (Hussain et al., 2013).

In the last two decades there has been a *rapid evolution in technology* with the emergence of the internet, smartphones, Facebook, Twitter, WhatsApp, and other social media technologies (Al-Rahmi & Othman, 2013). Such technological advances may have both a negative or positive impact on mental health of students (Lau, 2017). The negative impact may be seen in the overload of information that may overwhelm and confuse students, the portrayal of mental health as something that is abnormal and should not be disclosed, that to succeed in this world one needs to be attractive, rich, and extremely social able. Students' may feel anxious, stressed, and depressed if they do not have these attributes or if they see that they are a mismatch to what they see in social media and their lived environments, that is, they cannot fit into a "perfect" world. Studies reveal negative psychosocial effects of social media on students such as increased anxiety, depression, stress, mood disorders, suicide, substance use, aggressive behavior, obesity, inadequate sleep and eating disorders (Hawi & Samaha, 2017; Simsek & Sali, 2014). On a positive note technology and social media could also make students aware that they are not alone in their mental health experiences and it could be used to widen their knowledge about mental illnesses as well as the different methodologies available for them to seek help for their mental health problems. It assists in connecting young people who feel isolated or marginalized.

Social and systemic issues play a pivotal role in the mental health of students. Several studies have highlighted strong links between mental health on the one hand and poverty and social deprivation on the other (Harris et al., 2011). The struggles of students from poverty stricken backgrounds were mentioned earlier in this chapter in terms of not having tuition fees, accommodation and travel funds. Poor housing, unemployment, and social conflict are all associated with mental health problems (Anakwenze & Zuberi, 2013). In addition to poverty many students have mental health problems due to exposure to crime and violence (Archambeau et al., 2010). Poverty is known to make students feel helpless, hopeless, and insecure (Henriques, 2014). Social and systemic issues such as racism, xenophobia, sexism, classism, and

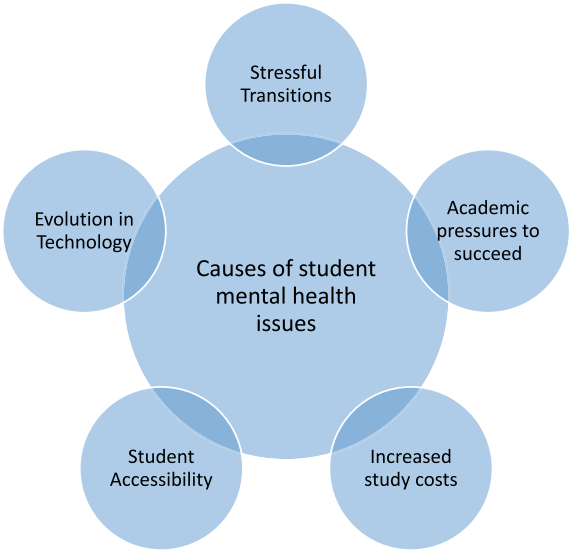

Fig. 12.1 Visual representation of causes of student mental health issues

ableism have been found to make students feel isolated and disempowered resulting in social mistrust of others (Carter et al., 2017; Rosenfield, 2012). In recent times there has been sporadic student disruptions across universities worldwide as a result of racism, sexism, xenophobism, classism, and sexual orientation (Herman et al., 2009a, 2009b; Kessi & Cornell, 2015; Mutanga & Walker, 2015; Peltzer & Pengpid, 2016; Kulick et al., 2017). Recent events in South Africa is a good example of such student disruptions where students boycotted classes amid violent protests against the exploits of colonialism, racism, gender-based violence, sexual harassment, and exorbitant tuition fees (Badat, 2016; Hodes, 2017; Shefer et al., 2018). The focus on "Black Lives Matter" has become a global phenomenon, especially at universities (Fig. 12.1).

Strategies to Support Student Mental Health at Universities

The author conducted an in-depth analysis of literature and explored the Web sites of several universities across the world to determine what is being done to support the mental health of students. Some of these universities included Ghent University, Universities UK, Harvard University, Oxford University, and the University of Cape Town—to name but a few. Several important strategies in relation to the promotion of student mental health emerged during the analysis and these are discussed below.

The first strategy is to establish a *Student Support Center* or Health Station that caters for the mental and physical health needs of all students. This was prevalent in virtually all the universities involved in the author's search. However, there were

discrepancies in the size and capacity of such Centers to provide support to a diverse range of students and their various needs. The Support Centers should be able to cater for large numbers of students diversified in terms of age, gender, race, ethnicity, socioeconomic status, dis(abilities), and sexual orientations. The Centers should be accessible to students in terms of human, material and physical resources, for example, there should be sufficient mental health professionals available to support students and students who are physically disabled should have wheelchair ramps o access the Support Centers. Mental health professionals working at these Centers should be highly trained and skilled in dealing with a variety of problems that could contribute to mental health challenges in students, for example, depression, anxiety, stress, suicide prevention, ADHD, study skills, financial problems, relationship difficulties, gender-based violence, HIV/AIDS, and sexual orientations and harassments. The physical location of the Support Center is very crucial. It should be easily accessible but it should also be discreet and away from university management offices so that students do not feel intimidated in seeking professional mental help. The author believes that a holistic approach should be adopted in the mental health support of students and as such propagates the establishment of Wellness Centers integrated within the provision of mental health support interventions, for example, such Centers should include fitness spaces, nutritional resources, cooking classes, etc. This highlights the feeling that student wellness is an integral part of what happens in the daily life of students at university (Cole, 2019).

Publicizing the mental health support services at the Student Support Center should be a crucial strategy of the Center and the university management as a whole. The promotion of such services should be done during careers days at high schools, open days at universities, and the webpage of universities. Many students do not utilize mental health support services due to social stigma (Eisenberg et al., 2009a, 2009b) so Support Centers should have dissemination strategies directed at de-stigmatizing the social stigma attached to mental health and publicize counseling services on-campus. The Centers should institute outreach programs to reach students who are not confident to make connections themselves. Support Centers that promote psychological safety and a sense of a caring community, that are welcoming and affirming, and promote inclusion and diversity where differences are respected and valued have a greater chance of being utilized by students (DePauw, 2017).

Universities should adopt *online self-help resources* as a strategy to support the mental health of students. Students who do not use mental health support facilities at the Student Support Center due to social stigma and intimidation may be more willing to use online support. Online support could include counseling sessions via SKYPE, telephone, conference calls, etc. The use of artificial intelligence (AI) as part of the 4th industrial revolution may be a good way of monitoring and supporting students with mental health challenges. The use of YouTube appears to be a common practice among university students experiencing anxiety, depression, and stress (Cole, 2019).

Universities that take the mental health of students into consideration usually have courses on mental health for undergraduates during the orientation process when they are first enrolled. This could be in a classroom or online lecture. However,

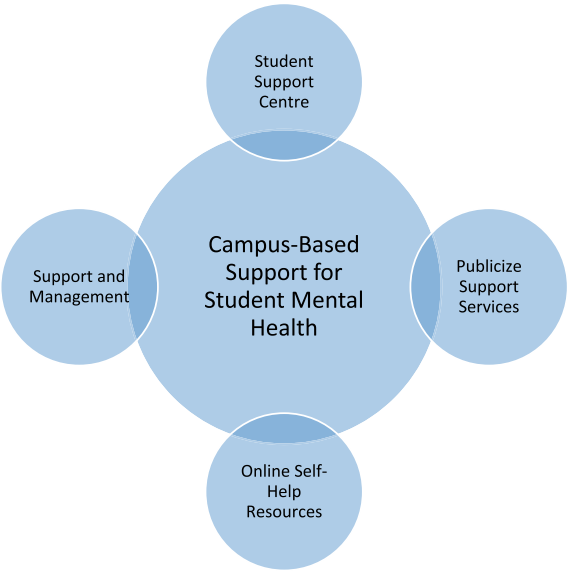

Fig. 12.2 Visual representation of campus-based support for student mental health

it is paramount that the orientation process is followed by workshops and refresher courses on mental health.

For all of the above-mentioned strategies to be effectively employed the *support of university leaders* will be essential. They could lead by example, for instance, by sharing their own testimonies related to mental health challenges so that students could seem that anyone could have a mental health problem and that there is nothing shameful about it. They will be able to see that a person does not have to be defined by a mental illness and that he/she could still make a great success of his/her life (Ketchen Lipson et al., 2019). University leaders should provide leadership on promoting student mental health through ensuring the allocation of human, material, physical, and financial resources. They should ensure that mental healthcare support, prevention, and promotion is provided all levels right from top management down to departmental levels. They should adopt a comprehensive and integrated approach to student mental health support throughout the entire campus that involves education and awareness programs, screening, peer support programs, faculty/staff training, and curriculum-based programs (Ketchen Lipson et al., 2019). Last, but not least, senior leadership at universities should ensure that mental health services are accessible, affordable, and structured to serve the needs of diverse students (Fig. 12.2).

Conclusion

Depression, anxiety, suicide, eating disorders, and substance addictions emerged in the literature review as the top five mental health problems experienced by many

university students. Several causes for these mental health problems were identified, namely the stressful transition from school to university, academic pressure to succeed, escalating number of students to universities, increasing university costs, rapid evolution in technology, social and systemic issues, such as racism and sexism. These contributory factors cogently indicate that the mental health problems of university students are exacerbated at multiple levels, such as the students themselves, their families, schools, universities, communities, and society at large. As such, Bronfenbrenner's bioecological systems theory would be an appropriate framework to conceptualize mental health support interventions for students. Several support strategies were identified in this chapter, namely the establishment of student support centers, publicizing mental health support services, online self-help resources, and the unconditional support of university leaders. While all these strategies may be located at universities across the globe the success of combatting mental health challenges of students would depend on a multidimensional and multidisciplinary approach that embraces the support and concern of all stakeholders.

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Chapter 13
Performance, Discrimination, and Work–Life Interface: Perspectives in Workplace Health and Well-being

Tusharika Mukherjee

Abstract Work organizations in the contemporary world are increasingly valuing and investing in employee health and well-being, primarily due to the costs associated with physical and mental ill-health. Moreover, as we spend a substantive share of adult life at work, the meaning and purpose derived from work have an overarching impact on our general satisfaction with life. Hence, both organizational and individual survival and growth hinge on employee well-being. This chapter offers a conceptual analysis of psychosocial factors in the workplace that impact employees at varying levels of functioning and explores the intra- and extra-organizational conditions that enhance or hinder employee well-being. Performance demands, lack of autonomy and commitment, discrimination and loneliness, and work–life imbalance constitute physical and mental health hazards and impede individual and organizational growth. Conversely, effective performance is embedded in autonomy (self-determination), positive work experiences, and organizational practices that promote positive organizational behavior and psychological capital. As discrimination is more indirect or subtle in workplaces, affirmative action singularly is insufficient as a countermeasure for the engendered health inequalities. Social support and trust inherent in the organizational climate and equitable policies are crucial in the prevention of social isolation including perceived discrimination and loneliness. Striving for balance as a response to work–life conflict and its impact on individual productivity and well-being rests on the assessment of boundaries between the work and non-work identities and prioritization. Perceived autonomy aided by organizational flexibility, supportive leadership, and empowering social structure is pivotal to achieving satisfaction and meaning in work. The salutary measures encompass an interconnected and sustainable structure for a concerted facilitation of workplace health and well-being.

Keywords Performance · Discrimination · Work–life interface · Workplace health · Well-being

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_13

Introduction

Human evolution in the last century has outpaced itself with profound changes in living. The predominant agent of this transformation has been the creation of human conglomerates as organizations with economic prospects. Marked with skill development, resource generation, cooperation, and competition, work establishments have been formed to be the most persuasive structures for sustenance and progress of civilization. At the behest of contemporary globalized–urbanized order, organization of work is not restricted to economic and technological forces like market, production systems, services, and automation, but has also instituted social and cultural agencies within its boundaries in a short span of time (Hannan & Kranzberg, 2017).

Health and well-being are heralded as the two salient precursors as well as outcomes of employee effectiveness in the contemporary understanding of work. Organizational longevity hinges on recognizing the value of workplace well-being and achieving it via creating sustainable work environments. Research in work psychology and organizational behavior has been consistently documenting the dynamics of person–environment factors that contribute to organizational development and success. The 2017 British Psychological Society report on improving well-being and productivity underlines the importance of environment, relationships, and change, in devising an optimal workplace where work can be meaningful and rewarding, while providing safety against psychological damage (Weinberg & Doyle, 2017). As statutory and voluntary employee welfare began to constitute organizations' response to the fast-changing work environment and culture, a subsequent paradigm shift in business and industry enabled recontextualize labor as a human resource and adapted to practices embedded in pro-people, pro-social, and pro-ecology perspectives. The World Health Organization classifies organizations as health-promoting entities based on the conceptualization, "workplace in which workers and managers collaborate to use a continual improvement process to protect and promote health, safety, and well-being of workers" (Burton & World Health Organization, 2010). In line with the changing connotations of work and its overarching impact on individual and organizational survival, in this chapter we address the issue of workplace health from three standpoints—individual job-related perspective: performance, autonomy, and commitment; social environment perspective: perceived discrimination and loneliness; and extra-organizational perspective: work–life interface. The chapter also focuses on employee perceptions and behavior, social interactions, and vulnerabilities that can be reconstructed through interconnected and mutually enhancing organizational provisions and changes in the pursuit of creating healthy work organizations (Fig. 13.1).

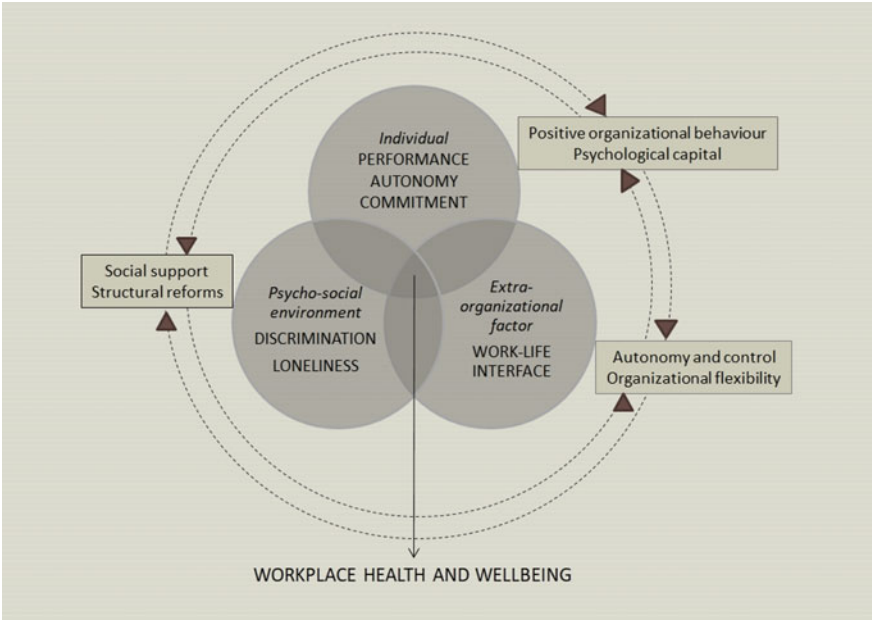

Fig. 13.1 Conceptual model representing factors affecting health and well-being in workplace

Work Performance

Work occupies a major portion of our lives and investment of time and effort; hence, its functionality cannot be restricted to mere economic benefits. Contrarily, work is estimated to satisfy a varied range of higher-order needs (e.g., affiliation and power), and provide pretext for overall life satisfaction, purpose, and meaning. From the inception of principles of "scientific management" by Taylor (1911), research in industrial and organizational psychology has been engaged in discovering the mechanisms that affect performance (Locke & Latham, 1990). Theories based on goal setting (Locke & Latham, 1990), expectancy (Vroom, 1964), and self-efficacy (Bandura, 1986) have systematically illustrated the work motivation–performance relationship and provided sufficient insight for innovation in employee training, self-management, leadership, and organizational practices.

Within the goal-setting paradigm, Locke and Latham claim that the goals an individual is consciously trying to set are the most fundamental determinants of task performance, and that the participative setting of goals leads to more effective performance than a mere external assignment of goals (Latham et al., 1988). Vroom's expectancy model is built upon the prediction that performance is a function of expectancy, i.e., effort will lead to performance, instrumentality, i.e., performance will result in reward and valence, i.e., the perceived value of the rewards or outcomes

of performance (Locke & Latham, 1990). Expectancy can be theorized as a subjective estimation that an effort or action will lead to successful performance or desired outcome, and it is based on the individual's belief in own capacity to lead to the outcome (Van Eerde & Thierry, 1996). The reference of self-belief in the expectancy model can be conveniently linked to Bandura's self-efficacy conceptualization which is constructed around the approximation of the ability to perform in a given situational context (Locke & Latham, 1990). Self-efficacy directly affects performance or can operate through establishment of personal goals. Locke and Latham point out that even when the goals are assigned, self-efficacy regulates how assigned goals affect one's personal goals upon which performance is contingent. Whether it is in setting goals, or expectancies, or in appraisal of ability, the three theories converge at the degree of control that an individual can exercise. Thus, understanding work motivation in light of autonomy and control is imperative to ascertain its repercussions on work behavior and health.

Research on antecedents of performance indicates that strain-inducing workplace conditions have cascading effects on physical and mental health. Personality, cognition, and stress are intricately linked and determine whether these effects will get streamlined or compounded as psychosocial hazards. The International Labour Organization highlights a combination of factors related to the job content, work organization, management, and employee competencies and needs, as well their interaction, that constitute psychosocial hazards. The psychosocial risks influence employee perception and experience of work-related stress. Their damaging repercussions on individual physical, mental, and social health are widely recognized. However, a concurrent, and perhaps a greater concern is the identification of new emerging hazards due to the changing nature of work, working population, and organizations (EU-OSHA, 2007). The World Health Organization's report on the health impact of psychosocial hazards at work highlights its expanse as a public health concern with increasing costs on health care, and as an issue that demands intervention at three levels—primary/organizational, secondary/individual's response to psychosocial risks, and tertiary/management and treatment of occupational disease and illness (Cartwright & Cooper, 1997; Hurrell & Murphy, 1996; LaMontagne et al., 2007).

Workplace conditions that accentuate psychosocial risks span a wide range of interrelated factors, as articulated by the World Health Organization (Leka & Jain, 2010). Risks emerging from the job itself (job content) include lack of variety, short work cycles, fragmented or meaningless work, under use of skills, uncertainty, and repeated exposure to people. Work overload or under load, time pressures and deadlines, inflexible shifts, unpredictable working hours (including longer unsociable hours), low job control or inability to participate in decision making, lack of control over workload and workplace. At the interpersonal level, poor communication, inadequate support for problem-solving, role ambiguity, and ill-defined organizational objectives make a non-conducive organizational culture. In addition to that, social or physical isolation, inadequate superior–subordinate coordination, interpersonal

conflict, bullying and harassment increase vulnerability. Job insecurity, inequitable pay, and stifled opportunities of growth and personal development can be accounted for psychosocial impact on workers (Leka & Jain, 2010; Leka et al., 2003). To elaborate it further, the job-strain model (Karasek, 1979), one of the most prominent conjectures, highlights psychological stress as a function of imbalance between job demand and job control. Exposure to job strain increases the risks of coronary heart disease by 40% among 13 European cohort studies during 1985–2006, as identified in a meta-analysis published in The Lancet. After controlling for sex, age, socioeconomic strata, region, lifestyle, and conventional risks, the population risk for job strain was found to be 3–4% (Kivimäki et al., 2012). Analysis of psychophysiological biomarkers of workplace stressors and health also reveals increased risk of ischemic heart disease, 50% greater risk of coronary heart disease, neuroendocrine stress response (Chandola et al., 2010; Eller et al., 2009; Kivimäki et al., 2006). In addition, work stressors also influence unhealthy behaviors like smoking, poor, or unhealthy diet and lifestyle (Chandola et al., 2010).

It has long been recognized that decentralized decision making, comprehensive training, salaried compensation, and employee participation foster performance (Youndt et al., 1996). Nevertheless, the evidence of satisfaction and meaning can be derived from performance that is embedded in positive work attitudes of autonomy (self-determination) and commitment. In addition, organizational practices aimed at nourishing psychological capacities that buffer or cushion adversity and facilitate positive individual–organizational exchanges are now seen as a necessity to devise sustainable workplaces and safeguard employee physical and mental health.

Autonomy and Work Motivation

Autonomy or individual control as a precondition to performance is a complex and multidimensional construct. One of the pioneering and most celebrated approaches to understanding autonomy in the workplace appeared in the Hackman and Oldham model (1975) which proposed five core job characteristics—skill variety, task identity, task significance, feedback, and autonomy—as the primary drivers of performance. Extensive research evidence supports the proposition that independence and discretion in work scheduling and ability to make choices on work processes are crucial for employee cognition of the work situation (Gagné & Panaccio, 2014). A prominent standpoint to explore work motivation is the self-determination theory (Deci & Ryan, 1985), which substantiates the role of autonomy. Ryan and Deci (2017) describe motivation as a continuum of heteronomous (regulated by others) or autonomous (self-governing) motivation. They delineate autonomy as central to internal motivation as opposed to other controlled forms that result in alienated behavior or actions that lack integrated self-endorsement. A critical point Ryan and Deci adduce here is that individuals can feel autonomous at varying degrees and that the urge to subscribe to external control or to be free from it can be actualized

autonomously. Nevertheless, autonomy orientation promotes gratification of intrinsic psychological need for self-determination (Hodgins et al., 2006).

A meta-analysis of 101 samples concerning autonomy and participation at work identified high levels of perceived control among those who rated higher job satisfaction, commitment, involvement, performance, and motivation (Spector, 1986). The study also revealed employees who perceived higher levels of control experienced fewer physical and emotional symptoms, reported less role ambiguity and role conflict, lower absenteeism, and intentions of turnover. Hodgins et al. (2007) assert that autonomous motivation is linked with cognition of relatively more honest, open, and satisfying interpersonal interactions. The authors affirm that lack of autonomy makes one vulnerable to external pressures and develops self-esteem that is contingent upon outcomes. Contingent self-esteem reflects less intrinsic motivation, and is often accompanied by experience of tension and pressure (Ferris, 2014). Crocker et al. (2003a, b) suggest that self-esteem may be contingent upon external factors like other's approval, appearance, competition and win over others, academic competence, family support, own virtues, and perceived God's love. Contingent self-esteem raises generalized defensiveness against situational cues or thoughts that are construed as threat to the sense of self-worth (Hodgins & Knee, 2002). Substance abuse in the form of binge drinking (Luhtanen & Crocker, 2005), perfectionism (Hill et al., 2011), narcissism—both covert and grandiose forms (Zeigler-Hill et al., 2008), decreased well-being (Crocker et al., 2003a, b), greater depression, anxiety, eating disorders, and disruptive behavior (Bos et al., 2011) have been identified as correlates of contingent self-esteem (Ferris, 2014).

In a 2019 study on managers (in healthcare organizations) operating under strict top management control in terms of decision making, were found to experience higher role conflict, reduced clarity in demands, poor support, stress, and increased health risk over time (Fallman et al., 2019). A meta-analytic study on organizational strategies to enhance employee intrinsic motivation via initiating autonomy supporting leadership behaviors, revealed positive linkages of autonomous work motivation with general well-being, work engagement, and positive work behavior; and negative association with general distress (Slemp et al., 2018). Besides the impact on work-related attitudes and behaviors, self-determination is also a significant determiner of perception of daily hassles and physical symptoms. Otis and Pelletier (2005) observed that higher self-determination and consequent lower turnover intention were inversely associated with perception of daily hassles including meeting deadlines, not achieving personal goals, uncertainty about future, interpersonal discord, and not meeting the family expectations. Moreover, perception of daily hassles was concurrent with perception of a wide range of physical symptoms including musculoskeletal system symptoms (e.g., backaches, swollen ankles), respiratory system symptoms (e.g., nasal congestion, coughing), digestive system symptoms (e.g., nausea, constipation), stress-related symptoms (e.g., headache, nervous movement of the eyelid), and more serious symptoms (e.g., nosebleed, racing heart). Likewise, coping with organizational change can be a difficult scenario for some organizations or individuals. Gagné et al. (2000) argue that perception of autonomy support can ease the transition, i.e., when employees are offered a choice in how

the change will be implemented along with independence in decision making, they perceive the change as less threatening and are less likely to resist it (Ryan & Deci, 2017).

Commitment

A prominent access to individual's relationship with the organization is to view it as a psychological state of identification and involvement with implications for continuing or discontinuing with the organization (Meyer & Allen, 1991a, b; Mowdey et al., 1982). It is well-documented that commitment at all three levels—affective (attachment to the organization), normative (obligation to remain), and continuance (perceived cost of leaving)—has varying influences on employee work behavior (Meyer, 2014). Research on organizational commitment converges on extrinsic (wage and benefits) and intrinsic (job satisfaction and positive interpersonal relations) rewards of identification and involvement with the organization (Mathieu & Zajac, 1990). Higher commitment exhibits higher extrinsic motivation, increased job involvement, reduced stress, and job satisfaction among employees, with predictable behavioral consequences like low turnover rates, as revealed in the meta-analysis by Mathieu and Zajac (1990). A second meta-analysis spanning over 25 years corroborated earlier evidence that variation in job performance can be attributed to differential commitment and that it has a subsequent positive outcome in organizational effectiveness (Jaramillo et al., 2005). Though scattered, research signifies linkages between well-being as well as physical–mental health and employee commitment. Meyer and Maltin's review (2010) demonstrates consistent positive relation between commitment and physical well-being, general health, positive affect, job-related well-being, self-esteem, and life satisfaction. The authors also examine the effects of low or absence of commitment and reveal higher physical strain, psychosomatic manifestation, mental health issues including anxiety, depression, negative affect, distress and job-related tension, and even burnout. In addition, the role of commitment in the relationship between stressor and strain has been documented in terms of (i) the buffer effect, when strong commitment gives a sense of purpose and safeguards against the effects of stressors, or (ii) the exacerbating effect, when strong commitment pushes one to experience the negative effects of stressors (Meyer & Maltin, 2010). What emerges from their review is that commitment moderates the degree to which the perceived stressor correlates with physical or psychological strain. This argument also holds true for the links between perceived stressor and early response to stress, as well as between the early response (felt stress) and longstanding strain including work-related depression, work-related irritation, and somatic complaints (Glazer & Kruse, 2008; Meyer & Maltin, 2010). Despite the noteworthy uniformity in acknowledging the value addition by employee commitment as a performance variable, what remains to be understood is the imperative alteration in commitment in the globalized workspaces, like virtual teams.

Performance in the workplace and physical–mental well-being share a dichotomized alliance, functioning as both an antecedent condition and a consequence of each other. Contemporary organizations have adopted supporting performance management programs to address the issues of employee commitment and satisfaction, but they are too scarce to cover a larger population, and are limited to certain industries, professions, and roles. Precisely, till date majority of the performance management initiatives have been centered on rewarding successful performers, identifying poor performers and targeting their training needs, and creating individual employee development plans based on an assortment of audits, performance reviews, feedbacks, and coaching (Lennon, 2018). Effective performance management system offers improved planning, measure, and control of employee performance by integrating explicit standards of performance and avoiding goal conflict or ambiguity (Brunetto & Farr-Wharton, 2005). Extant evidence upholds the effectiveness of performance management in achieving organization efficiency and outcomes, but how that can contribute to an individual's subjective preferences and well-being is largely obscure. In a review and critique of major devices of performance management, Tweedie et al. (2019) point out that acknowledgment of individual contribution has a bearing upon well-being as well as self-conception. Failure of the performance management system to ensure that results in a system that is judged coercive, disciplinary, and inequitable.

Positive Work Behavior

An alternative and relatively more balanced approach that has gained much popularity emerges from Seligman and Csikszentmihalyi's (2000) conceptualization of positive psychology. The implications for work psychology and organizational science emphasize the need for effective development, utilization, and application of positive traits, states, organizations, and behaviors (Luthans & Youssef, 2007). Though organizational behavior as a discipline has not been intuitively regarded as spearheading health, it does not have its roots in medicine or psychopathology (Campbell Quick et al., 2010), lately it has seen immense growth in promoting workplace health by consistently incorporating positive psychology evidence. *Positive organizational behavior* addresses pursuit of employee health and well-being by investing in cognitive capacities like creativity and wisdom, affective strengths like work engagement and humor, and facilitating psychological states like self-efficacy, optimism, hope, and resilience that assists in coping with organizational stress and supports performance (Bakker & Schaufeli, 2008). In addition to job performance, the positive psychological resource capacities share concordance with desirable work-related outcomes, as described by Youssef and Luthans (2007), including job satisfaction, work happiness, and organizational commitment. *Positive organizational scholarship,* built upon the postulation that life-building, capability and capacity-enhancing forces within the organization fosters humans' strength, virtues, resilience,

vitality, and thriving, represents the expansion of positive psychology movement in organizations (Dutton et al., 2005).

Psychological capital is a synchronous construct representing a higher-order individual characteristic consisting of self-efficacy, optimism, hope, and resilience. Luthans et al. (2007) assert that a true competitive advantage in the global market can be achieved through cultivating psychological capital which they refer to as "an individual's psychological state of development characterized by having confidence (self-efficacy) to take on and pit in the necessary effort to succeed at challenging tasks, making a positive attribution (optimism) about succeeding now and in the future, persevering toward goals, and when necessary redirecting paths to goals (hope) in order to succeed, and when beset by problems and adversity, sustaining and bouncing back and even beyond (resiliency) to attain success." A crucial point of diversion from earlier trait-based personality standpoints is that the positive capacities enlisted as positive organizational behavior are state-like resources that are dynamic and open to development. As a novel approach to human resource management, Luthans et al. (2007) opine that psychological capital offers more value than tacit knowledge built with experience at work (human capital) or social relationships (social capital). Moreover, the authors claim that psychological capital is a paradigm shift from psychopathology-based management of human behavior as the focus here is on identifying and nurturing human potentials instead of the ramification of problems.

Psychological capital when combined with a sense of vitality and learning leads to intrinsic motivation for task performance, self-development, and personal growth (Kleine et al., 2019). Spreitzer et al. (2005) call it "thriving a work" and use it as a hypernym for individual characteristics (knowledge and positive affect), interpersonal characteristics (support and trust), contextual features (job autonomy and climate of trust), agentic work behavior (task focus and exploration) aligned together to produce positive employee outcomes including health and development (Kleine et al., 2019). Kleine and colleagues (2019) in their meta-analytic study reveal that *thriving* improved subjective health and lowered burnout and was positively associated with job satisfaction, commitment, positive attitude toward self-development while reducing turnover intentions.

As we begin to decipher workplace health from the perspective of the social environment, we shift our focus to equity and inequity. Conceivably the most striking conversation in contemporary organizations revolves around diversity, inclusion, and empowerment. In taking a holistic approach to understanding workplace health, we discuss discrimination of various forms, loneliness, and pragmatic approaches to alleviate their impacts.

Workplace Discrimination

In the wake of open economies, urbanized societies, participative governance, many of the *de jure* forms of discrimination have been abrogated through social reforms

and human rights safeguard policies. Yet, subtle or occasionally sophisticated variations can be frequently noted as prejudice and intolerance continue to function within our civil order. Workplace discrimination is described as differential or less favorable treatment on the grounds of race, color, sex, religion, political opinion, national extraction, social origin, age, disability, HIV/AIDS status, trade union membership, and sexual orientation, or any other characteristics that are not related to individual merit of the inherent requirement of the job (United Nations Global Compact, 2021). Attitude of intolerance, hatred, or discriminatory actions in workplaces have been consistently reported against various socioeconomic–demographic sections, and they include women, aged persons, socioeconomically disadvantaged, racial and ethnic minorities (migrant workers), persons with infectious or chronic non-communicable disease, HIV/ AIDS, persons with physical and learning disability (Conyers et al., 2005; Levy & Sidel, 2013; McMahon & Shaw, 2005). The UN Global Compact recognizes that discriminatory behavior is not confined to access to employment, promotion, training, and vocational guidance, but can include issues pertaining to the terms and conditions laid out by the employer regarding recruitment, remuneration, hours of work and rest/paid holidays, maternity protection, security of tenure, job assignments, performance assessment and advancement, training and opportunities, job prospects, social security, and occupational safety and health. Workplace discrimination falls within the purview of multiple disciplines including law, human rights, and organizational science, each providing effective ways of identification and management of the conditions preceding and subsequently induced by discrimination. However, as discrimination has evolved in form, civil rights legislation and affirmative action work as deterrents only and are far from eliminating discriminatory behavior (King et al., 2013).

The extant literature on workplace discrimination recognizes it as a major structural determinant of social injustice (Levy & Sidel, 2006); however, the now well-recognized exacerbating physiological and psychological effects render it an issue of public health. According to Okechukwu et al. (2014) health inequities among workers are a prominent consequence of discrimination, harassment, abuse, and bullying, arising out of both historical and concurrent power imbalances in society that have their influences both within and outside the workplaces. This proposition finds substantial evidence in the *inverse hazard law* of social determinants of health, described as "accumulation of health hazards tends to vary inversely with the power and resources of the populations affected" (Krieger et al., 2008). A case in point is that occupational hazards like dust/ fumes, chemicals, noise, ergonomic strain, and job strain bear a reciprocal influence on social hazards like racial discrimination, sexual harassment, and workplace abuse. While occupational hazards have a direct physiological impact on health, viz. blood pressure and somatic covariates like hypertension medication and body mass index; social hazards affect both the health outcomes (blood pressure) and behavioral outcomes (like increased smoking and alcohol consumption). Though these effects are largely stress-mediated, they have a differential manifestation based on factors including socio-demographic characteristics (race/ethnicity, gender, age, poverty, education, nativity, and social desirability),

workplace characteristics (type of workplace, racial/ethnic, and gender composition), and response to unfair treatment (Krieger et al., 2008).

The health hazards like economic deprivation and discrimination are often accompanied and accentuated by hazardous living and working conditions. Clustering of deprived individuals further intensifies the risk of exposure of their societal groups to health hazards (Krieger, 2004; Krieger et al., 2008). In their study on a US sample with 40% under the US poverty line, they found that 79% reported at least one social hazard (racial discrimination, sexual harassment, workplace abuse) and 82% revealed exposure to at least one high-risk occupational hazard (dust, fumes, chemical, noise, ergonomic strain). Drbohlav and Dzurova (2017) affirm that workplace discrimination is a social hazard and a prominent determinant of health inequalities. In their report, they claim that discrimination predicted worsening self-reported health which was particularly skewed for female workers.

Women at Work

Human rights' slogans and social campaigns in the recent decades have customarily displayed concerns with women empowerment and gender equality. But the first parameter where gender equality fails to triumph is pay parity. Spanning varied professions women earn 77% of what men earn. The World Economic Forum describes it in terms of the Global Gender Gap Index which is built upon gender-based disparities on four dimensions—economic participation and opportunity, educational attainment, health and survival, and political empowerment (The Global Gender Gap Report, 2018). The 2018 report assesses the average pay parity to stand at 0.68 on a scale of 0 (disparity) to 1 (parity) and estimates this gap to take 202 more years to cease. Despite International Labour Organization's accession that pays parity is essential for promoting well-being of not only the individual but the entire family and that it is the most important step toward eliminating sex discrimination at work and achieving equality, it predicts that at the current rate of progress the timeline for bridging the gender gap in pay is at least until 2086 (ILO, 2015).

Women at workplace have globally confronted gender discrimination which has continued to impede their progress. Ridgeway and England (2007) argue that the primary reason for gender-based discrimination is cultural, but there are secondary influences in the form of organizational structures, equality practices, and antidiscrimination policies which are built upon the same socially transferred stereotypes. Often organizational policies appear gender-neutral but they are so intertwined within the social norms that they unintentionally add to formalizing gender bias in favor of men in the workplace (Bobbitt-Zeher, 2011; Ridgeway & Correll, 2004). Crusading against the universal patriarchal order, the unprecedented participation of women at work has succeeded in partially transforming the unbalanced representation into a more socially justified and equitable one. Nevertheless, women globally continue to be marginalized and predominantly regarded as an outsider to the hierarchy or

masculine hegemony. A principal sequel to gender discrimination is the underrepresentation of women in leadership positions in organizations known as the glass-ceiling phenomenon (Hymowitz & Schellhardt, 1986). Describing the discrimination narrative experienced by women (Bobbitt-Zeher, 2011) identifies seven types of discriminatory acts including expulsion, exclusion, sexual harassment, other forms of harassment, mobility, poor material conditions, and working setups. This ubiquitous gendering of organizations and organizational practices influences the gender composition of the workplace which in turn affects discrimination (Ridgeway & Correll, 2004) and makes women working in traditionally male-dominated occupations become more vulnerable to gender-based discriminations (Bobbitt-Zeher, 2011).

Discrimination against nursing mothers at work forces women to prematurely end lactation (Morris et al., 2019). As more women are choosing to become employed during their child-bearing years, breastfeeding practices and its impact on the health of both the mother and infant become more evident (Tsai, 2013). Breastfeeding has a direct nutritional and immunological advantage for the infant as well as the physical and mental health of the mother including lowered anemia, decreased likelihood of developing cancer of the breast, ovaries, or cervix, increased sense of achievement in providing nourishment, and ease in providing security and comfort to the child (Yimyam & Marrow, 2003). As breastfeeding rates plummeted with the rise in urbanization and maternal paid work, it has directly influenced infant-feeding practices, thereby impacting the health of both the child and the mother. Morris and colleagues (2019) observe that overt discrimination like denying feeding breaks and private rooms, asking mothers to feed in physically unsafe conditions, or offensive remarks like comparing breastfeeding mothers to animals, amounts to risking serious health consequences like illness and infections as well as sexual harassment and hostility. Yimyam and Marrow (2003) recognize the impending false dichotomy between the right to offer nutrition to the infant and the right to seek gainful employment that demands reconciliation between work and child-rearing.

A closely associated obstacle emerges for pregnant women which has a direct influence on perinatal depression. Pregnancy-related workplace discrimination includes no access to maternity benefits, difficulty negotiating maternity leave, prejudicial remark, and denied career progression opportunity and is associated with significantly higher levels of anxiety, fatigue, irritability, and depression (Cooklin et al., 2007). The social prejudices that classify women as less competent under different circumstances also sustain discrimination via an inverse notion that women with agency or superior performance are socially deficient. To add to the negative impact on hiring decisions and escalation to leadership roles, Rudman and Glick (2001) posit that women when perceived as intelligent, ambitious, or assertive, are seen as violating female gender stereotypes and as not being adequately feminine.

Ageism

The world population is aging. Improved public health facilities and improved life expectancy, control of disease, prevention of injury, coupled with declining fertility are projected to result in an increase in the proportion of people over 60 years between 2017 and 2050 (UN, 2020). The United Nations acknowledges that the changing demographic structure of the world has a direct impact on the labor and financial markets, demands for goods and services including housing, medicine, transportation, and social security (UN, 2017). As a response to this change, an increasing number of inclusive measures have been put into action whereby the number of older adults continuing to be employed or seeking gainful employment is growing. However, the major impediments to the employment intentions of older individuals and national or organizational inclusion policies are age-related discrimination and the allied harassment, lack of choices, and unavailability of healthy and good quality working conditions until retirement (UNECE, 2019). International Labour Organization agrees that ageism (primarily for people over 55 years) in the form of stereotypes, prejudices, and discrimination results in underutilization of the older workers. Ageism, age-based stereotyping and discrimination, is not restricted to employment but it gets expanded as more and more older people are denied training and career development opportunities in addition to the organizational changes (e.g., as a response to economic crisis, adoption of new technology, mergers, and acquisitions) and policies that directly or subtly make choosing premature retirement a necessity. As age-based stereotypes and covert forms or discrimination have been tolerated in workplaces, the impact on allied physical and mental health can be predicted to be much higher among those over 55 years as compared to younger workers.

Elucidating the sudden rise of age management at organizational and national policy levels in Europe, Walker (2005) recognizes that there has been a steep decline in the employment rates of older workers in the last two decades, and that the problem seems to be driven by "push factor" like reduced job opportunities and "pull factor" like early exit and reduced incentives to remain in work. Walker also points out that an early retirement or withdrawal from work has only been represented as a retirement issue rather than as a form of unemployment which changes the discourse around social justice. Vogt Yuan (2007) asserts that perceived age discrimination increases with age and it is not easily discernible. One of the reasons for its poor detection is that ageist behavior is often a combination of positive and negative connotations. For example, older individuals are evaluated as warm but incompetent (Cuddy & Fiske, 2002). Similarly, mixed evaluative stereotypes as kind, wise, and dependable, ugly, mentally declining, low worth, are used at the same time (Palmore, 1999). It is reported that the declining job prospects for elderly are a function of the widespread notion that older workers are poor performers and less productive (McCann & Giles, 2002). Furunes and Mykletun (2010) enunciate that less favorable treatment due to age amounts to direct discrimination, but more subtle implicit forms come into existence with normal workplace provisions and put elderly at a disadvantage. Posthuma

and Champion (2009) in their work on age stereotypes elucidate the common negative, inaccurate, or even distorted opinion about older workers including poor performance, resistance to change, lower ability to learn, shorter tenure (shorter time to reap the benefits of training investments), expensive (higher wages), which influence employment-related decisions like lower ratings in the interview and performance appraisals.

Analysis of stress caused by age discrimination reveals that elderly workers who report discrimination have elevated psychological distress and lowered psychological well-being. In addition to the missed professional opportunities and exclusion from training for further growth, age-based "everyday discrimination" has strong negative influence on workplace performance, job satisfaction, and well-being, while being a major predictor of job insecurity (Taylor et al., 2013). The authors also point out that job satisfaction and psychological well-being increase the probability of reducing the damaging effects of everyday discrimination, lack of support, and hindering psychosocial climate through reverse causation. Delineating perceived age discrimination as a stressor, Redman and Snape (2006) assert that it negatively affects perceived power and prestige of the job, and hinders continuance commitment. Secondly, there is a gender divide in perceived age discrimination where women perceive the injustice against them to be double-edged, i.e., gender and age conjoint (Vogt Yuan, 2007). Particularly relevant here is that the ageist remarks against women are about their appearance and sexuality, and women are evaluated on the basis of a male-based chronology of career development disregarding discontinuity due to childbirth and rearing (Duncan & Loretto, 2004). In many instances, organizational changes due to the adoption of technology and globalized workforce have perpetuated age discrimination via reinforcement of prejudices like inflexibility, resistance to change and inadaptability, and slow learning and lack of creativity. Irrespective of the discrimination being intentional or unintentional, a plethora of evidence concord that both the victim and the perpetrator view age as a potential barrier to continued work, it is imperative that employees perceive that their well-being is an organizational concern and that their individual contribution will be valued or rewarded by the organization, (Rhoades & Eisenberger, 2002) so that organizations are viewed as valuing and working toward fairness and justice.

Conscientious scrutiny of antidiscriminatory measures from the standpoint of their legal implications suggests that affirmative action to overturn past discrimination, can no longer be deemed as remedial as it was thought to be. Bartlett (2009) proposes three basic approaches to reduce discrimination in the workplace—"prohibit it; design the workplace so that people cannot engage in it; and change the preferences and intentions that lead to it." For example, Levinson (2011) believes that gender classification, even with the purpose of initiating preferential laws for women, has rarely assured absolute benefits to women. Rather it subtly serves to legitimize the social connotation of gender differences (reverse discrimination). In this context, an unequivocal remedy is to rethink and reformulate current statutes especially in light of neo-discrimination mechanisms. *Structural reforms* in the form of collaborative work cultures can be initiated where people feel more secure and valued (Bartlett, 2009). In addition, autonomy and competence enhancing practices

facilitate internal motivation. Affirmative action when combined with intrinsically motivated workers can be assumed to protect people from the damages caused by discrimination. The future of an egalitarian workplace rests on a regenerated organizational culture integrated within the superstructure of a discrimination-free reformed society and progressive thinking.

Workplace Loneliness

Social isolation in workplace may be intuitively attributed to unhealthy interpersonal relations and discrimination, while the reverse effects may be assumed with the implementation of measures for organizational justice and fairness. However, a point of argument here is whether one's mere presence in the social environment of the workplace would be sufficient to alleviate perceived social deprivation or loneliness. Yet to receive wide acceptance in work psychology and organizational behavior research (Wright et al., 2005), the impact of workplace loneliness cannot be undermined especially when loneliness is a widespread social anomaly (Ernst & Cacioppo, 1999). Approximately, 61 percent of Americans have been stipulated to fall in the category of being lonely (as measured by the UCLA's loneliness scale; Russell, 1996) in a 2019 national survey. In the same year, The World Economic Forum conferred loneliness the status of a global epidemic. Particularly prevalent among the younger generations, one in every three (i.e., 35%) adults between 18–25 years in Australia reported feeling lonely at least three times a week (Lim, 2019). The European Commission's concerns over the growing number of people frequently feeling lonely (7% of adults, with share as high as 10% in some nations) come jointly with growing percentages of socially isolated individuals. Defined as a psychological state arising out of qualitative or quantitative deficiencies in social relationships (Wright et al., 2005), workplace loneliness reflects unsatisfactory interpersonal communication and perceived lack of social support, or in other words an impoverished organizational climate.

A 2020 report on workplace loneliness carried out in the US population revealed that individuals who believe they are underemployed have impoverished interpersonal relationships in the workplace, poor work–life balance, are more likely to perceive loneliness. Consequently, there are greater incidences of not being satisfied with the quality of their work and more than twice the probability to contemplate quitting their jobs (Loneliness & the Workplace 2020 US report). Workplace indicators show that loneliness decreases as job tenure increases, with the highest loneliness (67%) being reported during the first six months of starting out at a position. Sense of belonging and satisfaction with work relationships, healthy in-person conversation during meetings, feeling of companionship with co-workers is associated with low perceived loneliness and attrition. Besides the in-office environment, remote working, frequent telecommuting, and industry type are the job-related contingencies. As far as industry type is concerned, those associated with entertainment like music and films have the highest percentages of perceived loneliness, followed by those who run their own business houses. Similarly, individuals either at the top (senior executive)

or at the bottom (entry level) of the organizational hierarchy revealed the maximum loneliness. (Loneliness and the Workplace 2020 US report).

Weiss (1973) in his seminal work on loneliness described it as a formidable, chronic condition which cannot be easily reverted (Cacioppo et al., 2014). The health impact of workplace loneliness, direct or incidental, encompasses multitude of issues like anxiety and depression, increased risk of cardiovascular disease, lowered immunity, and substance abuse (Darley, 2020). Describing the health correlates of perceived social isolation, Lim and colleagues (2020) infer higher susceptibility to dementia, increased inflammatory responses, stroke, and even early mortality. Evolutionary psychology and cognitive science research elucidate the heritability of loneliness and that it can be estimated for specific populations in a given environment (e.g., Bartels et al., 2008; McGuire & Clifford, 2000). Cacioppo et al. (2014) in their analysis of evolutionary mechanisms of loneliness revealed that (i) phenotypic differences are compounded by environmental influences and (ii) the quality of social connections, as opposed to quantity, is the major predictor of lifespan loneliness. The authors also elaborate that by virtue of human capability of duplicity and changing alliance, being in a social environment does not assure safe social connections particularly during the periods of vulnerability. Consequent cognitive shifts determine the impact loneliness will have on neurobiological activities associated with morbidity and mortality. Illustrating the linkages between social environment, perceived social isolation, and morbidity, Cacioppo and Hawkley (2009) argue that loneliness determines one's connection to social stimuli by making the social cues more prominent like turning hypervigilant to social threats and creating negative impressions of social information. As this bias is validated by negative/ aversive behaviors of others, it increases the likelihood of perceiving oneself as passive victim and engaging in defensive (self-protective) behavior (Cacioppo & Hawkley, 2005). As self-preservation sustains, even secure social environments are regarded as threatening, thereby further damaging social relationships of the individual experiencing loneliness. Cacioppo and Hawkley (2009) emphasize that these self-defeating tendencies activate neurobiological mechanisms with higher risks of morbidity and mortality (Cacioppo et al., 2014).

Loneliness is similar to social anxiety, jealousy, and depression, in operating as an effective response to exclusion or low inclusion (Baumeister & Tice, 1990). A crucial point of consideration is that lonely people do not always have reduced social interaction durations as compared to those who are not lonely, but lonely people are likely to spend more time amidst strangers and acquaintances where their inclusion is low (Leary, 1990). As loneliness is an issue manifesting in organizational context, it can be attributed to the nature of clustering within the organization. These clusters are governed by three mechanisms, namely contagion—loneliness in one person leads to loneliness in another; homophily—where likeminded people form association with each other only; and confounding—involving exposure to similar situations and similar perceptions that propagate loneliness (Wright, 2015). To understand coping with loneliness, it is crucial for the employee to perceive safety and trust in the organizational climate. Negative perceptions elicit antisocial behaviors from lonely persons which in turn pushes them toward periphery of employee interaction within

the same space (Cacioppo & Patrick, 2008). The loop of negative experience and subsequent negative behaviors continue to escalate loneliness, as described earlier. Organizations can utilize intervention strategies that are embedded in *social support* measures to enable workers to cope with loneliness. They can range from individual support to address organizational stress, to reforming organizational climate for creating a healthy work environment (Wright, 2015). Ameliorative strategies also encompass establishing norms that reconstruct organizational trust, openness and transparency, organizational identity, and positive organizational climate. Leaders' role as mentor and pathfinder is paramount in showcasing desirable social behavior as well as advancing remedial measures in coping with loneliness.

Work–Life Interface

Societal transformation and the enveloping effect of technological advancements have made a palpable impact on the degree to which work interferes with life and vice versa. The bisected yet interconnected domains of work and life outside work have generated significant interest in scientific research, organizational policies, and global healthcare practices. Tagged within the rubric of work–life balance, the conception of work–life conflict, work–life imbalance, work–life interference, or work–life fit, cumulatively focus on the need to achieve balance between work life and personal life given the effect of it (or lack of it) has on life satisfaction and quality of life (Noda, 2020; Yu, 2014).

Though work–life balance and work–life conflict are often used interchangeably, striving for balance is often regarded as a response to the inability to successfully combine work with personal and family life. Greenhaus and Beutell (1985) posit that work–life conflict is a form of inter-role conflict arising out of mutually incompatible role pressures from work and family domains. More recent understanding of work–life balance has been directed toward work interferences with family and family interference with work (Carlson et al., 2000). Carlson et al. (2000) elaborate that the conflict is manifested in three ways—in the form of time, strain, or behavior. Timebase conflict emanates from the inability to allocate time to either work or non-work roles owing to the share of time one of them demands. When strain experienced in one role hinders participation in another role, it amounts to strain-based conflict. Similarly, behavioral conflict ensues when specific behaviors in one role clash with the requirements in another. Changing patterns of work and a subsequent rise in work pressure, long working hours, and performance demands are observable sources of work-related strain. This accompanied by either unavailability or incapacity to draw replenishment from non-work roles including family and recreation, or psychosocial hazards originating from non-work roles have received wide recognition as both organizational and public health concerns. The two-way communication between work and non-work domains is elucidated by O'Driscoll (1996) through five models constructed from a theoretical proposition. Segmentation model classifies work and non-work roles as discrete domains in which there is no

discernible interplay. The spillover model suggests both positive and negative effects of the two domains on each other. The third model focuses on compensation and is built upon the replenishment-crosstalk where deficiency in one domain is restored by fulfillment of similar or complementary needs in the other. Guest (2002) illustrates that a monotonous job can be compensated for by challenges in community service activities. The instrumental model highlights the facilitator effects of one on another, whereby task fulfillment or achievement in one domain fosters the fulfillment of demands in another. The final model—conflict model—hinges on the interference of high demands in one sphere with the high demands in another, resulting in uneasy decisions and compromises and a perception of overload and pressure (Guest, 2002; O'Driscoll, 1996; Zedeck & Mosier, 1990). The different approaches hint at the sense of equilibrium or disequilibrium between work roles and non-work roles, but also demand clarity in defining what qualifies as work and non-work. This is particularly relevant as the requirements outside paid employment (the most agreed understanding of work) can be subjectively perceived as work as well, or the amount of non-leisure effort put in order to ensure success at gainful employment like travel from home to workplace, that make the blurring of borders between the two domains more perceptible (Guest, 2002). To delineate it more precisely, here we illustrate the exigencies of making work and life synchronous while exploring evidence of enrichment the two domains can draw from one another.

Research on physical and mental health outcomes based on time- and strain-based work–life conflict among employees revealed that 12.5% of the Swiss working population, i.e., every eighth person experienced work–life conflict emanating from work conditions including full-time positions, variable work schedules, frequent overtime, long commuting durations, and job insecurity (Hämming et al., 2009). The study indicated that high level of work–life conflict has pronounced physical health concomitants, namely increased risk of moderate or poor health, backache or lower back pain, headache, and more severe mental health problems like lack of energy and optimism, negative feelings and depression, sleep disorders, fatigue (general weakness and weariness). In a longitudinal study of employed parents, Frone et al. (1997) found that work–family conflict was related to heavy alcohol consumption, whereas family–work conflict predicted elevated levels of depression, poor physical health, and hypertension. To address the issue of escalating job stress among academics, Bell et al. (2012) studied the effects of ever-increasing job demands, excess of work hours, and pressures to adapt to changing technology. Their study illustrated that high perceived job stress was linked with increased work–life conflict and ill-being, and inversely with reduced work–life balance and well-being. The role of personality antecedents cannot be undermined as they predispose individuals to certain health risks. A meta-analysis revealed that higher neuroticism and negative affect added to work–life conflict vulnerabilities, whereas positive affect and self-efficacy had more ameliorative effects (Allen et al., 2012). Intuitively, burnout based on experience of emotional exhaustion and cynicism was found to be positively related with work–life conflict (Lee et al., 2013; Reichl et al., 2014).

As work–life conflict is deeply rooted in one's assessment of workplace and job demands, the role of organizational practices in supporting work–life harmony serves

as a major antecedent to individual management of work and non-work roles. Frye and Breaugh (2004) indicate an inverse relationship between perception of the usefulness of organizational work–life policies and individual work–life conflict. Comparable results emerged as use of flexible working hours was found to be associated with lower work–life conflict (Anderson et al., 2002; Hill et al., 2001), whereas negative career consequences (e.g., penalty for work flexibility demands), job dissatisfaction, turnover intentions and stress, and absenteeism was linked with work–family and family–work conflict (Anderson et al., 2002). Anderson and colleagues revealed that informal workplace practices like managerial support in employees' efforts to balance work or family commitments and the belief that alternative work arrangements can be initiated without damaging career advancement opportunities, assisted in reducing the perceived work–life conflict. An argument in line that calls for attention here is the coexistence of work–life conflict and work–life balance for an individual.

Evidence for influence of work–life balance can be found in the findings of positive relation to job and life satisfaction, and negative relation to anxiety and depression (Haar et al., 2014). As work–life balance is a concern for employees, more and more organizations have adapted to work–life supportive culture. It raises the likelihood of employees to perceive their employers as more supportive and family-friendly, which in turn promotes job satisfaction and well-being (Jang et al., 2011). Identifying the effects of work–life balance on satisfaction with life, Schnettler et al., (2020) discovered a positive relationship between the two variables, along with a positive crossover effect of own satisfaction onto the experience of satisfaction of one's partner. An elaboration of that can be seen in the spillover–crossover model that is grounded in the work-related spillover effects on home/family domain which then crosses over to the partner (Bakker & Demerouti, 2013). Sharing of experiences and family responsibilities enables positive transfer of perceived satisfaction among couples, which translates into work–life enrichment (Steiner & Krings, 2016) and a concurrent increase in positive interpersonal interaction and well-being at least at the family front. Focusing on family-supportive work environments Allen (2001) asserted that perceived organizational support predicted perception of being treated favorably, which served as a precursor for positive employee behavior in reciprocation. Allen further notes that despite the fact that work–life balance policies supported within the organization have the power to elicit positive attitudinal and behavioral outcomes, it is not widely known if such effects could be moderated by national, more precisely statutory regulations (Beauregard & Henry, 2009).

A crucial argument to consider in the work–non-work analysis is the permeability of borders of the two domains and the nature of cross-border movement that occurs between work and home (Guest, 2002). Clark (2000) takes a novel approach of work/family border theory to address this seldom reached balance. According to the theory, people are border crossers who routinely engage in movement across domains and their behaviors are determined by the environments in each domain. If the contrast between work and non-work domain is stark in terms of values and culture, it directly impedes easy transition. Individual ability to handle the differences and complexities has a wide range, where those who have successfully integrated work with family are least likely to differentiate emotionally, cognitively, and behaviorally between

work and home. Clark further argues that despite integration being touted as the most desirable form of work–life balance, it is far from being an absolute demarcation as even the most effective border crossers vary across time. On the contrary, individuals who practice segregation of domains can potentially derive need gratification and enrichment resources from their mutually exclusive existence in work and home.

In the wake of increasing popularity of virtual workspaces and work from home culture, the argument is about the degree to which individuals can exercise *autonomy and control* of the physical and psychological boundaries. In this context, the major thrust lies on the type of border, its permeability, and flexibility. While physical (spatial location) and temporal (work hours) can be more objectively designated, psychological borders (domain-specific allocation of thoughts, emotions, and behaviors) are mostly self-drawn. Particularly relevant to the contemporary home-office culture is the porousness of the border where family can interfere during work hours in spite of the physical borders, or where negative emotions from work are carried over to family (Clark, 2000). Of equivalent relevance is the degree of flexibility that work–life borders offer by allowing elements of competing domains to blend. Clark proposes that work–life balance will be facilitated when domains share common attributes and the borders are weak (permeable and flexible to allow blending). Conversely, work–life balance will be facilitated when domains are notably different and have strong (non-porous and rigid) borders. Several implications emerge from the perspective of organizational policies, where workplace strategies often fail to sustain employee productivity. Adaptation and integration are vital to *organizational flexibility* which is characterized by reduced top-down control and enhanced individual empowerment. Flexible workplaces are built around decentralized structures with capacity to learn from unpredictable changes and promote self-organized (autonomous) development (Englehardt & Simmons, 2002). Organizations implementing flexible measures like home-office and flexible work hours fall short of actualizing corresponding changes in the work culture. Precisely most work–life protocols are targeted at meeting organizational interests rather than employee interest, in a way that balance is supported at every level of organizational functioning (Clark, 2000). Further, employee participation and choice must be supported by organizations with the objective of empowering them to autonomously create a balance between work and home.

Management of work–life conflict rests on managing boundaries where individuals make choices between integrating work and non-work roles with possibilities of spillover, or separating the domains to reduce infringement, or unifying the two styles by identifying the value of both domains in one's life (Kossek, 2016). The differences based on functioning as work-centric, family-centric, dual-centric, or non-work-centric (prioritizing avocation or engagements of personal interest more than gainful employment or family) enable identification with life areas which provide impetus for growth and satisfaction (Kossek, 2016). From organizational policy and employee health perspective, organization leadership and management can restructure work environments to incorporate support through education, training, and purposeful communication.

Conclusion

Organizations are transforming and the array of individual, organizational, and extra-organizational components is becoming vast. Work conditions related to performance, autonomy, and commitment; discrimination and loneliness; and work–life interplay, as described in this chapter, occupy a central position in organizational research and formalized workplace practices. However, the inherent challenges are often multilayered, complex, and interconnected. As a pivotal point of departure, their assessment as a problem of health and well-being has not gained much prominence. There is a growing need to understand work processes and organizations from a health perspective in order to facilitate targeted interventions, ameliorative actions, and promotion of healthy (positive) workplace culture. The first step toward creating a psychologically healthy workplace lies in perspective-taking and analyzing the potential risks and costs of undermining its merit.

Research and innovation in the direction of supportive organizational climate, positive interpersonal relationship between individuals or within teams, autonomy and employee participation in decision making, positive organizational behavior is contributing to make work a positive experience. As meaning and purpose are increasingly being regarded as the major indices of workplace performance outcome, a subsequent shift in leadership styles and management is becoming eminent. Similarly, despite affirmative action for eliminating workplace discrimination are strategies implemented to reduce organizational constraints to well-being, social support and empowerment are progressively being considered crucial for individual identity and optimal engagement. Management of work and life particularly in today's era also calls for increased communication and effective support to equip workers and organizations to cope with its dynamicity. Societies across the globe have resolved to collectively work toward the mission of sustainable development. The need of our times is to prioritize individual–organization–environment coalesces as the road to organizational growth and sustainability in the contemporary globalized and technology abundant work sphere is through universally acknowledging the values of meaning and purpose in work, reduced inequality, inclusivity and justice, and employee health and well-being.

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Part III
COVID-19 and Its Impact

Chapter 14
Medical Aspects and Mental Health Challenges During COVID-19 Pandemic

Subhash Chandra Parija, Sukanto Sarkar, and Sunayana Choudhury

Abstract COVID-19 pandemic is a global crisis resulting in significant mortality and morbidity worldwide. Together with the severe acute respiratory syndrome (SARS) coronavirus which became a pandemic in 2002–2003 and the Middle East respiratory syndrome (MERS) which was surfaced in 2012, the current and novel pathogen-novel coronavirus 2019 is the third highly pathogenic human coronavirus that has emerged in the last two decades with rapid transmissibility. The major concern now is to save lives especially of the vulnerable population and also develop herd immunity which will protect the community as a whole. However, this pandemic has a significant impact on mental health and poses a challenge to an individual's psychological resilience. Patients, health professionals, and the general public are under severe psychological pressure which may lead to numerous psychological problems, such as anxiety, fear, depression, and disturbed sleep. The most prominent psychological symptoms seen are anxiety, depression, and stress-related symptoms apart from drug abuse, domestic violence, and higher rates of suicide. The whole population, i.e., those affected with the infection and those not infected, are equally affected with mental health issues. The health care worker who is at high risk to develop the disease has been reported to have disturbed mental health well-being. Various psychological treatments like awareness talk, demonstrating health coping strategies, dealing effectively with stress along with lifestyle modifications have shown to be helpful in such a situation. Psychological crisis intervention will play a pivotal role in the overall deployment of disease control. A mental health helpline which can provide easy access to mental health professionals and serve as a platform for expert counseling facilities for common people, patients, vulnerable population, and students is the need for this hour. It can help to deal with the fear, anxieties related to the infection and also the anxieties related to the uncertainties in the near future.

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_14

This chapter will focus on the various medical aspects and mental health challenges during COVID-19 pandemic and the various strategies to overcome them efficiently.

Keywords COVID-19 · SARS · Pandemic · Psychological impact · Mental health · Psychological treatment

Introduction

Coronaviruses are RNA viruses that were discovered in the 1960s and are typically present in mammals and birds with potential for human disease. The classification of the different types of coronaviruses described so far is as shown in Fig. 14.1.

Coronaviruses were considered trivial viruses till 2002, after the emergence of SARS-CoV which caused pandemic in 2002–2003 (Habibzadeh & Stoneman, 2020). Unlike other coronaviruses that infect humans, SARS-CoV (2003–2003), MERS-CoV (2012), and the current SARS-CoV2 present with severe respiratory disease. The existence of the SARS-CoV2 came into focus with sequencing of virus from patients affected with unexplained pneumonia outbreak in Wuhan city of China in December 2019. The disease caused by this novel coronavirus (2019-nCoV) (also named as SARS-CoV2 by WHO) has been known as COVID-19 and has been causing huge outbreaks globally till today with mounting tolls (Bao et al., 2020; Li et al., 2020f).

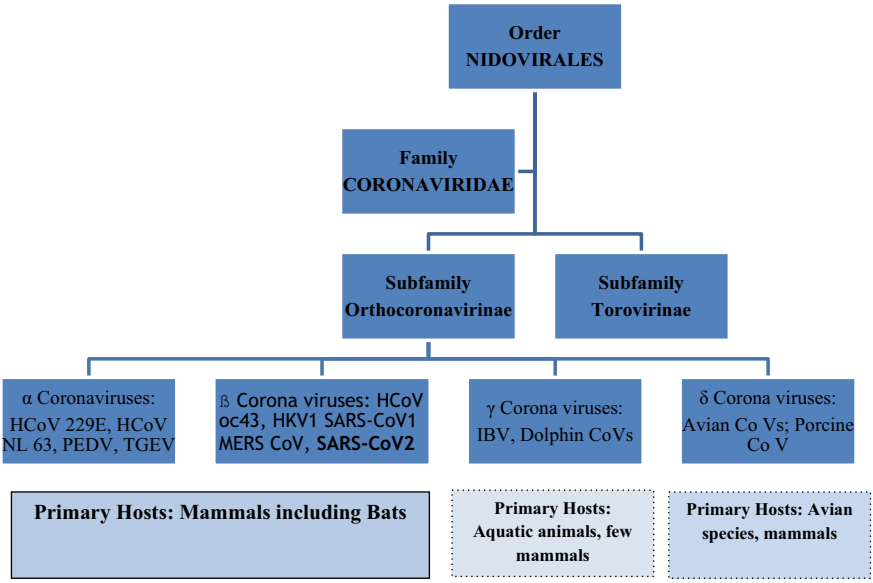

Fig. 14.1 Classification of the different types of coronaviruses. Shors (2021)

Novel Coronavirus 2019: An Overview

The causative agent of the so-called COVID-19 is the new virus labeled as 2019 novel coronavirus (2019-nCoV) by the WHO on 12 January 2020. The disease was formerly labeled as COVID-19 on 11 February 2020 by the WHO. On the same day, this virus was named as SARS CoV-2 by the International Committee on Taxonomy of Viruses (ICTV).

SARS-CoV-2 belongs to the ß coronavirus genera of coronavirus family and is the third known zoonotic coronavirus disease after SARS and MERS2. Although the primary and intermediate hosts of SARS and MERS are known, it has not yet been proved if a specific animal source harbors SARS CoV-2. It was proposed that SARS CoV-2 is a chimerical virus between a bats coronavirus and an unknown coronavirus and snakes are the most likely wildlife reservoirs. Subsequently it supported the theory that SARS CoV2 is transmitted from bats to humans (especially chrysanthemum headed bats). SARS CoV-2 genetic sequence has 86% homology with SARS CoV5 and high similarity with bat coronaviruses.

The current pandemic virus, 2019-n CoV or SARS-CoV-2, is structurally related to SARS-CoV that caused the 2002–2003 SARS pandemic. However, the present COVID-19 outbreak has thrown critical challenges for the Public Health, Research and Health Care teams all over the world.

SARS-CoV-2 is a novel strain of beta coronavirus, identified to be a responsible cluster of severe pneumonia cases in Wuhan, around January 2020, distinct from SARS-CoV and MERS-CoV (GISAID, 2020). On 11 February 2020, this novel virus was named severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Gorbalenya et al., 2020) by International Committee on Taxonomy of Viruses (ICTV) and as coronavirus disease COVID-19 (WHO, 2020a) by WHO on the same day. On 11 March 2020, World Health Organization (WHO) declared this severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) as pandemic (WHO, 2020b). Human transmission occurs by respiratory droplets, by close contact with an infected person during the act of coughing or sneezing thus transmitting aerosols within a distance of about 6 feet (Chan et al., 2020a).

Classification

Coronaviruses (CoVs) are enveloped, positive-sense, single-stranded RNA viruses that belong to the family Coronavirdiae, and order Nidovirales. Based on genomic organization and analysis of phylogenetic relationship, they are classified into the subfamily Coronavirinae that includes Alphacoronavirus (αCoV), Betacoronavirus (βCoV), Gammacoronavirus (γCoV), and Deltacoronavirus (δCoV) (Chan et al., 2013).

Analytical pattern on evolution of coronaviruses identified bats and rodents are the origin of αCoV and βCoV, while avians are the source of origin for γCoV and δCoV.

The first CoV, which was demonstrated during 1960s, was named as HCoV-OC43 and HCoVs229E (Drosten et al., 2003). Currently, all CoVs have been grouped in four genera, namely Alpha CoVs (HCoV-NL63, HCoV-229), Beta CoVs (HCoV-OC43, SARS-CoV, HCoV-HKU1, and MERSCoV), Gamma CoVs, and Delta CoVs (Fehr & Perlman, 2015).

Human coronaviruses which cause milder symptoms and commonly infect people include 229E, NL63, OC43, and HKU1. In certain circumstances, coronaviruses which evolve from animals that infect animals become a novel human coronavirus with severe forms of disease which include SARS-CoV, MERS-CoV, and the recently emerged 2019-nCoV.

Structure and Composition

Coronaviruses are spherically enveloped viruses measuring approximately 120- to 160-nm in size. The virus contains an unsegmented single-stranded positive-sense RNA (27–32 kb), which is the largest genome among RNA viruses. Isolated genomic RNA of coronavirus is highly infectious. The most specific feature of this virus is 20-nm-long club or petal-shaped projections on the outer surface of the envelope, giving the appearance of a solar corona. Within the envelope is the nucleocapsid which is helically symmetrical, measures around 9–11 nm in diameter.

Spike (S), membrane (M), envelope (E), and nucleocapsid (N) proteins are the main structural proteins present in the coronavirus. All these structural proteins are encoded within the 3′ end of the viral genome. The spike (S) glycoprotein (~180–220 kDa) makes up the petal-shaped peplomers on the surface of the virus. The trimeric S glycoprotein is a class I fusion protein which mediates attachment of the virus to the host receptor.

The membrane (M) glycoprotein is the most abundant and small structural protein in the virion (~20–35 kDa). This protein serves as a matrix protein embedded in the lipid bilayer and interacting with the nucleocapsid (N) and the spike (S) protein. The coronavirus E proteins (~8–12 kDa) are highly divergent and found in small quantities. The main function of E protein is to facilitate assembly and release of the virus, thereby playing an important role in pathogenesis.

The nucleocapsid (N) protein is heavily phosphorylated (~50–60 kDa) and it is this phosphorylation that tends to trigger a structural change by enhancing the affinity for viral RNA. This protein binds to nsp3 in the replicase complex, and M protein. Interaction of these proteins helps the viral genome to adhere to the replicase–transcriptase complex (RTC), thus packing the encapsidated genome into viral particles.

Some viruses, including human coronavirus OC43 (HCoV-OC43), contain a fifth structural protein, the hemagglutinin-esterase, HE (~65 kDa) that causes hemagglutination and has acetylesterase activity. This activity increases S protein-mediated cell entry thus helping viral spread through the mucosa (Brooks et al., 2019).

Genome and Viral Replication

SARS-CoV-2 is a single-stranded RNA virus that belongs to the genus coronavirus in the family Coronaviridae.The genome and the virion, measuring ~ 30 kb and 70–90 nm that are similar to other coronaviruses (Chan et al., 2020a; Kim et al., 2020). The genome encodes for all four structural proteins that are required to make assembly of complete virus particles. The genome of SARS-CoV-2 lacks the hemagglutinin-esterase gene.

On entry into the host cell, attachment SARS-CoV-2 to the host target cell receptor occurs by the interaction between the S protein and its receptor, virion gets attached to the target cell receptor, angiotensin-converting enzyme 2 (ACE2), being expressed on alveolar epithelial type II (AECII) cells, and also on extra pulmonary tissues such as heart, kidney, endothelium, and intestine (Yan et al., 2020). In the infected host cell, coronaviruses, S are cleaved by a furin-like protease enzyme into two separate polypeptides, S1 and S2. Of these cleaved S proteins, S1 forms the large receptor binding domain, while S2 forms the stalk of the spike protein. Following receptor binding, the virus must next gain access to the host cell cytosol via endosomal pathway. In the cytoplasm of infected cells, the viral RNA is released, which then undergoes translation and generation of replicase polyprotein pp1a and pp1b. These proteins are cleaved subsequently by virus encoded proteinases into small proteins. Finally assembly of virion takes place at the endoplasmic reticulum (ER) and Golgi complex. These assembled virions are then subsequently released out of the cells via vesicles (Hoffmann et al., 2020).

Immunopathogenesis of SARSCoV-2

Following entry of virus into the host cells, these viral antigens are processed and presented to the virus specific host immune cells, cytotoxic T cells. Subsequent activation of cytotoxic T lymphocytes releases excessive amount of proinflammatory cytokines (IL-1β, IFN-α, IFN-γ, IL-12, IL-6, IL-18, TNF-α, IL-33, TGFβ, etc.) and chemokines (CCL3, CCL2, CXCL8, CCL5, CXCL9, CXCL10, etc.), which leads to cytokine storm syndrome (CSS). Studies have shown that this cytokine storm syndrome is a lethal and uncontrollable inflammatory event in a patient infected with SARS CoV2. (Zumla et al., 2020; Li et al., 2020f).

Clinical Characteristics of COVID-19

COVID-19 infection is similar to the severe acute respiratory syndrome (SARS) that affected 29 countries, around 8,098 people, with 774 patients dead in the Asian countries.

Similarities Between SARS-CoV-2 and SARS

There are striking similarities between the two viruses (Hossam & Ashour, 2020; Chan et al., 2020b).

> The genome of SARS-CoV-2 has 86% similarity with SARS CoV 5; Bats are the probable primary hosts of origin of both SARS CoV-2 and SARS-CoV; Large and densely populated human settlements in close proximity to live animal markets are the source of outbreak in both the viruses [Huang market in SARS CoV2 and Guangdong market in SARS CoV]; The primary route of transmission for both viruses is respiratory droplets; After droplet spread, the ACE 2 is the receptor utilized by both the viruses for respiratory cells entry; The median incubation time and the initial estimate of transmissibility rate are similar for both the viruses; The progression to severe disease follows the similar pattern in both the viruses: ARDS occur 8-20 days after onset of first symptoms and HRCT findings of lung disease show greatest severity by 10days after initial onset of symptoms; The poor prognostic factors in both the diseases are elderly and presence of cardio respiratory and metabolic comorbidities.

Elderly patients are more symptomatic and have higher fatality rates compared to younger adults whereas males are proportionately higher in number than females in. The transmission rate varies from 0.3% to 3.77%. The case fatality rate is around 1.36% to 33% with an average around 3.17%.

Angiotensin-Converting Enzyme 2 (ACE2) is the identified receptor for SARS CoV-2. ACE2 is expressed on type I and type II alveolar epithelial cells with 83% expression on type II AEC. Males and Asians ethnicity have higher levels of ACE2 expression than females and other ethnic groups, respectively, which probably explain the observed predominance of cases in males and non-caucasians. ACE2 binding ability of SARS CoV is higher than SARS CoV (10–20 times) (Li et al., 2020f) (Table 14.1).

Coronavirus Infection: How Is It Different from Common Flu?

As the COVID-19 outbreak continues to evolve, comparisons are drawn in relation to influenza. Both cause respiratory disease, yet there are important differences between the spread of both the viruses. This has important implications for the public health measures that can be implemented to respond to each virus (Adhikari et al., 2020).

Firstly, COVID-19 and common flu have a similar disease presentation. Both cause respiratory disease, which presents as a wide range of illness from asymptomatic or mild through to severe disease and death. Both the viruses are transmitted by contact, droplets, and fomites. In terms of the differences, influenza has a shorter median incubation period (the time from infection to appearance of symptoms) and a shorter serial interval (the time between successive cases) than COVID-19 virus. The serial interval for COVID-19 virus is estimated to be 5–6 days, while for influenza virus, the serial interval is 3 days. Further, transmission in the first 3–5 days of illness and the appearance of symptoms is a major driver of transmission for influenza while there

Table 14.1 Clinical Studies on COVID-19

Author	N	Age Range (years)	Mean Age (years)	Sex (Male %)	Predominant clinical symptoms
Huang et al., (2020)	136	25–89	-	66	Fever, cough, dyspnoea
Chen et al. (2020a)	99	21–82	55.5	67	Fever, cough, hemoptysis
Chung et al., 2020	21	29–77	51	13	Fever, cough, myalgia
Chen et al. (2020b)	29	26–79	56	21	Fever, cough, dyspnoea
Wang et al. (2020a)	138	42–68	56	75	Fever, cough, dyspnoea, myalgia
Liu et al. (2020)	137	20–83	57	61	Fever, cough, myalgia
Chang et al. (2020)	13	34–48	34	10	Fever, cough, myalgia
Wang et al. (2020b)	34	–	8	14	Fever, cough
Yang et al. (2020)	52	33.6–85.8	59.7	35	Fever, cough, dyspnoea

are people who can transmit the COVID-19 virus 24–48 h prior to symptom onset, i.e., the pre-symptomatic phase does not appear to be a major driver of transmission. Also, the reproductive number—the number of secondary infections generated from one infected individual—is around 2 and 2.5 for COVID-19 virus, which is higher than for influenza.

Children are an important vehicle of transmission in case of influenza virus in the community. For COVID-19 virus, initial data indicates that children are less affected than adults and that clinical attack rates in the 0–19 age group are low. Further preliminary data from household transmission related studies suggests that children are infected from adults, rather than vice versa.

While the range of symptoms for the two viruses is similar, the fraction with severe disease appears to be different. For COVID-19, data to date suggests that 80% of infections are mild or asymptomatic, 15% are severe infections, requiring oxygen and 5% are critical infections, requiring ventilation. In influenza or common flu the percentage of severe or critical infection is relatively less than 1%.

Mortality for COVID-19 is two times higher than for influenza, especially seasonal influenza. The crude mortality ratio is between 3–4%, but the infection mortality rate is lower. For seasonal influenza, mortality is usually well below 0.1%. However, mortality is to a large extent determined by various factors and varies from country to country. Mortality rates are low in India in relation to other developed countries.

Now if we see the difference in between the two infections it is clear the corona viral infection is more severe, with high mortality and prone to cause more severe illness. It affects mainly the elderly and people with comorbid disorders like diabetes, hypertension, and pulmonary disease.

Drugs Used for COVID-19

It has been more than six months since the first COVID-19 infection was reported. Now, even as the SARS-CoV2 pandemic has left over half a million people dead, there is still no cure against the virus that causes COVID-19. As such, antibiotics do not help with viral infections, but some old antiviral drugs (https://www.business-standard.com/topic/drugs) have been repurposed to treat COVID-19 patients. Researchers worldwide are testing various possible treatments that would help patients recover faster from the disease (Sanders et al., 2020).

Most of the organizations including WHO advocate supportive care which is aimed at relieving the symptoms and might include pain relievers (ibuprofen or acetaminophen), cough syrup or medication, rest, and fluid intake.

The US Food and Drug Administration (FDA) granted emergency-use authorization for antiviral drug remdesivir (developed by Gilead, originally for Ebola) to treat severe COVID-19 patients. Several corticosteroids like dexamethasone have also been recommended for use, apart from supplemental oxygen or mechanical ventilation (Md Insiat Islam Rabby, 2020).

Immunosuppressant drugs, too, are being tried to treat COVID-19 patients with abnormal immune response against the virus. Doctors have also prescribed drugs (https://www.business-standard.com/topic/drugs) like Roche's Tocilizumab, used typically for rheumatoid arthritis. The immune system of patients with COVID-19 often goes into an overdrive and produces an excess of immune-signaling molecules called cytokines. This cytokine release syndrome, popularly called the "cytokine storm," leads to hyper inflammation. This, in turn, exacerbates breathing difficulties and might lead to acute respiratory distress syndrome (ARDS). Drugs like Tocilizumab and Interferon alfa-2b (used to treat Hepatitis B & C) help suppress the immune system response by blocking certain receptors called interleukin-6 (IL6). Interferon alfa-2b is under clinical trial for COVID-19 treatment now.

Below is the list of common drugs that are being used in India for treating COVID-19 patients. These are all "off-label" uses of drugs or approved for "emergency use," as none of these is a proven treatment for the disease. Some are undergoing trials, too (Naveed et al., 2020).

Hydroxychloroquine (HCQ)

India is using HCQ as a prophylactic (or preventive) for frontline medical workers, police, etc. It is also approved as a treatment in mild cases with some caveats (not to be used on people with retinopathy, cardiac rhythm disorders, and kids below 15 years of age). After US President Donald Trump touted this drug as a magical medicine for COVID-19, several global trials like the WHO Solidarity trial and UK's Recovery trial have not found conclusive evidence to suggest proven benefits of HCQ.

Favipiravir

Oral antiviral drugs approved for use in Japan for influenza patients recently got the regulator's approval in India for emergency use on patients with mild to moderate conditions. Mumbai-based Glenmark conducted clinical trials for India and launched the drug, within a month of the launch. Researchers have suggested that favipiravir gets incorporated into the viral RNA which induces mutations to the RNA and eventually causes reduction in viral load. The drug may be binding itself to certain areas of the viral RNA polymerase (enzyme) and it stops the enzyme from doing its work (i.e., making new RNA). Basically, it can help stop the virus from making more copies of itself inside the patient's body. The drug cannot be used for patients with renal or hepatic (liver) conditions.

Remdesivir

Developed by US-based Gilead Sciences for Ebola, this drug has been approved in India for hospital use. It is an injectable drug, and two companies have launched it so far—Hetero's Covifor and Cipla's Cipremi. Clinical trials have shown that remdesivir helps shorten the recovery time and in turn the hospital stay. It, however, does not reduce mortality. Remdesivir works by faking out genetic building blocks and thus interrupting the viral replication. This stops the virus from making copies of it, reducing the viral load.

Tocilizumab

This drug is used in hospitals to treat severe COVID-19 patients, especially those experiencing cytokine release syndrome. It works to reduce the inflammation that happens when a patient's immune system reacts abnormally.

Itolizumab

The drug was launched in 2013 to treat plaque psoriasis. The drug was approved on July 11 by the Drug Controller General of India (DCGI) for restricted emergency use for treating moderate to severe coronavirus (https://www.business-standard.com/about/what-is-coronavirus) disease cases. The drug works by regulating the immune system which helps slow down the release of inflammation-causing cytokines. It works best when given to patients before the immune system is hyper-activated.

Steroids

Indian clinical management protocol has use of steroids like dexamethasone. This inexpensive steroid has been found to be effective in treating patients. According to the World Health Organization (WHO), "it was tested in hospitalised patients with Covid-19 in the United Kingdom's national clinical trial 'Recovery' and was found to have benefits for critically ill patients." WHO further said, according to preliminary findings, the treatment was shown to reduce mortality by about a third for patients on ventilators, and mortality was cut by about a fifth for patients requiring only oxygen. Dexamethasone falls under a broader class of drugs called corticosteroids and is a steroid known for its powerful anti-inflammatory properties. It is administered for various conditions like allergies, immune system disorders, even arthritis. Methylprednisolone is another corticosteroid being used by Indian doctors to handle moderate to severe COVID-19 cases.

Heparin

A common anticoagulant drug (that reduces blood clots from forming in the body), this is used in treating COVID-19 patients. The SARS-CoV-2 virus works by using its spike protein to attach to human cells and begin infection. According to recent findings, heparin can bind with the surface spike protein and can potentially block the infection. Researchers at Rensselaer Polytechnic Institute in the USA have said heparin could effectively neutralize SARS-CoV-2. So far, low-molecular-weight heparin has also been used to reduce the risk of developing clots in patients as the virus triggers a thrombotic pathway leading to formation of blood clots. Clots can develop in veins of legs, etc., when people are hospitalized and confined to beds. If the clot is dislodged, it can cause stroke, myocardial infarction (commonly understood as heart attack), pulmonary embolism, etc. Heparin is an anticoagulant and a low-cost drug.

Convalescent Plasma Therapy

In this experimental therapy, blood plasma from patients who have recovered from COVID-19 infection is collected and transfused into a currently sick person. It gives the receiver a "borrowed immunity" as the antibodies that a recovered person has are passed on to the sick person. This helps them fight the pathogen. This therapy was used in SARS1 in 2003 and also in MERS in 2012. Plasma banks for this have already been set up in some states.

Past Pandemics and Their Impact

An epidemic is a disease that affects a large number of people within a community, population, or region whereas a pandemic is an epidemic that's spread over multiple countries or continents. For example, when COVID-19 was limited to Wuhan, China, it was an epidemic and subsequent geographical spread turned it into a pandemic. The classic pandemic was the Spanish flu pandemic which happened in 1918 was an unusually deadly influenza pandemic caused by the H1N1 influenza A virus. Lasting more than 12 months from spring 1918 to early summer 1919, it infected 500 million people, i.e., about a third of the world's population at the time. The death toll is estimated to be as high as 100 million, making it one of the deadliest pandemics in human history (Spinney, 2018). The 2009 swine flu pandemic was an influenza pandemic that lasted for about 20 months, from January 2009 to August 2010 (Pederson, 2018; Pfefferbaum et al., 2012).

Other pandemics in recent times were the AIDS pandemic, Ebola virus pandemic, severe acute respiratory syndrome (SARS) pandemic in 2003 and subsequently the Middle East respiratory syndrome (MERS). Both SARS and MERS are caused by the new coronavirus (nCoV) (Yin & Wunderink, 2018). Mental health well-being is the most integral part of each pandemic as it not only causes mortality but it also increases psychological morbidity in terms of fears about our health and the health of our loved ones, fears associated with an economic downturn, social isolation, and the uncertain future. All these will cause stress-related symptoms like depression, anxiety, insomnia, and different bodily symptoms. It can also cause worsening of the pre-existing medical conditions like diabetes, hypertension, and asthma (Reynolds et al., 2008). Pandemics often cause severe fear and the terms like "the end of the world," "hospitals are overwhelmed," "people will die without receiving treatment," and "there will be no jobs to do, no food to eat" (Lee et al.,). Uncertain prognosis, lack of adequate treatment, shortage of protective gears and testing facilities, public health measures that infringe on personal freedoms, large and growing financial losses, media news and press releases, information on social media are among the major stressors that undoubtedly will contribute to widespread emotional distress and increased risk for psychiatric illness associated with pandemics (Lima et al., 2020; Asmundson & Taylor, 2020a, 2020b).

Specific Challenges Related to COVID-19 Pandemic

Mental health issues are a great challenge during pandemics like COVID-19. The immediate concern is rightly how to save lives and restrict the spread of infection. But another important question is the effect on the long-term mental health of human beings. The future with COVID-19 is unclear and an ongoing global effort to monitor and understand the mental issues is urgently needed (Kar et al., 2020). Mental health issues are expected in the whole population but special emphasis should be given to vulnerable populations like people infected with COVID-19 and their families, health care workers and their families, mental health issues for special populations like students, elderly, children, migrant workers, stranded people in different cities and countries, etc. (Rehman et al., 2020). Also the effect of lockdown and social isolation on the general population is enormous which leads to uncertainties in relation to job, business, finances, travel, and future projects (Kar et al., 2020; Rehman et al., 2020). However, there are specific recommendations from international bodies like the National Health Commission and World Health Organization (WHO) regarding addressing the mental health issues especially handling emergency psychological crises during this COVID-19 pandemic (WHO, 2020d).

The reason that COVID-19 is causing much distress and a wave of uncertainties is because of the following factors:

1. It is more infectious and lethal than the common flu.
2. Though it severely affects mostly the elderly and people with comorbidities, there are various instances that young individuals without many medical issues also succumb to this disease.
3. There is no specific drug to treat the virus nor their specific vaccines available currently to prevent a healthy population from getting infected.
4. There are also lots of uncertainties about the future course and progress of the infection.

All these contribute to mental distress in individuals which is evident by the rising mental health issues seen in the population while coping with the COVID-19 pandemic. Social distancing, wearing a mask, avoiding gatherings, frequent washing of hands, avoiding unnecessary travel, and experiencing frequent lockdown and restriction of movement are the new normal which also can contribute to stress and subsequent mental health issues (Adhikari et al., 2020).

Quarantine and Lockdown

Another aspect of the pandemic worth addressing is the quarantine and lockdown and its effect on mental well-being. When the COVID-19 infection started spreading in Wuhan, the Chinese government implemented a strict lockdown of the city. Residents started comparing the situation to “the end of the world,” “overwhelmed situation,”

and "severe shortage of food and money." "Panic in Wuhan" was a common headline at newspapers and magazines (Ingrid, 2020). The psychological effects of lockdown can be understood in different perspectives. Firstly, the announcement of lockdown indicates a serious situation and might worsen in future. Secondly, lockdown is associated with a loss of control and a sense of being trapped, which is more in families which are separated geographically. Thirdly, there is a direct effect of lockdown on employment, financial issues, availability of essential commodities, and social isolation. Lastly, uncertainty about the future and a fear that lockdown will be extended further and normalcy will not be restored soon in near future (Thakur & Jain, 2020).

Psychological and Emotional Impact of COVID-19

The novel coronavirus 2019 (COVID-19) pandemic has created a global crisis and healthcare infrastructure across several nations worldwide are struggling to deal with it (Bao et al., 2020). The rising number of frontline health workers who are infected has also put a strain on the workforce. Further, the unpredictability and uncertainty related to estimation of duration for which the situation would persist and disrupt lives (Zandifar & Badrfam, 2020), number of individuals it will infect and kill worldwide, and future public safety has made things worse. All these are likely to have serious and long-standing repercussions for the psyche and mental health of individuals and societies (Pfefferbaum & North, 2020).

"In February 2020, a 50 year old man in a village in Andhra Pradesh, India; and in March 2020, a 36-year-old man in a village in Bangladesh committed suicide because they and the villagers thought that they were infected with COVID-19 since they were suffering from symptoms of fever and cold. Unfortunately, no diagnosis was made and an autopsy in one of them confirmed non COVID19 status. In Delhi, India, a man, suspected to be infected with COVID-19 and admitted in the isolation ward of the Safdarjung Hospital allegedly committed suicide by jumping off the seventh floor of the hospital building. In King's College Hospital, London, a young nurse took her own life while treating COVID-19 patients." Elevated levels of xenophobia (fear of foreign or unusual objects and events) of COVID-19, misconceptions, social prejudice & avoidance by hichthe virus to family and others, constant fear of infection, distress & helplessness of witnessing infected people die, are factors that in various combinations and degrees may have contributed to these tragedies (Goyal et al., 2020; Mamun & Griffiths, 2020; Chen et al., 2020a).

During ongoing pandemics, disruption in usual activities, routine, livelihoods, separation from/loss of family members or friends or colleagues, persistent fears of getting infected or dying, coping with prolonged uncertainty and unpredictability have detrimental effects on mental health in the short term and potentially in the long term as well (Rajkumar, 2020).

Impact on Various Populations

Public health emergencies are well known to impact the health, safety, and well-being of individuals and societies. The repercussions are likely to be manifested through a wide range of emotional reactions from experiencing "distress" to "psychiatric symptoms or syndromes"; indulgence in unhealthy behaviors (excessive substance use); as well as noncompliance with public health directives (protective gears, home confinement) among infected patients and the general public (Asmundson & Taylor, 2020a, 2020b).

Patients Infected with COVID-19

Suspected or confirmed patients with COVID-19 infection predominantly experience fear related to fatality and high infectivity (Wang et al., 2020a; Li et al., 2020f). Those undergoing quarantine are likely to experience anger, denial, despair, insomnia, boredom, loneliness, depression, anxiety, substance abuse, tendency to self-harm and suicidality (Wang et al., 2020a; Li et al., 2020f; Dong & Bouey, 2020; Yi et al., 2020; WHO, 2020e). Even the survivors of COVID-19 are vulnerable to developing various mental health disorders like post-traumatic stress disorder, anxiety, and depression (62). Patients may develop obsessive–compulsive disorder (OCD) while trying to implement and continue with COVID-19 related safety behaviors as well (Li et al., 2020f). Also, physical symptoms related to COVID-19 infection like cough, fever, hypoxia together with side effects of prescribed medications (corticosteroids) may cause additional distress and anxiety (Kar et al., 2020; Wang et al., 2020a).

Family Members and Close Contacts

The family members and close contacts of persons with COVID-19 face various psychological repercussions during isolation or quarantine. Feelings of anxiety, worry, shame, guilt, or stigma for already sick and/or quarantined family members, and related concerns about the outcome of infection and stigma on family and friends are widely evident (Wang et al., 2020a). It has been found that family members and close contacts of people infected with COVID-19 may develop PTSD and depression (Goyal et al., 2020), while those who lose their loved ones may tend to experience anger and resentment (Goyal et al., 2020). Further, isolated or quarantined children have higher probability of developing grief, acute stress reactions, and adjustment disorder (Kar et al., 2020; Shah et al., 2020).

Further, in current circumstances, to adhere to social distancing rules and avoid contagion, those who have lost loved ones are unable to undertake the natural mourning process, funeral and crematoria services, or perform last rites. This may lead more people to develop pathological grief reactions and adjustment disorders subsequently.

Healthcare Workers

Healthcare professionals, particularly frontline workers directly involved with diagnosing, treating, and caring for patients infected with COVID-19, are vulnerable to developing emotional distress and other mental health problems. A steady and enormous increase in the number of confirmed and suspected cases, excess workload, unpredictability and confusion within the work environment, intermittent shortage of protective devices, involvement in resource-allocation decisions distraught with emotional or ethical concerns, perceived inadequate support and stigmatization may all contribute to their mental health burden (Lai et al., 2019; Pfefferbaum & North, 2020). Apart from these they have to cope with the distress of losing patients in unprecedented numbers while trying to protect their own health. To care for health care workers and colleagues as patients can be emotionally challenging too (Maunder et al., 2003). Work may often involve being caught in unusually adverse and dehumanizing conditions due to overwhelming numbers of admitted cases, critical cases and deaths. Risk of exposure to the virus, concern about infecting and caring for loved ones, dilemma of prioritizing professional versus personal duty and responsibilities are some of the additional challenges that further contribute to the burden on healthcare workers (Tsamakis et al., 2020; Rana et al., 2020; Zhang et al., Zhang, Wang, et al., 2020). While on COVID-19 duty, inaccessibility to food, water, beverages, and even restrooms can be physically challenging and may lead to other health complications like dehydration and oxygen saturation imbalances among frontline medical workers (doctors and nurses) directly caring for patients infected with COVID-19.

Moreover, it is also documented that in dispensing care to patients healthcare workers are vulnerable to develop certain specific mental health conditions like ***vicarious traumatization (VT)*** and ***secondary traumatic stress (STS)*** which bear significant mental, emotional, social, and economic costs. ***Vicarious traumatization (VT)*** (McCann & Pearlman, 1990) refers to "harmful changes in the cognitive schema of professional helpers related to self, others, and the world as a result of exposure to graphic and/or traumatic material." It is associated with disruptions in five areas of psychological need, viz. safety, trust, esteem, intimacy, and control and "can result in decreased motivation, efficacy, and empathy" (Baird & Kracen, 2006). ***Secondary traumatic stress (STS)*** (Figley, 1995; Stamm, 1999) refers to "a syndrome characterised by exhaustion, hypervigilance, avoidance, and numbing among health care professionals, family members, friends, and caregivers of people who have experienced traumatic events and suffer from post-traumatic stress disorder (PTSD) themselves" (Baird & Kracen, 2006; Elwood et al., 2011; Figley, 1995; Stamm, 1999). It

is due to secondary exposure of the traumatic event (Guitar & Molinaro, 2017). **VT** and **STS** are associated with various mental, physical, and emotional problems for health care professionals like burnout, decreased self-worth and low morale. As a result they can lead to higher staff turnover and decreased productivity among them (Showalter, 2011; Simon et al., 2005). They are both an occupational hazard and an organizational concern (Baird & Kracen, 2006; Louth et al., 2019; McCann & Pearlman, 1990). However, emerging research has also indicated development of **vicarious resilience** in the form of strength, growth, and empowerment among few health care providers affected by **VT** and **STS** (Puvimanasinghe et al., 2015).

Adverse psychological reactions to severe acute respiratory syndrome (SARS, 2003) outbreak were observed and well documented among health care workers (Maunder et al., 2003; Bai et al., 2004; Lee et al., 2007b; Chua et al., 2004). In fact, during Middle East respiratory syndrome (MERS) coronavirus infection, health care workers were found to be at higher risk of developing symptoms of PTSD (Lai et al., 2019; Maunder et al., 2003). Therefore, it is imperative that employers and organizations implement necessary measures to support the mental well-being of their staff (Maunder et al., 2003).

Children and Women

According to the UNESCO Director-General Audrey Azoulay "the global scale and speed of the current educational disruption is unparalleled" (WHO, 2020d).

This is a new and challenging situation for children as well. Physical distancing from friends due to social distancing norms can be distressing. School closure has led to a disruption of daily routine and structure in their lives. School routine is an important coping mechanism for most children with access to various resources like cognitive stimulation, socialization, peer support, creativity, extracurricular and fun activities. There can also be fears and queries related to COVID-19 itself. All these can make them anxious and stressed which may manifest in boredom, restlessness, irritability, hypersensitivity. During times of crisis children can also seek more attachment and be more demanding of parents (Kar et al., 2020; WHO, 2020d).

Further, in several countries, Board, College, University exams have been postponed indefinitely or canceled creating a huge academic and financial burden on young students. Cancelation of anticipated events, delayed exams, crucial time lost in career development and academic progress, lack of clarity about future prospects and job markets have left them confused, helpless, and frustrated. This may culminate in sleeplessness, decreased appetite, and irritability among the older children and youth. Remaining healthy in order to undertake upcoming exams can be an added stressor (WHO, 2020d; Rajkumar, 2020).

Moreover, children in abusive homes are socially isolated with the possibility of abuse exacerbating especially during present conditions of stress and economic uncertainty. Increased incidence of neglect, exploitation, and child abuse were also reported during the Ebola outbreak in Africa. A surge in reported cases of domestic

violence in comparison with the previous year was noted during COVID-19 in a province in China in February 2020 (WHO, 2020d).

As the pandemic continues, it is essential to support children and adolescents experiencing distress related to bereavement, parental unemployment, loss of household income. It is also important to monitor the long-term mental health outcome among them in order to understand the effect of the pandemic, prolonged school closures, and public health safety measures on their well-being.

Across many countries during COVID-19 pandemic, incidence of domestic violence has increased significantly, as governments world-over enforced strict quarantine rules to prevent the spread of COVID-19 (Taub, 2020; Van et al., 2020). The contributing factors seem to be exposure to economic and psychological stressors, increase in negative coping mechanisms (such as alcohol misuse), social isolation and an inability to access usual support systems or escape abusive environments. In India too there has been an increase in domestic violence among women during the extensive lockdown phase (Gulati & Kelly, 2020).

General Public, Older Adults, and High Risk Individuals

Necessary restrictions like social isolation and quarantine are likely to have detrimental impact on mental health both in short and long run (Dong & Bouey, 2020). Indian society being a collectivistic culture that is rooted in social connectedness and social support is perhaps feeling the impact of essential public safety measures like movement restrictions, self-isolation, social distancing and quarantine more strongly (Muktar, 2020). The psychological impact of quarantine may manifest in post-traumatic stress symptoms, confusion, and frustration (Brooks et al., 2020).

When faced with a public health emergency/infectious life threatening diseases people tend to develop more of negative emotions like anxiety, aversion, or fear along with negative cognitive appraisals as a means of self-protection. Behaviorally, this may be reflected in overreacting to situations, excessive avoidance, and blind conformity. Moreover, persistent negative emotions experienced over long periods of time may endanger the immune system of people and disrupt normal physiological mechanisms (Kiecolt-glaser et al., 2002; Mortensen et al., 2010; Schaller, 2006; Schaller, 2006; Schaller et al., 2015; Slovic, 1987). Few studies involving sociodemographic characteristics mentioned greater psychological impact of the pandemic on female gender and student population associated with higher levels of stress, anxiety, and depression. The uncertainty and potential negative impact on academic progression may adversely affect students' mental health. Also, the general public lacking formal education were found to have greater likelihood of depression during this time (Wang et al., 2020a).

This crisis is also likely to impact the mental health of the vulnerable individuals, particularly those who are isolated or with pre-existing mental and physical health difficulties. Patients with chronic physical illnesses (like chronic renal failure, diabetes mellitus, and cardiac diseases) in need of regular follow-up to hospitals may

deteriorate. Patients with pre-existing severe mental illness (SMI) are also affected by inaccessibility to care. Those hospitalized in closed wards are at high risk of infection while outpatients are facing significant difficulties to receive maintenance treatment which can lead to a relapse of their condition (Ho et al., 2020). Older adults, particularly the once in isolation or with cognitive decline/dementia, may experience more stress and exhibit symptoms of increased anger, agitation, anxiety, and withdrawn behavior during the outbreak or while in quarantine (WHO, 2020e). Also, the emotional distress, anxiety, and challenges related to circumstances around COVID-19 may cause symptom exacerbation, resurgence, or relapse in patients with past history of mental illness as they are already vulnerable (Kar et al., 2020; WHO, 2020d).

The concept related to emergence of traumatic responses through exposure to victims/survivors of trauma can be extended to large scale public health disasters like the COVID-19 pandemic as well. Such impact exceeds psychological and emotional tolerance of the general public causing serious distress and indirectly leading to significant physical and mental symptoms (Mathiet, 2014). Some of these symptoms include sleep disorder, loss of appetite, physical decline, fatigue, inattention, fear, numbness, irritability, and despair. Often these may be accompanied by trauma reactions and interpersonal conflicts which may even result in suicide (Creighton et al., 2018).

Migrant Population

The psychosocial issues among migrants during COVID-19 are many. During the lockdown period of India the nationwide ban on travel, lack of work led to severe financial crisis to take care of daily expenses and tackle the strict quarantine rules. All these have resulted in high levels of anxiety, which in turn induced stress, depression, and panic attacks among internal migrant workers (Choudhari, 2020). The migrant workers are suffering from high degrees of anxieties and fears due to various concerns in COVID pandemic and are in need of psychosocial support. The major factors that might affect the predisposition of the internal migrant workers for adverse mental health manifestations are lack of jobs, financial constraints, away from family, social isolation, substance abuse and proneness to develop common mental illness (Rothman et al., 2020).

Psychosocial Intervention

Unlike trauma experienced during natural disasters leading to PTSD, the effects of life threatening viral infections are usually depressive and anxiety disorders. Some groups may be more vulnerable than others to the psychosocial effects of pandemics. In particular, infected patients, frontline workers (healthcare and others), high risk

individuals (including the elderly, people with compromised immune function, and those living in congregate settings), and people with pre-existing medical, psychiatric, or substance use conditions, or those with vulnerable psychological traits are at heightened risk for adverse psychosocial sequalae (Li et al., 2020f).

Common psychological reactions like frustration, worry, nervousness, loneliness, annoyance, anger, sadness, fear, helplessness, and guilt are typically experienced during and after such crises (Ahorsu et al., 2020; Banerjee, 2020; Cheung et al., 2008; Zhang, 2020). During and after the severe acute respiratory syndrome (SARS) pandemic in 2003, the suicide rate among elderly population was found to increase in Hong Kong (Cheung et al., 2008). In extreme situations, such mental health problems can lead to suicidal behaviors (e.g., suicidal ideation, suicide attempts, and actual suicide). Other disturbing emotional responses like grief and bereavement, shame, post-traumatic stress symptoms, panic attacks, sleep problems, mood problems, boredom, stigmatization, marginalization, mass hysteria, xenophobia, uncertainty, and ambivalence are also seen (Mukhtar, 2020) (Wang et al., 2020a).

It has been reported that greater satisfaction with health information received from government and health authorities was associated with less psychological impact of the pandemic and lower levels of depression, stress, and anxiety (Wang et al., 2020a; Rubin & Wessely, 2020). Accurate and updated health information, especially focusing on number of recovered individuals, status of medicines/vaccines, routes of transmission helped to avoid/minimize adverse psychological reactions among people receiving them as evident from lower levels of reported anxiety and stress (Wang et al., 2020a).

There is now a pressing need for mental health support, assessment, treatment that calls for urgent mobilization of mental health care services. Effective and timely addressal of such wide scale and diverse mental health issues require multilevel, multiorganizational, and multidisciplinary collaboration and coordination.

Recommendations for Mental Health Service Provision: Policies and Framework

It has been recommended that mental health interventions for the public must be formally integrated into public health preparedness and emergency response plans for tackling the pandemic. There is an urgent need for mental health bodies and academic associations to identify and organize mental health expert teams who would coordinate with health authorities. These teams can formulate guidelines and instructions for administration and initiation of mental health services, develop emergency psychological crisis intervention modules, and establish psychological assistance special teams to provide professional guidance, training, and preparedness for other personnel involved (National Health Commission of China, 2020). The guidelines should be implemented under the guidance of trained mental health professionals.

Such multidisciplinary intervention teams can be created in India as well to function at national, state, district, and municipality levels (Fig. 14.1).

Principles of Psychosocial Intervention

Any psychological intervention should be based on *principles* of:

1. *Integrating* psychological crisis intervention into general deployment of pandemic prevention and control in order to *reduce potential psychological damage* caused and *promote social stability.*
2. Implementing *targeted interventions for different groups* and *preventing secondary trauma* for both providers and patients. The target groups include:

    a. Confirmed patients
    b. Suspected patients
    c. Health care and related personnel
    d. People in close contact with the patient (family members, colleagues, friends, etc.)
    e. Patients who do not want to seek medical treatment
    f. Susceptible people and the general public

Specialized mental health support should also be delivered to individuals with pre-existing mental or physical disorders, healthcare and aid workers, especially nurses and physicians working directly with sick or quarantined individuals (Shigemura et al., 2020; Cosic et al., 2020). This should include regular clinical screening for anxiety, depression, and suicidality in patients suspected/diagnosed with COVID-19 and frontline health professionals.

Separate interconnected mental health service teams can be constituted, viz.,

- **Psychological intervention medical team**—comprising psychiatrists, clinical psychologists, and psychiatric nurses, this can be an autonomous team or part of the medical team. Staff with experience in psychological crisis intervention should be preferred.
- **Psychological assistance hotline team**—comprising mental health workers with psychological hotline training and volunteers experienced in psychological crisis intervention in public emergencies. Psychological assistance training on COVID-19 outbreak and supervision should be made mandatory before joining (Bouey, 2020).

All psychosocial interventions must begin with necessary **psychological evaluation** to understand the risk factors, mental health status, and needs of the target individuals/groups. The intervention must be based on findings of initial psychological assessment or screening done. All these services can be provided both through **Onsite** and **Online** platforms (Fig. 14.2).

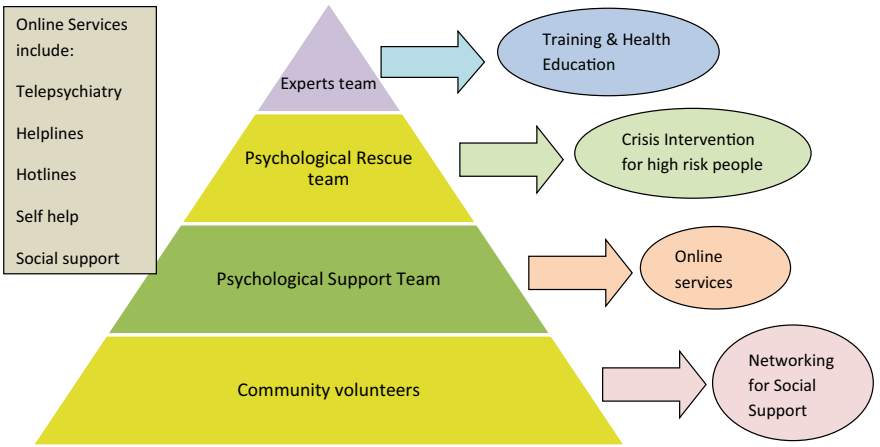

Fig. 14.2 Organization framework for management of psychological crisis during COVID-19 pandemic

Strategies for Psychosocial Intervention

Psychological management services during such pandemics will specifically involve provision of.

- Psychological First Aid (PFA)
- Psychological Crisis Intervention (PCI)
- Psychological Support

Psychological First Aid (PFA) is a systematic set of helping actions used by disaster mental health professionals and others to provide immediate support to trauma survivors. It aims to reduce the initial distress and assist with short- and long-term adaptive functioning. Five empirically supported principles on which PFA interventions are based during the early to middle stages of post disaster or trauma include: **(a) Promoting sense of safety, (b) Promoting calming, (c) Promoting sense of self and community efficacy, (d) Promoting connectedness, and (e) Instilling hope** (Ruzek et al., 2007).

According to the WHO PFA Guide (2011), *"Psychological first aid involves humane, supportive and practical help to fellow human beings who have suffered a serious crisis event."* (WHO, 2016). Current PFA models have been designed in such a way that it can be delivered in any setup by anyone who can access and offer early assistance to the affected people including any health personnel, disaster response or humanitarian workers, to ordinary volunteers and community individuals. The goals of PFA are pragmatic and constructed around practical areas of action (WHO, 2019).

The Action Principles of PFA (WHO, 2016)**.**

First, personnel must ***prepare to learn about the situation, the impact and resources & services available.***

- **LOOK**—check for safety, serious distress reactions urgent basic needs
- **LISTEN**—ask about needs and concerns, listen non-judgmentally without pressuring to talk, comfort, and help in calming down
- **LINK—**connect affected people with available support services, like accurate information, helping to prioritize and solve problems, connecting with loved ones and other social support)

Skills of good communication, both verbal and as well as non-verbal, are essential for PFA. PFA is a time-limited assistance. PFA helpers "enable affected individuals to mobilize their own coping resources to regain control of situations, and to connect with available services and supports that they may need in the course of their recovery. PFA helpers also refer people in need of specialized care to professional health or mental health services" (WHO, 2019).

A **psychological crisis** occurs when an individual perceives an event or change in its environment as significant and threatening has exhausted all coping resources to deal with it, and is unaware or unable to pursue other alternatives and experiences a state of psychological disequilibrium (Caplan, 1964; Smead, 1988; Brenda et al., 1995). Through intervention timely and skillful support is provided to help them cope effectively with the situation in concern and thereby prevent potential harm in future to their physical and/or emotional health (Brenda et al., 1995).

Psychological crisis intervention, to be provided by a mental healthcare team, must be dynamic, adapted to suit different stages of a pandemic, i.e., during and after the outbreak (114). It should simultaneously address 2 major issues, viz.,

- Fear of disease
- Difficulty in adaptation.

During the second phase after the outbreak, APD is an effective method to address the psychological impact of disaster among medical staff. It includes:

- **Anticipate (A)**—involves providing pre-event stress training in the context of high casualties, operational challenges, and compromised safety.
- **Plan (P)**—facilitating development of a "personal resilience plan" for coping with such situations. It includes identifying and anticipating response challenges.
- **Deter (D)**—helps to learn how to monitor one's stress and use the "personal resilience plan" in real intervention response (Fig. 14.3).

The aim is to include technology in the process of intervention, and to integrate intervention in the early phase with rehabilitation in the later phase. Also such models can be jointly developed with other mental health institutions or shared with them to enhance mental health services (Zhang et al., 2020b).

After a public health outbreak, psychosocial support is mainly delivered to the quarantined people and health care workers attending to them. Telemedicine and online interventions to provide psychological intervention and support can be administered by psychologists, social workers, psychiatrists as well as family members to isolated or suspected patients, and close contacts.

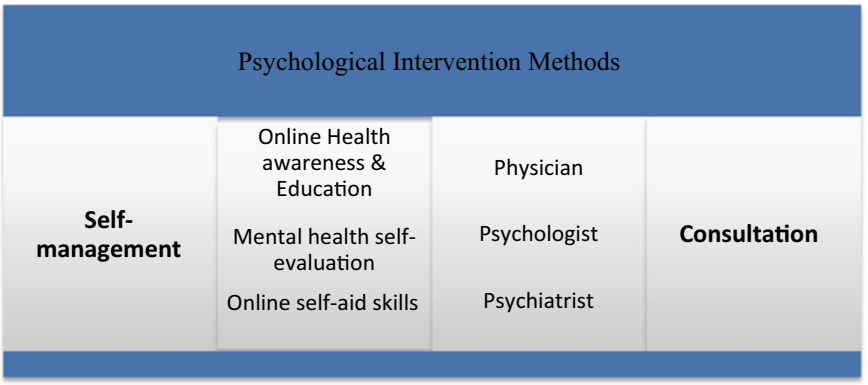

Fig. 14.3 Online psychological intervention for COVID-19 pandemic

Still, certain important concerns remain.

- One of the challenges to psychological crisis intervention is organizing and setting up of an intervention team during lockdown and risks involved to personal health when such services are provided onsite (Zandifar & Badrfam, 2020).
- Further, in developing countries including India, low rate of mental health service utilization, paucity of online mental health services, inaccessibility of digital technology for elderly, or people belonging to low socioeconomic status are some of the additional challenges of online mental health service provision (Yao et al., 2020).
- In India and several other countries, the acute shortage of psychiatrists and other mental health specialists (Andrade et al., 2014; Marr, 2019) can easily overburden the mental health care system with anticipated surge in upcoming demands, posing a threat of global public mental health crisis.
- Few problems with psychological interventions may result from a lack of efficient liaison between medical professionals and psychologists or counselors.

The Way Forward

Stigma and **discrimination** tend to isolate and marginalize particular groups and are major barriers to seeking health interventions as well as the recovery process. Therefore, addressing stigma through awareness, information sharing and training both during the immediate response phase as well as the recovery period will be of utmost importance.

Collaborative efforts with **community and faith-based organizations** may facilitate culturally appropriate mental health planning, preparedness, and response. Such activities should be coordinated with non-government and government organizations (Gierer, 2020).

Digital psychiatry using tele-psychiatry, internet-based computer-aided mental health tools and services, as well as an array of other new technologies, can help globally and urgently during the coronavirus pandemic. Increasing the availability of tele-psychiatric services using smartphones, along with mental health awareness and self-help apps may be a promising way forward, particularly for high risk individuals (Lovejoy, 2019).

In the face of a pandemic/disaster most people are resilient and do not succumb to psychopathology. In fact, some may even find new strengths (Goyal et al., 2020). Majority of people are expected to cope well with such a public health crisis if available resources like information and awareness, shared concern, timely support, connectedness, and solidarity exist. Thus, the COVID-19 crisis can also be reappraised as an opportunity for personal growth, mental health promotion, family bonding, or building relationships by focusing on activities (within one's control) like maintaining hygiene, healthy diet and sleep pattern; exercising, practicing yoga/meditation/mindfulness; engaging in art, music, or recreational activities, exploring new interests and acquiring new hobbies and skills, composing, gardening, cooking, reading, playing games, and journaling personal observations and experiences. These are protective strategies to cope with stress, anxiety, and panic that help to build resilience (Wood & Runger, 2016).

Conclusion

As the COVID-19 pandemic continues to rage, the extent of its psychological, social, and economic fallout needs to be closely monitored. Further, particular influences on such outcomes of a constellation of pre-pandemic, peri-pandemic, and post-pandemic factors, across different countries or regions, must also be noted.

For most people, including patients and health workers, the emotional and behavioral responses to the COVID-19 pandemic situation are part of an adaptive response to extraordinary stress, where psychotherapeutic techniques based on stress-adaptation model could be beneficial (WHO, 2020b; Drosten et al., 2003).

However, in order to reduce the negative psychosocial impact on public mental health (current emotional distress and long-term outcome), a crucial part of the health response of authorities to 2019-nCoV must include: (1) establishment of multidisciplinary mental health teams (including psychiatrists, psychiatric nurses, clinical psychologists, and other mental health professionals; (2) up-to-date communication with reliable data about the situation; and (3) psychological interventions (mostly internet and technology based) for patients and healthcare providers directly involved in the pandemic. In this context, the urgent development and timely implementation of mental health assessment, support, treatment, and services is a pressing need of the hour (Fig. 14.4).

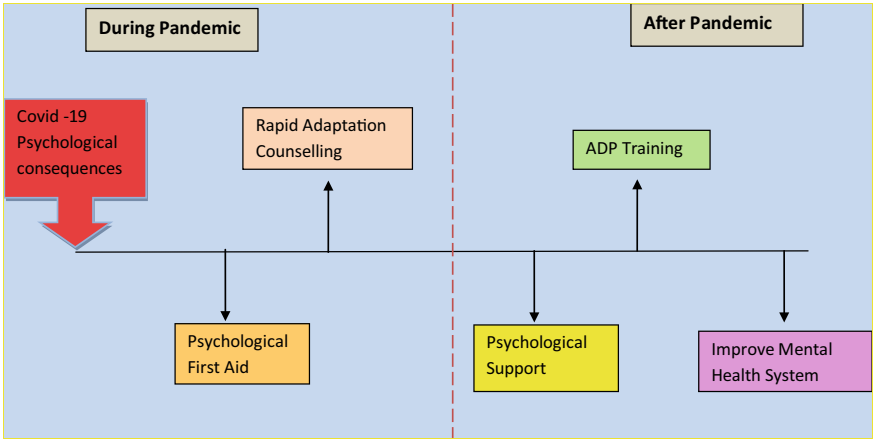

Fig. 14.4 Psychological intervention for pandemic: the two-stage model

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Chapter 15
COVID-19 and Mental Health of Indian Youth: Association with Background Variables and Stress

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Abstract The coronavirus has become a public health concern of the decade, affecting the economic, social, and psychological stability of the whole world. Having understood the detrimental impact of the pandemic to the mental health of people of all age groups, youth is understood to be the most vulnerable population who receives its direct impact. The broad objective was to study the mental health status of Indian youth and its association with various demographic variables. Psychological stress and mental health was another relationship that was explored. A group of 317 participants between the age group of 19 to 29 voluntarily took part in the online survey. Gender was found to be associated with overall mental health status ($p < 0.01$) as well its correlates, namely anxiety ($p < 0.05$), depression ($p < 0.05$), and loss of behavioral control ($p < 0.01$). Association between age and loss of positive affect ($p < 0.05$), number of siblings and loss of behavioral control ($p < 0.01$), and family environment and overall mental health scores ($p < 0.001$) were found. Similarly, feeling of restlessness during lockdown ($p < 0.001$), availability of support ($p < 0.001$), and feeling the need to consult a mental health professional were associated with the overall mental health score as well as all its sub-scales. Further, there were strong negative correlations between psychological stress and overall mental health

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https://doi.org/10.1007/978-981-16-8263-6_15

scores, as well as that of anxiety, depression, and loss of behavioral control and positive affect sub-scales. The study highlighted the need for psychological support services for the youth population of the country to cope with and adapt to the new situation.

Keywords Mental health · Stress · Youth · India · Demographic variables: COVID-19

Introduction

Rapid spreading and unprecedented emergence of infectious diseases have become a major public health concern of the twenty-first century (Mak et al., 2010); the torrential impact of epidemics like SARS (2003), novel Influenza A H1N1 (2009), and Ebola (2014) on the physical and mental health of people is understood to be its key characteristics (Xiang et al., 2014). Soon after its outbreak in late December 2019, followed by its uncontrollable spreading, the World Health Organisation (WHO, 2020) declared the new coronavirus (2019-nCoV) as a public health emergency of international concern (PHEIC). Adding to medical emergency, the pandemic has severely affected the economic, social, and psychological well-being of the whole world (Viswanath, 2020). Many studies have established the detrimental effect of such epidemics on the public mental health, in the form of post-traumatic stress disorder, depression, and anxiety (Shultz et al., 2015). Commonly reported mental health issues in India additionally included insomnia, denial, anger, and fear as well (Roy et al., 2020). Consequently, youth population is assumed to be severely affected by and is vulnerable to develop such psychological problems: A recent China-based cross-sectional study on the impact of COVID-19 pandemic found that nearly 40.4% its youth have high proneness to psychological problems (Liang et al., 2020). However, most of the studies have restricted their investigation to the children, adolescents, pregnant women, and geriatric population only, thereby leaving the youth mental health status unexplored.

COVID-19 in India

The detrimental impact of 2019-nCoV in India aggregated even further due to factors such as high population density, limited medical care facilities, high illiteracy rates, and social misconception about the pandemic. In India, the first case was reported in January 30, 2020, and had immediately underwent a series of nationwide lockdown. By September 2020, the per-day cases in India had peaked due to heightened community transmission and had continued to spread in alarming rates of 90,000 cases every day. The repercussion of this was reflected on all sectors including, but not limited to education, economy, transportation, employment, entertainment,

tourism, and commercial establishments. Food insecurity, interstate migration of laborers, unemployment, and economic instability further aggravated the condition. The second wave of COVID-19 sometime in the end of March 2021 badly affected the Indian population. The number of detected COVID-19 positive cases based on people who came forward for testing is increasing rapidly. Every day is breaking the record of previous day. As of today (May 1, 2021), more than four lakhs (401,993) new COVID-19 cases and 3523 deaths in the last 24 h reported in India (https://economictimes.indiatimes.com). Non-availability of oxygen cylinder and medical facilities across the country caused lives of lot of people affected by COVID-19. Perhaps elections in four states and in one Union Territory in India and Kumbh Mela—a spiritual gathering held in Haridwar contributed significantly for faster spread of COVID-19.

In addition, the youth of the country have specific concerns in the job market, such as lay-off, salary-cut, ineffective working from home setup, and financial insecurity. Youth, who are found to be working in unorganized sectors, such as frontline workers, and among the ones who had to rejoin on-site when economic unlocking is declared in the country are facing the pressure of being susceptible to nCoV. While the possible concerns of youth in education could be non-working of academic institutions, fear of losing a year of study, delayed entry into job markets, ineffectiveness of online classes and poor economic conditions, and unwelcoming career prospects. Readily available pandemic-related information such as its spread and death rates, updates about the time-consuming vaccine development procedures, news of people committing suicide and similar disturbing information could affect the youth more than any other population. COVID-related protocols such as isolation, home and institutional quarantine, and movement restriction have also definitely contributed to the poor psychological functioning of the youth (NIMHANS, 2020).

Therefore, in this study, we aim to examine the general status of mental health of youth with special reference to depression, anxiety, and loss of behavioral control and positive affect. The association of youth mental health with background variables such as age, gender, level of education, parents' education, family type, sibling, family income, family environment, support facilities, feeling of restlessness, and worry is further explored. In addition, the impact of psychological stress on mental health of youth is evaluated. Therefore, the study hypothesizes that the status of mental health of male and female youth does not differ significantly (H1), there exists an association between mental health of youth and background variables such as age, gender, level of education, parents' education, family type, sibling, family income, family environment, presence of support, restlessness, and the feeling of seeking mental health support during lockdown (H2), and there exists an association between stress and mental health of youth with special reference to depression, anxiety, and loss of behavioral control and positive affect (H3).

Materials and Methods

A cross-sectional online survey conducted among Indian youth between June 3, 2020, and August 3, 2020, during COVID-19 pandemic in the country.

The participants of the study were Indian youth aged between 16 and 29 (n = 317). Three study tools which were used for data collection are as follows:

(i) Background Information Schedule (BIS, Deb, 2020): The schedule particularly designed for this study aimed to collect the background information of the participants, has two brad sessions: first session with 15 questions related to demographic and socioeconomic background of the participants and second session with five questions related to online mode of study, which is not made to use in the current study. In all the questions, responses are captured in the form of either "Yes" or "No".

(ii) Mental Health Inventory (MHI-18, Veit & Wear, 1983): This is an 18-item questionnaire which is used to assess the mental health status of the tested through four sub-scale named (a) Anxiety, (b) Depression, (c) Loss of behavioral control, and (d) Loss of positive affect. Some of the items of MHI-18 include (*i) Did you feel depressed? (ii) Have you felt calm and peaceful? (iii) Have you been moody? (iv) Were you a happy person? (v) Were you able to relax without difficulty?* There is evidence for high psychometric support of the constructs of the Mental Health Inventory (Veit & Wear, 1983). Reliability was achieved using a representative sample of 5089 respondents in the RAND Health Insurance Experiment. The overall Mental Health score was 0.64 (McDowell, 2006). Subjects were asked to answer every question based on how you feel, and how things have been for you during the past four weeks. If you are not sure which answer to select, please choose the one answer that comes closest to describing you. The response ranges from 1 = all of the time to 6 = none of the time. The higher score indicates the negative states of mental health. A recent Kashmir-based study among the youth has ascertained the Cronbach alpha coefficient to be 0.72. The Cronbach alpha for the present sample was found to be 0.909.

(iii) The Perceived Stress Scale (PSS) (Cohen et al., 1983): It is a widely used psychological instrument that consists of ten items measuring the perceived stress over the past month. It is a measure of the degree up to which situations in one's life are appraised as stressful. Items were designed to tap how unpredictable, uncontrollable, and overloaded respondents find their lives. For example, *(i) In the last month, how often have you been upset because of something that happened unexpectedly? (ii) In the last month, how often have you felt nervous and "stressed"? (iii) In the last month, how often have you been able to control irritations in your life?* and *(iv) In the last month, how often have you been angered because of things that were outside of your control?*. In this ten-item scale, *p*ositively stated items number 4, 5, 7, and 8 are reversed scored and summed across all the items. Andreou et al. (2011) ascertained the psychometric properties of PPS-10 in general population and

found the Cronbach's alpha value as 0.82. Perera et al. (2017) estimated the internal consistency to range from 0.68 to 0.78. Reliability analysis of the PSS, using Cronbach alpha, was done for the present study subjects, and it was found to be 0.772.

Procedure for Data Collection: An online survey by using the above questionnaires in English among the Indian youth aged between 16 and 29 years was conducted using a non-probability convenient sampling. The survey link was provided in the Web site of the Rajiv Gandhi National Institute of Youth Development, Ministry of Youth Affairs and Sports, Government of India, and information about the online survey was shared with the youth through various social network sites for voluntary participation. A total of 317 samples participated in the study voluntarily from different parts of the country.

Data Analysis: Statistical analysis was performed using the Statistical Package for the Social Sciences (SPSS) version 22.0 software. Both descriptive and inferential statistics (independent T-test, one-way ANOVA, Chi-square tests, and correlation) were done to assess the relationship between the variables. Significance level of $\alpha = 0.05$ was applied for all statistical tests.

Findings

Table 15.1 provides the demographic and socioeconomic particulars of the study participants, referring to which it can be seen that nearly equal proportion of male and female individuals participated in the study along with one third gender individual. Half (49.8%) the study sample belonged to the age group of 19–22 years, 32.5% were aged between 23 and 26, 11.7% were above 27 years, and 6% were less than 18 years. Incidentally, all the participants were students, among whom, 54.6% were postgraduate students, 22.7% were graduate students, 15.5% were pregraduation students, and 7.3% were Ph.D. Scholars. Considering the educational level of the parents, only 15.5% participants had fathers who were postgraduates and above, and 16.1% had their mothers qualified as postgraduates and above. The third quarter hailed from nuclear families with varying proportions of single child (12.6%), one sibling (45.4%), two siblings (22.7%), and three siblings and above (19.2%). Nearly half the population had their monthly family income to be less than 25,000 INR, while 9.1% had more than one lakh INR. 77.9% identified their family environment to be congenial. Interestingly, equal proportion of participants reported their restlessness and absence of restlessness in relation to the lockdown. 85.5% reported to be worried about their exams and future career, and 33.4% felt the need to consult a mental health professional for support. 73.8% of the participants reported to be backed up by someone to share their personal feelings and emotions.

Table 15.2 depicts the relationships between background characteristics and mental health status of the participants. Gender was found to be associated with overall mental health status ($p < 0.01$) as well as its correlates, namely anxiety (p

Table 15.1 Background information

Characteristics		N (%)
• Gender	Male Female 3rd Gender	160 (50.5) 156 (49.2) 1 (0.3)
• Age	< 18 years 19–22 years 23–26 years ≥ 27 years	19 (6.0) 158 (49.8) 103 (32.5) 37 (11.7)
• Education	< Graduate Graduate student Postgraduate students Ph.D. Scholar	49 (15.5) 72 (22.7) 173 (54.6) 23 (7.3)
• Father's education	Studied up to class 10 Studied up to class 12 Graduate Postgraduate and above	120 (37.9) 59 (18.6) 89 (28.1) 49 (15.5)
• Mother's education	Studied up to class 10 Studied up to class 12 Graduate Postgraduate and above	143 (45.1) 64 (20.2) 59 (18.6) 51 (16.1)
• Family type	Nuclear Joint	237 (74.8) 80 (25.2)
• Sibling	Single child One sibling Two siblings Three and above	40 (12.6) 144 (45.4) 72 (22.7) 61 (19.2)
• Family income (per month)	< 25,000 25,001–50,000 50,001–100,000 > 100,000	152 (47.9) 90 (28.4) 46 (14.5) 29 (9.1)
• Family environment	Congenial Not congenial	247 (77.9) 70 (22.1)
• Are you feeling restless because of lockdown?	Yes No	161 (50.8) 156 (49.2)
• Are you worried about exam and future career?	Yes No	271 (85.5) 46 (14.5)
• Is there anybody with whom you can share your personal feelings/emotions?	Yes No	234 (73.8) 83 (26.2)
• Do you feel like to consult a psychologist/counsellor for mental health support?	Yes No	106 (33.4) 211(66.6)

Table 15.2 Relationship between background characteristics and the mental health status of the participant

Characteristics	MHI_ Anxiety Mean ± SD	*p* value	MHI_Depression Mean ± SD	p-value	MHI_Loss of behavioral control Mean ± SD	*p* value	MHI_Loss of positive affect Mean ± SD	*p* value	Total MHI Mean ± SD	*p* value
Gender Male Female	19.92 ± 4.88 18.46 ± 5.79	0.016*	16.03 ± 4.22 14.84 ± 4.59	0.019*	16.26 ± 3.88 14.97 ± 4.33	0.006**	18.81 ± 5.12 17.86 ± 5.03	0.098	70.75 ± 14.88 65.89 ± 17.41	0.009**
Age < 18 years 19–22 years 23–26 years ≥ 27 years	19.11 ± 6.57 19.37 ± 5.16 18.80 ± 5.70 19.73 ± 4.86	0.779	16.00 ± 5.46 15.47 ± 4.50 15.15 ± 4.51 16.14 ± 3.65	0.667	15.47 ± 3.36 15.75 ± 4.21 15.52 ± 4.42 15.65 ± 3.80	0.976	[1]21.16 ± 5.11 18.61 ± 4.97 17.80 ± 5.431* 17.49 ± 4.36	0.037*	71.22 ± 16.73 68.94 ± 15.68 67.02 ± 17.94 68.89 ± 14.88	0.698
Education < Graduate Graduate student Postgraduate students Ph.D. Scholar	19.06 ± 6.11 19.77 ± 5.21 18.97 ± 5.28 19.57 ± 5.29	0.741	15.40 ± 4.63 15.87 ± 5.10 15.27 ± 4.12 15.86 ± 4.60	0.784	15.39 ± 3.71 15.81 ± 4.60 15.54 ± 4.14 16.48 ± 4.07	0.728	18.67 ± 4.96 19.28 ± 5.21 18.08 ± 5.10 17.04 ± 4.99	0.208	68.27 ± 16.03 70.77 ± 16.65 67.45 ± 16.32 68.91 ± 17.32	0.569
Father's education Studied up to class 10 Studied up to class 12 Graduate ≥ Postgraduate	19.27 ± 5.29 20.17 ± 4.79 18.76 ± 5.65 18.71 ± 5.80	0.407	15.50 ± 3.96 16.13 ± 4.25 14.88 ± 4.56 15.69 ± 5.56	0.424	15.78 ± 3.75 15.78 ± 3.97 15.53 ± 4.38 15.39 ± 5.02	0.934	18.08 ± 5.01 19.10 ± 4.71 18.27 ± 5.22 18.37 ± 5.65	0.656	68.26 ± 14.68 70.84 ± 15.65 67.39 ± 17.15 67.90 ± 19.75	0.658

(continued)

Table 15.2 (continued)

Characteristics	MHI_ Anxiety Mean ± SD	*p* value	MHI_Depression Mean ± SD	p-value	MHI_Loss of behavioral control Mean ± SD	*p* value	MHI_Loss of positive affect Mean ± SD	*p* value	Total MHI Mean ± SD	*p* value
Mother's education Studied up to class 10 Studied up to class 12 Graduate ≥ Postgraduate	19.48 ± 5.12 19.61 ± 5.16 18.32 ± 5.18 18.96 ± 6.56	0.490	15.66 ± 4.16 15.82 ± 4.33 15.13 ± 4.34 14.90 ± 5.55	0.626	16.11 ± 3.59 15.63 ± 4.53 15.12 ± 3.93 14.98 ± 5.31	0.259	18.32 ± 6.01 18.67 ± 4.94 17.69 ± 4.64 18.90 ± 6.09	0.613	69.39 ± 14.56 69.15 ± 16.59 66.05 ± 16.17 67.52 ± 21.07	0.592
Family type Single Joint	19.23 ± 5.63 19.14 ± 4.61	0.880	15.48 ± 4.45 15.46 ± 4.53	0.973	15.60 ± 4.15 15.79 ± 4.25	0.727	18.21 ± 4.99 18.85 ± 5.45	0.331	68.15 ± 16.76 69.23 ± 15.37	0.617
Sibling Single child One sibling Two sibling ≥ Three	17.85 ± 6.20 19.08 ± 5.71 19.76 ± 4.68 19.74 ± 4.71	0.264	13.73 ± 5.06 15.56 ± 4.72 15.96 ± 3.64 15.80 ± 4.14	0.078	[1]14.15 ± 5.02 15.47 ± 4.15[1*] 15.60 ± 3.58 17.11 ± 3.90[1*]	0.004**	17.60 ± 5.61 18.44 ± 5.11 18.18 ± 4.57 18.92 ± 5.41	0.630	62.16 ± 20.05 68.57 ± 16.55 69.06 ± 13.83 71.32 ± 15.59	0.061
Family income (per month) < 25,000 25,001–50,000 50,001–100,000 > 100,000	19.23 ± 4.90 18.90 ± 5.29 19.76 ± 6.81 19.17 ± 5.80	0.855	15.70 ± 4.11 14.89 ± 4.40 15.80 ± 5.23 15.50 ± 5.22	0.566	15.71 ± 3.76 15.56 ± 4.40 15.74 ± 4.45 15.45 ± 5.12	0.983	18.27 ± 4.53 18.51 ± 5.57 18.96 ± 5.98 17.52 ± 5.16	0.675	68.78 ± 13.74 67.86 ± 17.66 69.43 ± 20.66 67.11 ± 18.68	0.921

(continued)

Table 15.2 (continued)

Characteristics	MHI_ Anxiety Mean ± SD	*p* value	MHI_Depression Mean ± SD	p-value	MHI_Loss of behavioral control Mean ± SD	*p* value	MHI_Loss of positive affect Mean ± SD	*p* value	Total MHI Mean ± SD	*p* value
Family environment Congenial Not congenial	19.80 ± 5.14 17.10 ± 5.75	0.000***	15.92 ± 4.25 13.87 ± 4.84	0.001**	16.28 ± 3.84 13.43 ± 4.55	0.000***	19.20 ± 4.76 15.43 ± 5.24	0.000***	70.99 ± 15.43 59.17 ± 16.57	0.000***
Are you feeling restless because of lockdown? Yes No	17.06 ± 4.76 21.42 ± 5.09	0.000***	13.69 ± 4.22 17.37 ± 3.91	0.000***	14.10 ± 3.95 17.24 ± 3.78	0.000***	16.78 ± 4.86 20.01 ± 4.85	0.000***	61.57 ± 14.46 75.71 ± 15.18	0.000***
Are you worried about exam and future career? Yes No	18.67 ± 5.20 22.39 ± 5.40	0.000***	15.01 ± 4.35 18.28 ± 4.15	0.000***	15.16 ± 4.04 18.50 ± 3.82	0.000***	17.85 ± 4.92 21.43 ± 5.19	0.000***	66.48 ± 15.62 80.30 ± 16.19	0.000***
Is there anybody with whom you can share your personal feelings/emotions? Yes No	20.09 ± 5.03 16.73 ± 5.59	0.000***	16.13 ± 4.28 13.60 ± 4.46	0.000***	16.42 ± 3.82 13.46 ± 4.37	0.000***	19.26 ± 4.80 15.87 ± 5.16	0.000***	71.76 ± 15.06 59.09 ± 16.48	0.000***

(continued)

Table 15.2 (continued)

Characteristics	MHI_ Anxiety Mean ± SD	*p* value	MHI_Depression Mean ± SD	p-value	MHI_Loss of behavioral control Mean ± SD	*p* value	MHI_Loss of positive affect Mean ± SD	*p* value	Total MHI Mean ± SD	*p* value
Do you feel the need to visit a mental health professional for support? Yes No	16.69 ± 5.17 20.46 ± 5.05	0.000***	13.38 ± 4.20 16.56 ± 4.21	0.000***	13.58 ± 3.94 16.68 ± 3.90	0.000***	15.90 ± 4.80 19.61 ± 4.81	0.000***	59.60 ± 14.71 73.00 ± 15.35	0.000***

Note *$p < 0.05$; **$p < 0.01$; ***$p < 0.001$; SD: Standard deviation

< 0.05), depression ($p < 0.05$), and loss of behavioral control ($p < 0.01$). However, female participants had lower scores on overall mental health as well as the three aforesaid sub-scales as compared to their male counterparts. An interesting association was observed between age and loss of positive affect ($p < 0.05$) wherein the increase of age witnessed decreases in the loss of positive affect; participants below the age of 18 have lesser loss of positive affect than their older counterparts. A significant association was found between number of siblings and loss of behavioral control ($p < 0.01$) wherein scores tend to increase as the number of siblings increase. Single children secured the least scores on this sub-scale, while those with three or more siblings scored the highest. Family environment was associated with the overall mental health scores ($p < 0.001$) as well as all the sub-scales of mental health inventory, namely anxiety ($p < 0.001$), depression ($p < 0.01$), and loss of behavioral control ($p < 0.001$) and positive affect ($p < 0.001$); participants from congenial family environments secured better scores on all these components. Similarly, feeling of restlessness during lockdown ($p < 0.001$), availability of support ($p < 0.001$), and feeling the need to consult a mental health professional were associated with the overall mental health score as well as all its sub-scales. Participants who felt restless during that time, who did not have someone to share their feelings/emotions as well as who needed to seek the help of a mental health professional, scored poorly in all the sub-scales and the total score of the mental health inventory, as compared to their counterparts.

Hence, hypothesis 2, which states that "*there exists an association between mental health of youth and background variables*", is retained in relation to age, gender, family environment, presence of support, restlessness, and feeling of seeking mental health support during the lockdown.

Table 15.3 provides the association between stress and mental health status of the youth with special reference to the four sub-scales, viz. anxiety, depression, loss of behavioral control, and loss of positive affect. Significant relationships were found between overall psychological stress and the status of mental health. There were strong negative correlations between psychological stress and overall mental health scores as well as that of anxiety, depression, and loss of behavioral control and positive affect sub-scales. This means, as scores on the mental health inventory decrease, psychological stress increases.

In light of this finding, hypothesis 3 stating that "*there exists an association between stress and mental health of youth with special reference to depression, anxiety, and loss of behavioral control and positive affect*" is retained.

Discussion

The study that intended to explore the mental health status of the youth in relation to stress and demographic details during the phase of COVID-19 pandemic yielded relevant findings.

Table 15.3 Association between stress and mental health of youth with special reference to depression, anxiety, and loss of behavioral control and positive affect

	Psychological stress items	MHI—Anxiety *r* value	MHI—Depression *r* value	MHI—Loss of behavioral control *r* value	MHI—Loss of positive affect *r* value	Total MHI *r* value
1	In the last month, how often have you been upset because of something that happened unexpectedly?	−0.389***	−0.441***	−0.365***	−0.426***	−0.470***
2	In the last month, how often have you felt that you were unable to control the important things in your life?	−0.422***	−0.433***	−0.455***	−0.418***	−0.502***
3	In the last month, how often have you felt nervous and "stressed"?	−0.526***	−0.570***	−0.459***	−0.455***	−0.584***
4	In the last month, how often have you felt confident about your ability to handle your personal problems?	−0.323***	−0.299***	−0.437***	−0.407***	−0.416***
5	In the last month, how often have you felt that things were going your way?	−0.316***	−0.309***	−0.384***	−0.318***	−0.383***

(continued)

Table 15.3 (continued)

	Psychological stress items	MHI—Anxiety *r* value	MHI—Depression *r* value	MHI—Loss of behavioral control *r* value	MHI—Loss of positive affect *r* value	Total MHI *r* value
6	In the last month, how often have you found that you could not cope with all the things that you had to do?	−0.335***	−0.348***	−0.303***	−0.267***	−0.362***
7	In the last month, how often have you been able to control irritations in your life?	−0.275***	−0.251***	−0.340***	0.294***	−0.321***
8	In the last month, how often have you felt that you were on top of things?	−0.226***	−0.195**	−0.280***	−0.283***	−0.283***
9	In the last month, how often have you been angered because of things that were outside of your control?	−0.471***	−0.519***	−0.378***	−0.439**	−0.525***
10	In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	−0.576***	−0.546***	−0.495***	0.495***	−0.621***
	Total psychological stress	−0.660***	−0.692***	−0.637***	−0.669***	−0.764***

Note *$p < 0.05$; **$p < 0.001$; ***$p < 0.001$; r = Pearson correlation coefficient

The demographic variable gender was found to have a significant association with the mental health status wherein women were found to obtain lower scores in the overall mental health status as well as its sub-scales, namely anxiety, depression, and loss of behavioral control and positive affect. Strong evidence of gender difference in the prevalence of anxiety and depression is found wherein higher proneness was found among girls and women. Lack of autonomy, socially determined roles and responsibilities and norms (WHO, 2002) coupled with occurrence of uncontrollable events such as COVID-19 seemed to be affecting their mental health. It was also the time when working women had struggled to balance between working from home as well as their household chores and they have a huge increase in their workload to meet the demand of everyone at home.

Age had a significant association with the loss of positive affect. The scores on the sub-scale loss of positive affect took a decelerating trajectory with increasing age. That is, participants below the age of 18 showed better mental health, followed by age group of 19–22 and 23–26; the oldest group of participants in the present study scored the lowest among the lot, to indicate their poor mental health in terms of losing positive affect. Interpreting this finding in the light of COVID-19 would urge one to link this with the economic repercussions of the pandemic that has led to loss of jobs and poor career prospects for the youth in the country. Association between poor mental health and job insecurity (Wilson et al., 2020) and the associated psychological threat during the pandemic (Viswanath, 2020) among the youth worldwide have been a proven understanding. Their overall proneness toward developing psychological problems during COVID-19, as assumed by Liang et al. (2020), could be linked to this pattern seen in the population with age. The significant form taken by the scores on behavioral control sub-scale with the number of siblings was such that behavioral control seemed to be better as number of siblings increased. Therefore, single children have highest loss of behavioral control, while those with three or more siblings had the better behavioral control. Poor emotional regulation and self-control is found among only-children as compared to children with siblings during the pandemic (Yang et al., 2017). The absence of a support figure from one's own generation as a support system could be influencing the loss of behavioral control among them. This finding implies the scope of further research on the coping mechanism and regulatory behavior among the group of study during such crisis situations.

Congenial family environment revealed its positive association with the overall mental health of the study participants. Significant association was seen with all the sub-scale, viz. anxiety, depression, and loss of behavioral control and positive affect, to indicate that congenial family environment has a strong influence on the better mental health of youth in the country. Several studies have proven that strong nurturing capacity of good family environment (Kaur, 2017), the backing of a strong support system, and feeling of togetherness during a crisis situation would facilitate the overall mental health of the family. This factor becomes particularly relevant during the lockdown in the country where individuals were confined only to their homes from where the youth manages their studies and work. Supportive family environment would have provided financial, emotional, and psychological backup,

thereby decreasing their vulnerability to psychological distress. The same point is proven again in this study in yet another manner wherein participants who did not have a support system to share their troubling thoughts and emotions depicted a significant negative relationship with the overall mental health scores as well as with its sub-scales. Evident results such as significant association between feeling of restlessness as well as the need to consult a mental health professional were found to be significantly associated with poor mental health scores.

Further, there were strong negative correlations between psychological stress and overall mental health scores as well as that of anxiety, depression, and loss of behavioral control and positive affect sub-scales. As scores on the mental health inventory increase, psychological stress also increases. An Indian study conducted by Dangi et al. (2020) assessed the COVID stress during the 21-day lockdown (March 24 to April 14, 2020) among the youth to find severe stress for nearly 73.26% of the youth after 15 days and 80.86% of youth after 21 days. This unprecedented lockdown, which continued for months beyond the speculated time, is assumed to have torrential impact on the youth. Fear of getting infected, tremendously increasing death rates, unfamiliar quarantine and social distancing rules, restrictions and newly imposed regulations on movement and transportation, shortage in food supply, inability to reach families, loss of job, and the combination of various such factors would have amplified the stress level, thereby curtailing the mental health.

The study implied that women are higher proneness to poor mental health during the nCov'19 and so stressed on their need for additional care and support. The vulnerability of youth in the country was also found to be increasing with their age. Further implications included the importance of maintaining congenial family environment and other support systems to navigate through the pressing times.

Conclusion and Recommendations

Demographic variables such as gender, age, and number of siblings were found to be associated with the mental health of the youth. In comparison to their male counterparts, women had poor mental health outcomes. Mental health outcomes became poorer as one age and as the number of siblings reduces. Congenial family environment and availability of support enhanced mental health while feeling of restlessness and the need to consult a mental health professional curtailed mental health. Stress was negatively correlated to mental health wherein, with increasing stress, proneness to and incidence of anxiety, depression, and loss of behavioral control and positive affect increased.

Increasing awareness regarding COVID stress has to be disseminated across all age groups and gender to gain insight on the support services to be provided to the vulnerable. This should be targeted to make attitudinal and behavioral changes in the public toward youth who are anxious about their future due to job insecurity and lack

of entitlement, toward women who are struggling to balance between the demand of their work and household chores, and toward families who are troubled by the repercussions of the pandemic to emphasize on the need of togetherness to navigate through the pandemic.

Youth should be motivated to utilize their time during lockdown to equip themselves with the needed skills as expertise, targeting for a prospective career start or growth. They can make use of online classes/training and indulge in productive discussions to keep them productively occupied. Involvement in recreational activities and physical exercises, nurturing of hobbies or learning new skills could be some ways to enhance mental health and psychological fitness.

Limitations of the Study Since the study utilized online mode of conduction, cross-checking of the data and ensuring full involvement of the participants were very little. Size of the sample was very small compared to the youth population in the country, and therefore, the findings cannot be generalized. Furthermore, there was only one participant to represent the third gender community, whose information could not be amply utilized due to poor representation size.

Ethical Issues The present study was subjected to ethical approval and obtained the clearance (Ref. No. RGNIYD/ADMIN/20–21/SEC/001). All procedures performed in collecting data from the participants were in accordance with the ethical standards of the institution and/or national research committee and with the 1964 Helsinki declaration in mind. Participation in the study was voluntary, and participants were ensured about confidentiality of information.

Conflict of Interest Authors declare no conflict of interest in the publication of this research. All authors read and approved the final version of the manuscript.

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Chapter 16
The Psychological Implications of COVID-19: A Mental Health Perspective

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Abstract This planet has witnessed several pandemics earlier in its history. The last pandemic, Spanish flu which was far more deadly, happened about a century ago and apart from a few centenarians, nobody who is alive today has any experience of living during the time of pandemic. COVID-19 discovered about 9 months back has reached almost every continent and country. With around 29 million known COVID-19 infected people, about a million deaths and with billions are affected due to quarantines, lockdowns, and restrictions on movement of person and goods, and social distancing measures. This has resulted in adversities and hardships in the areas such as financial, employment, school, family, and health. All these directly affect the mental health and well-being of an affected individual as well as their family members. Some of the common mental health conditions observed are anxiety about coronavirus infection, and worries about stigma, well-being, and future of the family members. In addition, the prevailing situation has further worsened people with already existing mental health conditions, such as inability to consult the mental health professionals due to COVID safety measures and fear of contamination in the mental health institutions. To mitigate mental health issues and to improve psychosocial well-being, NIMHANS, with the help of the government and other institutions, adopted several measures, such as creating IEC materials for the general public, coun-

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_16

seling people who are quarantined, and starting a national telephone free helpline. This chapter will discuss the efficacy of online counseling, related issues, experiences, lessons learned and offer suggestions for the future.

Keywords Counseling · Efficacy · Mental health · Well-being · COVID-19 · Anxiety

Introduction

COVID-19 has evolved over the past 9 months to spread across the world and has disastrous consequences with loss of life and economy. With over 29 million cases all over the world, and over 50 lakh cases in India, and about 80,000 deaths, a rising concern has been a wave of mental health concerns all over the world. In the wake of this unprecedented public health emergency, the only means of containing the spread of the virus has been community mitigation strategies. This includes social distancing, isolation/quarantine measures that have forced people from all backgrounds to stay indoors, removed from the outside world and the human contact they were generally acclimatized to. Anticipating an impending mental health pandemic, the government took several initiatives to address the same. One such initiative by the Ministry of Health and Family Welfare in collaboration with the National Institute of Mental Health and Neurosciences (NIMHANS) has been the National COVID-19 Helpline for Psychosocial Support and Mental Health Services (PSSMHS) that has attempted to address these concerns by providing 24 × 7 telephonic supports for the general public by trained mental health professionals. The National Institute of Mental Health and Neurosciences has come up with several such initiatives such as IEC materials and videos on various aspects of COVID-19 and mental health issues, by quickly adapting to the growing mental health demands of the general population. In this chapter we discuss the experience of running one such initiative toward the provision of psychosocial support and mental health services in the midst of the COVID-19 pandemic at a tertiary care Centre for Excellence, in India.

Disasters and Mental Health

The United Nation International Strategy for Disaster Reduction (UN-IDSR) defined disaster as "a serious disruption of the functioning of a community or a society causing widespread human, material, economic or environmental losses which exceed the ability of the affected community or society to cope using its own resources" (Makwana, 2019). Disasters can be further sub-typed into natural or man-made

disasters. While natural disasters include flooding, earthquakes, landslides, man-made disasters include industrial accidents, bio-warfare, industrial and chemical accidents. The National Disaster Management Authority (NDMA) India defines biological disasters as "natural scenarios involving disease, disability or death on a large scale among humans, animals and plants due to microorganisms like bacteria, or virus or toxins." These biological disasters can present as pandemics, when they impact large populations or regions, spreading across countries and continents worldwide. (National Disaster Management Guidelines: Management of Biological Disasters, 2008).

Disaster mental health deals with mental health in the face of a calamity, what can best be described as a "normal reaction to an abnormal situation" (Nyamai & Njenga, 2000). Most individuals struck by disasters, natural or man-made, face unprecedented changes in their life that they were not accustomed to. These changes can lead to different levels of psychological distress in the population. Psychological reactions such as anxiety, irritability, sadness of mood, and hopelessness have been recorded in the general population (Martin, 2015). Following natural disasters, common psychological reactions include shock, grief, avoidance behaviors related to the disaster (Eyre, 1999). Man-made disasters are usually followed by reactions that include anger, guilt, self-blame, and paranoia (Makwana, 2019). Unlike individuals with mental illness, this affects the group of individuals directly or indirectly affected by the disaster as a whole. Following the resolution of the disaster situation, there is usually a resolution in the psychological reactions, with only a few individuals that go onto develop clinically diagnosable level of psychiatric illness (Understanding the Psychological Consequences of Traumatic Events, Disasters, and Terrorism, 2003).

COVID-19 Pandemic and How It Differs From Other Disasters In Its Mental Health Impact

COVID-19 has presented unique challenges in its containment and management. From curbing the spread of the virus or lack of a cure for COVID-19 visible in the horizon, doctors, scientists, and public health specialists are struggling to find a way to stop the spread of this virus. A worrying concern has been the wave of mental health concerns that has emerged world over in the midst of COVID-19. The rise in mental health symptoms has been a consequence of worldwide lockdowns, strict social distancing measures, and loss of job, income and life for individuals across the world, along with the general fear of acquiring the COVID-19 infection.

The sudden trauma that accompanies natural or man-made disasters may not be replicated in a more prolonged pandemic like COVID-19. However, uncertainty in prognosis, a shortage in resources to contain the pandemic, no vaccine yet available for prevention of the illness, and increased risk of illness in first-line responders makes this particular viral pandemic the focus of an impending mental health

pandemic affecting individuals across continents and socioeconomic strata (Pfefferbaum & North, 2020). The COVID-19 pandemic has threatened multiple facets of well-being of an individual and even communities and countries at large, with its direct and indirect consequences affecting the mental and physical well-being of individuals. There are several factors where COVID-19 differs from other disasters in predisposing the general population to psychological reactions.

- The risk of the individual or their loved ones acquiring the infection which mainly spreads through droplets and fomites.
- The risk of economic and financial instability or loss brought by the global economic shutdown, recession and economic depression.
- The emotional vulnerability of the population at large due to nationwide lockdowns, and strict social distancing protocols.
- The increased risk of infection posed to frontline workers and their families.
- Inability to grieve for lives lost to COVID-19 due to strict infection control policies pertaining to disposal of bodies.
- Continued uncertainty about the future, with respect to lack of life-saving treatment or prevention measures.
- Short-term consequences of missed treatments, such as inability to obtain treatment and/or medication for various conditions such as depression, schizophrenia, cancer, or tuberculosis due to inability to obtain the medication/treatment as a result of the lockdowns and affected healthcare scenario.
- Long-term ramifications of missed vaccination for children due to lockdowns, missed diagnosis of any health condition, either physical or mental health conditions. For example, lockdown restrictions and/or fear of contacting the virus, parents who suspect that their child is not developing at the normal pace, might delay the visit to a child mental health professional for consultation. This might delay the diagnosis of any developmental problems if present in their child and in turn the precious time is lost in providing treatment at the right time, where the brain is still plastic and more suitable for intervention.

Studies have shown a higher rate of stress, anxiety, and depression among the general population in China soon after the COVID-19 pandemic (Wang et al., 2020). As the infection spread across continents, it became increasingly clear that the COVID-19 pandemic had clear psychological implications that needed addressing. An increase in social stigma, xenophobia, hysteria and panic and a failure to comply with enforced social distancing protocols was observed all over the world (Lee et al., 2020). Common psychological reactions include panic, anxiety, reduced sleep, feelings of sadness, fear of acquiring infection, and an increase in substance use (Mental Health in the times of COVID-19 Pandemic: Guidance for General Medical and Specialized Healthcare Settings, 2020). Mental health professionals remaining vigilant for the development of these psychological reactions and taking measures to prevent them may go a long way in preventing the impending mental health

pandemic that may have severe consequences following COVID-19 (Banerjee, 2020). Providing psychological first aid and psychosocial support is vital in mitigating the distress and enhancing the coping strategies of people to deal with this biological disaster.

Common Psychological Reactions during COVID-19

COVID-19 changed our perceptions of "normal" overnight. It has been observed that since the onset of the pandemic, common psychological reactions seen among the general population include stress, anxiety, depression, feeling vulnerable and frustrated and the general uncertainty around COVID-19.

COVID-19 impacts different groups of individuals in different ways. Some of the vulnerable groups who are likely to be impacted by the mental health consequences of COVID-19 include (Table 16.1):

Individuals in quarantine include those who are either suspected or confirmed cases of COVID-19 and are at increased risk of being psychologically impacted by the illness. Individuals in quarantine are more prone to suffer from emotional disturbances from social isolation, frequent mood fluctuations, irritability, and insomnia (Mental Health in the times of COVID-19 Pandemic: Guidance for General Medical and Specialized Healthcare Settings, 2020). They may also be more likely to develop emotional exhaustion, remaining hypervigilant about bodily symptoms and a heightened anxiety about acquiring the infection. Those with medical symptoms resembling COVID-19 may also experience guilt and feel overwhelmed about passing the infection to their loved ones.

A particularly cruel aspect of the COVID-19 pandemic has been its impact on bereaved family members (Morris et al., 2020). Though the mortality rate amounts to about 2% of the general population in India, the COVID-19 pandemic has overwhelmed healthcare facilities and frontline workers, in ensuring a dignified burial/cremation of the dead. In the aftermath of COVID-19, family members do not get to bid farewell to the dying loved one in person, and are even unable to see the deceased after their passing (Morris et al., 2020). Most healthcare facilities resort to mass burial at designated sites to prevent infection spread. All of these factors make it distressing to the bereaved family members who are unable to process the passing of their loved ones in a timely and appropriate fashion.

Of particular importance are the vulnerable groups such as children, pregnant women, elderly and persons with physical or mental ailments. The impact of COVID-19 on these individuals is more serious and likely to have lasting consequences. The psychological symptoms may also present differently in these individuals with children presenting with dullness, lethargy, hypervigilance about COVID-19, fear, and anxiety (Seshadri, 2020). The elderly have been particularly affected by COVID-19 with a difficulty to maintain their activities of daily living, inability to meet loved ones like before, lack of social contact results in loneliness, anxiety, insomnia in this group (David, 2020).

Table 16.1 Groups of individuals who likely require psychosocial support for mental health issues during COVID-19 pandemic (Ravindran et al., 2020)

Group 1	This group deserves special attention, as they not only have been directly affected by the viral illness, they have to accept the diagnosis knowing its consequences and the implications of no cure being found yet
COVID-19 Suspected persons and positive individuals and individuals in quarantine	Additionally, these individuals are in isolation and cannot seek comfort from their loved ones. Many might blame themselves for passing on the virus to a loved one. Further, the financial expenditure associated with the treatment might burn a hole in the family's finances and savings. It is prudent to take specific measures to address the mental health needs of these individuals
Group 2 Bereaved family members	Those who have lost members of their family to COVID-19 or its complications remain at greater risk, both from being suspected cases themselves and also from not being able to grieve and pay respects to their loved ones on their passing, since the virus is highly contagious
Group 3 General public	Comprises the majority of the individuals. Those who are neither confirmed nor suspected cases, but suddenly faced drastic changes in their daily routine, and those who feel lost and anxious about the COVID-19 pandemic, about their personal and professional lives being compromised. Associated with the general concern about what the future holds in store for them
Group 4 Special groups	Children and adolescents, elderly individuals, pregnant women and women in the postpartum period, migrant laborers, employees of unorganized sectors, such as construction laborers, automobile drivers, and other daily wage workers
Group 5 Frontline workers	Healthcare workers, policemen, security personnel and those involved in provision of essential services are not only at risk of acquiring the illness while in the line of duty, they also stand the risk of infecting their loved ones. Most frontline workers working in the COVID pandemic have self-isolated themselves for a varying number of days after their duty hours, and this puts them at added risk of feeling lonely, anxious, and stressed
The target population in this service was Group 3 and Group 4: the general public	

The frontline workers of the pandemic are the most vulnerable group. Having to deal with the illness for long hours in PPE and with little time for self, the frontline workers have been up and center in the fight against the pandemic. This group is often separated from loved ones for days on-end and often shuffles between the hospital and quarantine often. They also have increased worries about spreading the infection to their loved ones.

Vulnerability Factors for Developing Psychological Reactions During COVID-19

Disasters collectively affect the mental health of the population. The premise of psychological reactions during disasters is that it is a "normal reaction to an abnormal situation" and that once the disaster situation improves, the mental health of the population would also improve and might come to the pre-disaster level (Nyamai & Njenga, 2000). However, there are certain vulnerability factors that predispose some individuals more than others to develop psychological reactions during COVID-19. These are:

Individual-related factors	• High risk groups such as children, pregnant women, elderly • Parents of very young children • Unmarried individuals living alone • Caregivers of elderly • Persons with mental illness
Sociocultural, economic factors	• Loss of job, livelihood • Uncertainty over future • Impaired activities of daily living • Unable to pursue previously pleasurable activities, travel restrictions
Illness-related factors	• Contact with COVID-19 patient • Individuals recovered from COVID-19 • Bereaved families • Those seeking constant information about COVID-19 from social media and news sources

Effect Of COVID-19 On The Risk of Developing Psychiatric Symptoms

- **Loneliness and Social Isolation**

Since the onset of COVID-19, nations have maintained that curtailment of community spread of infection was the most reliable measure to prevent COVID-19 related case

rate and mortality. This had led to nationwide lockdowns and strict travel restrictions over the past several months. Being restricted to their homes and being unable to step out and meet family and friends has led to people feeling increasingly lonely and despondent. Loneliness can be defined as a state of being without any company. It is a risk factor for developing more serious psychiatric disorders such as anxiety, depression, insomnia, or adjustment disorders. Loneliness over a long period of time may even impact the overall physical activity of the individual and predispose him/her to physical ailments such as frailty and falls (Bannerjee & Rai, 2020). A study conducted in the USA suggested that there was a significant increase in the number of individuals feeling lonely as compared to before COVID-19. For most individuals struggling with loneliness and their fears about COVID-19 being compounded by social isolation, it is important to take active steps to prevent the same (Berg-Weger & Morley, 2020).

- **Frustration and Boredom**

Another common concern among individuals is the frustration that accompanies social isolation and being restricted at home. Many such individuals report feeling bored, not knowing what to do with their time, feeling anxious about how best to spend their day and a difficulty in working from home. A sudden and drastic change in the daily activities, a lack of routine of many of those impacted by COVID-19, could result in individuals feeling this way. Boredom and frustration could impact other negative emotions and predispose individuals to develop more serious psychiatric illnesses. (Mental Health in the times of COVID-19 Pandemic: Guidance for General Medical and Specialized Healthcare Settings, 2020).

- **Anxiety**

One of the most common psychological reactions to the COVID-19 pandemic has been a widespread fear and paranoia about COVID-19. Anxiety pertaining to COVID-19 ranges from non-specific fears about the individual or his loved ones acquiring COVID-19, to more pervasive concerns about the economic impact of COVID-19 on individuals and society as a whole and also some enduring questions, such as, "When the Pandemic will finally end?" These questions have been linked to increased stress and anxiety levels in a study conducted by Serafini et al. (2020). Students, those who suffered significant losses in their jobs and livelihoods and front-line workers, are at particular risk to develop anxiety and stress during the pandemic (Mental Health in the times of COVID-19 Pandemic: Guidance for General Medical and Specialized Healthcare Settings, 2020).

- **Depression**

Many individuals also report having pervasive feelings of sadness, hopelessness, inability to enjoy activities they previously enjoyed doing (Mental Health in the times of COVID-19 Pandemic: Guidance for General Medical and Specialized Healthcare Settings, 2020). Some may also complain of fatigue, irritability, mood fluctuations, and variations in their appetite. Though most of these symptoms are self-limiting,

some of these individuals may go onto develop moderate to severe syndromal depression that needs acute psychiatric intervention. Some individuals may also report having frequent suicidal ideation and may even attempt suicide. It is important to recognize the warning signs early in these cases and immediately refer such patients for timely psychiatric interventions on an emergency basis.

- **Substance Use Disorders during COVID-19**

For individuals suffering from substance use disorders in the past, the lockdown has had a significant impact on the patterns of substance use. Initially during the times that there was a complete lockdown on sales of substances like liquor and tobacco, many individuals reported psychiatric emergencies with symptoms of acute drug withdrawal. Over time, as the lockdown restrictions eased, and the sale of these substances went back up, individuals previously dependent on these substances reported an increase in substance abuse patterns. (Mental Health in the times of COVID-19 Pandemic: Guidance for General Medical and Specialized Healthcare Settings, 2020) Confounding factors include a lack of routine, and individuals not knowing how to spend their time productively.

- **Worsening of Patients with Pre-Existing Mental Illnesses**

Individuals with pre-existing mental illnesses are a vulnerable group of individuals who have been particularly affected by the pandemic. Since many of the out-patient facilities have been impacted by COVID-19 and psychiatrists have been roped into the general pool of doctors to fight COVID-19 infection, a significant number of psychiatric patients have been affected. There is also a shortage of available psychiatric medication and shortage of medical facilities admitting psychiatric patients. This has contributed significantly to the mental health crisis during COVID-19 (Mental Health in the times of COVID-19 Pandemic: Guidance for General Medical and Specialized Healthcare Settings, 2020).

Addressing the Mental Health Consequences of COVID-19

Mitigation of Mental Health Crisis during COVID-19

- **Shift of Psychiatric Services to Tele-Mental Health Services**

The mental health community has been plagued with the dilemma of patient outreach since the onset of the pandemic. Many mental health practitioners and counselors have shifted over to the provision of tele-mental health services from routine OPDs. This has been a double-edged sword, as this has enabled individuals to access mental health care from the safety and comfort of their homes on the one hand, but affected the outreach and human contact aspect on the other.

Tele-mental health remains the future of psychiatric practice as studies so far have shown no difference in patient outcomes when OPD consultations were compared with tele-consultations. (Mental Health in the times of COVID-19 Pandemic: Guidance for General Medical and Specialized Healthcare Settings, 2020).

- **Ensuring Provision of Emergency Psychiatric Care**

Throughout the COVID-19 pandemic, patients suffering from psychiatric illnesses have faced difficulties with respect to maintain follow-ups, procurement of medication, and to have stable familial support. As a result, many patients suffering from chronic psychiatric illnesses have worsened. Those requiring emergency psychiatric care have also been affected due to logistical issues like lack of available infrastructure as most hospitals had been converted to cater to COVID-19 infected patients. Other factors such as lack of available public transport during nationwide lockdowns have made most families refrain from taking their patients to the hospital. However, maintaining open channels of patient outreach via local mental health professionals, and guiding family members in acquiring adequate help to bring their patients to functional psychiatric facilities would greatly help alleviate the distress of the individual as well as their family. (Mental Health in the times of COVID-19 Pandemic: Guidance for General Medical and Specialized Healthcare Settings, 2020).

- **Availability of Psychotropic Medication**

There have been difficulties in acquiring medication for patients in the COVID-19 imposed lockdown due to lack of transport, available government facilities that provide psychotropic medication (Mental Health in the times of COVID-19 Pandemic: Guidance for General Medical and Specialized Healthcare Settings, 2020). During this time, having central and state government policies for ensuring mental health services being treated as essential and liaising with district mental health professionals to provide community outreach and provision of essential medication is important.

Prevention of Mental Health Issues during COVID-19: Focus On Positive Mental Health

- **Health Education Strategies**

During times of such great uncertainty, it is prudent to educate the general population about the facts and dispel myths about COVID-19 through proper channels. Frequent and timely communication from central health agencies at national, international level would help in preventing psychological reactions like widespread panic, fear, hypervigilance about COVID-19 symptoms and ensure that the masses are well-educated about the illness, risk reduction and get proper information about social distancing strategies.

- **Maintaining Adequate Channels of Communication**

Ensuring that individuals in the society have the access to readily available mental health facilities helps in opening channels of communication 24x7 with the general public. Looking at the mental health implications of COVID-19, having a mental health crisis helpline would help mitigating the distress faced by the general population within the comfort and safety of their homes. There should also be regular communication and de-briefing between mental health teams at district, state, and national levels to make provision of mental health care more seamless.

- **Use of Electronic and Print Media to Educate The Masses on Psychosocial Aspects of COVID-19**

Just as there are information brochures, pamphlets, and videos on the signs and symptoms of COVID-19, it is important to educate the general population about the psychosocial aspects of a pandemic. This would help in not only validating their mental health concerns but also help them in being more vigilant toward such issues developing among their loved ones, especially in the vulnerable populations. Use of online forums and social media platforms would also be prudent since these platforms are more popular among the general public and more likely to be accessed often.

Providing Psychosocial Support in COVID-19 Pandemic

As discussed above, people have been experiencing a range of psychiatric manifestations from anxiety—panic symptoms, hypervigilance, and disturbed sleep and appetite. COVID-19 pandemic has changed conventional means for mental health professionals to reach out to patients, making OPD and IPD services seem relatively redundant and bringing to the forefront unconventional approaches for consultations and therapy. During this time, the appropriate use of technology can help cut across barriers to reach out to distressed individuals. A focus on the use of the video conferencing mediums and telephonic services for outreach helps maintain social distancing safety protocols while addressing the mental health needs of patients. Telemedicine thus is emerging as the new "norm" globally.

The psychosocial needs of the entire population cannot be generalized and specific groups have different needs that need different approaches to deal with them.

Protective Psychological Factors during COVID-19

- **Resilience**

Resilience has been defined as "the ability of adults in otherwise normal circumstances who are exposed to an isolated and potentially disruptive event, such as the

death of a close relation, or a violent or life-threatening situation, to maintain relatively stable, healthy levels of psychological and physical functioning" (Bonnano & Galea, 2007).

Resilience equips an individual with the ability of navigating through transient traumas in life and eventually recover from the incident. Resilient individuals have the ability of maintaining personal and professional responsibilities in the face of trauma and usually report minimal adverse psychological symptoms. Resilience among Indian population is known to be relatively high, which is a protective factor against the individual developing serious psychiatric illness.

Experience of Dealing with COVID-19 Pandemic at a National Centre For Excellence

Establishing a National Level Helpline for Psychosocial Support

Lessons learnt from previous biological disasters have demonstrated that uncertainties about the illness can lead to anxiety among individuals and can also lead to certain high-risk behavior in the form of increased substance abuse, not complying to rules and public advisories, and a burden on the pre-existing mental health infrastructure of the nation (Gaygisiz, et al. 2012; Jeong, et al. 2016).

The World Health Organization has defined psychosocial support intervention as "an intervention using primarily psychological or social methods for the substantial reduction of psychosocial distress" (Bordoloi & Khoja, 2006). Strategies such as counseling, exploring familial support, psychoeducational approaches and lastly, rehabilitative measures for provision of psychosocial support in disasters have been delineated by the WHO. After a biological disaster, it becomes more challenging for mental health professionals to deliver psychosocial first aid (PFA) to those in utmost need of it. COVID-19 confronts mental health professionals with unique challenges to provide psychosocial care to the general population.

With respect to the COVID-19 pandemic, the challenges in reaching out to the target population and providing mental health interventions are as novel as the virus itself. Some of the barriers in reaching out and providing psychosocial support to people in the time of this pandemic are:

- Direct contact is vital to offer any kind of support to the people in the community. With a high risk of transmission from direct contact and droplet transmission, scope for direct human interaction has become limited.
- To curtail the spread of the virus, global lockdown and social distancing protocols have been enforced. Suspected and confirmed cases face the added burden of stigma of suffering from a highly contagious illness and are forced to face their anxieties. This in itself is a source of mental health issues in this population.

- There is a dearth of trained mental health professionals to deal with the emerging mental health pandemic.
- Addressing basic needs such as shelter and food/clean water is vital with the possibility of mental health concerns being placed secondary, due to the rapid need to address the essential concerns first.

A novel initiative by the Ministry of Health and Family Welfare (MOHFW), Government of India to address the growing mental health needs of the population during COVID-19 is the National Helpline for Psychosocial Support and Mental Health Services. The helpline was initiated by the National Institute of Mental Health and Neurosciences (NIMHANS) at the behest of MOHFW and now involves several central and state mental health institutions and is also inclusive of state and district mental health programs throughout the country (Ravindran et al., 2020).

The Helpline was initiated as a pilot with NIMHANS at the helm of operations initially handling nationwide calls with nine dedicated numbers that were active 24 × 7. The helpline started on 28 March 2020, right after the pandemic struck and India went into a nationwide lockdown. During the initial days of establishing the helpline, there were difficulties with respect to shifting mental health care and provision of psychosocial support to tele-mental health services. With mental health professionals unable to meet the aggrieved individuals in person, gauging the severity of illness and understanding the level of psychosocial support needed was a particular challenge.

The helpline services were rendered with the help of over 600 volunteers who were mental health professionals, i.e., psychiatrists, psychologists, and psychiatric social workers from all over the country that took up the helpline services on a voluntary basis. The helpline volunteers were trained using material and resources in the form of SOPs developed by the psychosocial disaster management team at NIMHANS.

The calls received by the helpline varied during different phases of the pandemic. Though initially the calls were mostly about distressed stranded individuals grappling with the immediate aftereffects of the lockdown and anxieties about developing the COVID-19 infection, it eventually became increasingly specific to mental health concerns faced by people directly or indirectly affected by the pandemic. The calls were handled in a tier system at NIMHANS, where the calls were first routed to volunteers who, then would refer more challenging cases to senior mental health professionals for further discussion. The helpline has catered to the psychosocial needs of over 50,000 individuals all over the country since its inception. The calls pertaining to mental health issues took anywhere between 15 to 20 minutes for professionals to address the mental health concerns.

Callers Presented With Three Main Kinds of Complaints To The Helpline:

- **Calls about logistical issues pertaining to the lockdown**
- Callers wanting to know about bus and train schedules, those stranded in different areas of the country unable to reach home, those with failing businesses and looming economic losses, those who were concerned about the sudden change in their daily activities due to the lockdown.
- **Calls about COVID-19 pandemic and infection related queries**
- Individuals who were infected with the virus or had family who were infected, individuals who had gotten exposed to patients with COVID-19, recovered COVID-19 patients and individuals who had lost loved ones to the pandemic. This group also included calls from healthcare workers who were working on the frontlines and COVID-19 centers during the pandemic, often at great personal expense. In this regard, a separate line was dedicated to cater to only healthcare professionals' needs.
- **Calls about the mental health impact of the pandemic and callers needing psychosocial support**
- A majority of the calls in recent months have been focused on the psychosocial needs of the population, with many individuals reporting feelings of sadness, anxiousness, and feeling distressed by a lack of routine and being locked within their homes over the past few months. These individuals are allowed to ventilate and be reassured using the basics of psychosocial first aid on a telephonic basis. Those individuals with considerable distress are followed up by the team. Those requiring medico-legal interventions were helped by liaising with appropriate district level government authorities on priority basis (Figs. 16.1 and 16.2).

Dealing With New Onset Psychological Symptoms

The mental health consequences of the COVID-19 pandemic also include individuals who have newly developed psychological symptoms. Though most individuals do not go onto develop a syndromal psychiatric illness in the event of a disaster, it is important to recognize and address these symptoms promptly failing which the individual may deteriorate. Individuals who called the National COVID-19 Psychosocial Support Helpline with new onset psychological symptoms were triaged depending on the degree of severity of their symptoms. After a brief assessment of their complaints, individuals with new onset anxiety related to COVID-19 were reassured with facts about the illness from reliable sources such as the WHO, MOHFW documents. Furthermore, they were asked to restrict their duration of watching information related to COVID-19, and encouraged to engage their time in productive hobbies, develop new skills. They were also advised to try and follow a regular routine, taking out some time for physical exercise and relaxation exercises such as yoga, to keep

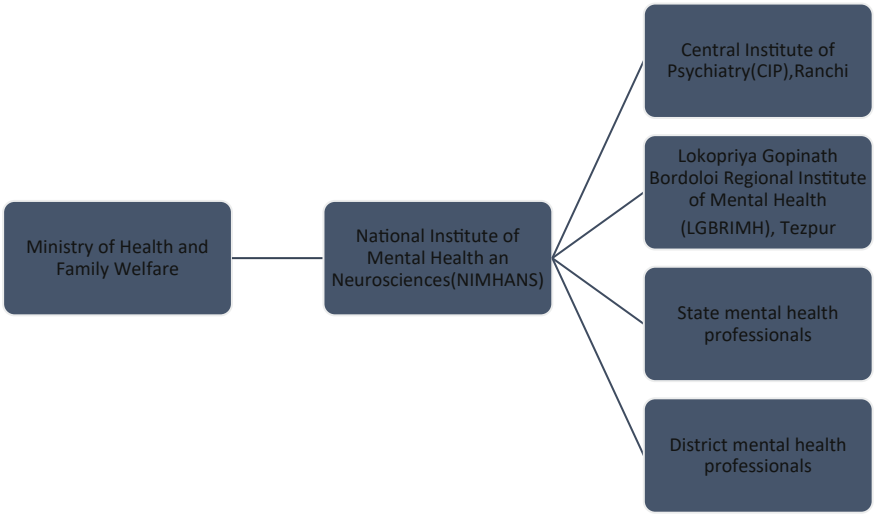

Fig. 16.1 Establishing the National COVID-19 psychosocial support helpline

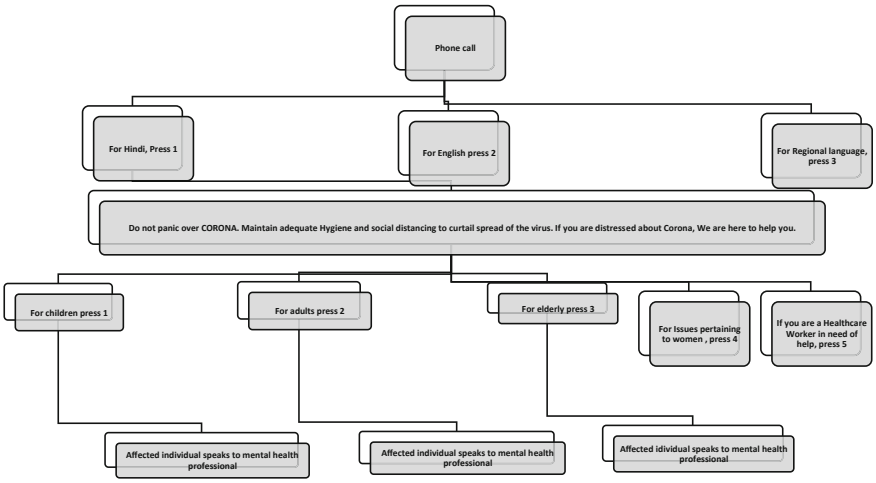

Fig. 16.2 Representation of the National COVID-19 psychosocial support IVRS helpline functioning

their mind refreshed and calm. Those requiring acute psychiatric attention, with more serious psychiatric concerns were immediately referred to the nearest psychiatric hospital. Whenever feasible, the individuals were connected with local doctors in their region for ease of access. In Bangalore, the emergency psychiatric services at NIMHANS remained functional throughout the lockdown period to address these concerns.

Maintaining Continuum of Care for Old Patients

- **Continuum of Care Project**

Non-compliance to treatment is closely related to relapse, worsening of symptoms, re-hospitalization and poorer outcomes in case of severe mental illnesses. Studies on factors affecting treatment adherence have shown that distance from the clinic or hospital also contributes to non-adherence, apart from patient and illness factors, doctor-patient relationship, and side effects of medications. In this context, when the nationwide lockdown was announced, in order to ensure that patients getting treatment from NIMHANS continue to receive care, the Continuum of Care (COC) project was initiated. The patients who were due for their regular follow-ups in the subsequent weeks were enlisted and an attempt was made to telephonically reach out to them. Whoever was reachable, their general and mental health condition was enquired about. If they were maintaining well on the previous dose of medications, they were suggested to continue the same medications. Further, they were directed to the nearest Primary Health Centre where the District Mental Health Program (DMHP) was running, to procure their medications. Patients who had relapsed or had new onset of symptoms were advised to enroll for Tele-After Care (TAC) service, wherein tele-consultation was done and medications adjusted as per the need. By this proactive measure, it was possible to reach out to thousands of patients and care-givers who were unable to come for their routine follow-up and the best feasible care possible via telephonic reach out was done.

In Karnataka, due to the robust DMHP program running in every district it was possible to guide the patients to their nearest center for procurement of medications. Within the Bengaluru city, 11 urban health centers were identified and psychotropic medications were made available in them to improve the accessibility for patients to procure medicines.

- **BBMP Initiative**

The Bruhat Bengaluru Mahanagara Palike (BBMP) is the administrative body responsible for civic amenities of the Greater Bangalore metropolitan area, which has a population of 6.8 million in an area of 741 km^2. BBMP is restructured into five smaller palikes (Central, West, East, South, and North BMP) functioning under Greater Bengaluru Authority. The DMHP of BBMP covers these areas. The DMHP team along with NIMHANS were provided with duty by the Government of Karnataka, to address the psychological issues of the general public during the pandemic.

NIMHANS in liaison with the DMHP psychiatrists catered to two groups of people:

1. Quarantined international air travelers and
2. Migrant population placed at camps by the BBMP.

Quarantined International Air Travelers

Quarantine involves restriction of movement or separation from the rest of the population, of healthy persons who may have been exposed to the virus, with an objective of monitoring and early detection of cases. Quarantine of international travelers comes under the legal framework of International Health Regulations (2005) which emphasis on dignity, respect, and personal freedom of quarantined individuals. The World Health Organization (WHO) issued guidelines for quarantine to control the spread of COVID-19 which also emphasizes the psychosocial support to be provided for these individuals. As per the guidelines, Government of India made it mandatory for all the international air travelers to undergo 14 days of quarantine. In the city of Bengaluru, all the high-risk individuals (aged above 60, individuals with comorbidities such as diabetes and hypertension) were placed on institutional quarantine while other travelers were instructed for home quarantine.

As the quarantined population can feel anxiety and depressive symptoms, a multidisciplinary team consisting of Psychiatrists, Clinical Psychologists, and Psychiatric Social Work from NIMHANS, contacted the quarantined individuals to screen for psychological distress and to provide brief interventions over phone calls.

A questionnaire comprising four questions to screen for anxiety, depression, sleep disturbance, and suicidal thoughts was developed for this purpose. The stress level on a scale of 0 to 100 was rated as per the individual responses. Psychosocial support in the form of providing tips to keep oneself occupied during quarantine, sleep hygiene and emphasis on the need for quarantine were provided to each one individually. A total of 1602 individuals were reached out of which 58 of them needed referral to a higher center for further psychological and pharmacological interventions. The most common symptom reported was anxiety, which is about 13.7%. The major themes were related to illness such as anxiety about developing COVID-19 and anxiety regarding the COVID test results. Many of them also reported of the stigma being faced by them due to the hostile neighborhood, even after them completing 14 days of home quarantine. Individuals with adequate social support, secure jobs, and busier schedules of work from home reported almost nil distress and coped better with the loneliness during the quarantine period.

Migrant Workers

As per the national economic survey of 2017, annually there are about 9 million migrants who displace internally, both inter- and intra-state for the purpose of employment. Most of them are seasonal migrants who move to urban cities for jobs in the informal sector such as laborer's at construction sites, workers in hotels, and other microindustries. These people generally go back to their hometowns during harvest period. Therefore, they do not have a permanent place to stay when working in the

cities. They mostly dwell in the slum areas and around their sites of work in unstructured tents and temporary shelters. Given this, they can usually have poor quality of life with poor access to clean water, sanitation, and shelter.

In this background, the pandemic coupled with lockdown added to the distress of this population. With loss of income and overcrowded shelters, most of them wanted to go back to their hometown. However, the sudden announcement of nationwide lockdown led to chaos with migrant workers flocking the railway stations and bus stands with desperation to get back home. Therefore, the respective state governments had to set up camps to provide food and shelter for them.

The BBMP formed mobile health units to screen the migrant workers put up at such temporary camps in the city of Bengaluru and also to identify stranded migrant workers and mobilize them to reach such camps. A team from NIMHANS composed of Psychiatrists, Clinical Psychologists, and Psychiatric Social Workers were part of these mobile health units to provide psychosocial support to the migrant workers in these camps. Over 5000 such workers from all over India, staying in 140 different camps were covered. The most common concerns among them were uncertainty of their current situation, loss of income, worries about the health of their family members back home, and eagerness to meet them but unable to travel. Their concerns were listened to and validated. A group-based intervention by addressing all their concerns and re-emphasizing the need for lockdown and information about the COVID-19 illness and means of spread were provided to them. At most places, such brief interventions provided relief among them. The wish to go back home to their family prevailed across all the camps, which is understandable. The measures being taken by the government to arrange for their travel were explained to them.

Tele-psychotherapy

Tele-therapy can be in conjunction with tele-consultation when the psychiatrist assesses and prescribes medications or it can be a separate scheduled session. NIMHANS in collaboration with Indian Psychiatric Society and Telemedicine Society of India released the "Telepsychiatry operational guidelines 2020." This guideline was made in compliance with the "Telemedicine Practice guidelines" released by The Ministry of Health and Family Welfare, New Delhi and NITI Aayog in March 2020 and Mental Health Care Act, 2017. It was advised to follow similar guidelines while conducting tele-psychotherapy sessions.

For patients enrolled in the Tele-After Care program who needed psychotherapy, along with consultations, therapies were carried out during the lockdown period. The other scheduled clients who were not able to attend in-person sessions were also offered tele-psychotherapy. The development of operational guidelines and enrolment of many patients for tele-services are in favor of long-term tele-services utilization and sustainability, even after the end of the pandemic period.

Developing Information, Education, and Communication Material Related to COVID-19

Information, education, and communication materials, popularly known as IEC materials, usually consist of brochures, pamphlets, posters, audio, and/or video clips. At the beginning of the lockdown, the Ministry of Health and Family Welfare, Government of India, entrusted NIMHANS to create IEC materials on psychosocial and mental health issues during COVID-19. In this regard, faculties from different behavioral sciences departments of the NIMHANS (such as Department of Mental Health Education, Psychiatric Social Work, Psychiatry, Psychiatric Nursing and Clinical Psychology) were nominated to form a committee to develop the IEC materials. The committee members, with the help of other experts within the institute with particular domain expertise, developed several posters, flyers, brochures, and videos (in English as well as in Hindi), covering the several aspects and different populations in the times of COVID-19 (Cherian et al., 2020). Some of the topics covered were,

- Mental health of elderly during COVID-19
- Mental health of children during COVID-19
- Social stigma associated with COVID-19
- Psychosocial support for migrant workers—Promoting Mental Health
- Dealing with stress related to postponement of exams in view of COVID-19
- Promoting mental well-being of police personnel during COVID-19
- Quitting tobacco at the time of COVID-19
- Psychosocial support to persons with disabilities during COVID-19
- How pregnant women can handle COVID-19 related anxiety
- How postpartum women can handle COVID-19 related emotional distress
- Psychosocial support for women suffering from domestic violence during COVID-19
- Handling parental stress during COVID-19
- Stress management for frontline health worker
- Yoga and stress management.

These IEC materials were distributed among the concerned population as well as made available on the Web site of the Ministry of Health and Family Welfare. It was also used in webinars conducted to address some of the target groups.

Challenges Faced By Mental Health Professionals during The COVID-19 Pandemic

The COVID-19 pandemic was challenging in many unique ways for professionals from different walks of life. With respect to provision of mental health, some of the common issues faced by mental health professionals were the accessibility and outreach difficulties faced due to the imposition of lockdowns and strict social

distancing protocols. As most of the practice in mental health relies on human contact, and provision of a safe environment to enable individuals to share their mental health concerns, continuation of a normal OPD and IPD practice was difficult.

Shifting of most mental health services to online and tele-mental health platforms came with its own unique set of challenges, difficulty in accessing patients with ease, call-drops, and connectivity issues.

Psychiatrists were also roped into the general pool of the doctors providing acute medical care for COVID-19 patients in hospitals as a result of which they were not able to provide mental health care to their usual patients as before.

Directions: Adapting to the New Normal

The past few months have seen unprecedented changes in the way mental health practitioners work and execute their services. Strict social distancing protocols that are here to stay have made tele-mental health practices come to the forefront of fighting the psychological implications of this pandemic. It is important to adapt to this new normal and be better prepared for the mental health consequences during different phases of COVID-19 pandemic. The initiatives undertaken at NIMHANS thus far were baby steps in this direction. We hope that these initiatives would help in laying the roadmap to better prepare for such pandemics in the future.

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Chapter 17
Floating Laborers of India and Their Welfare: A Situation Analysis

Aleena Maria Sunny

Abstract Migration is a pronounced trend that has massively contributed to the industrialization process across the world. This vast labor pool that floated from a less-developed place to a more-developed place for better livelihood is our population of interest. This chapter examines the health and well-being of the floating laborer community of India, who are involved in some form of development projects both within the nation. It identifies the role of socioeconomic and political correlates in setting the context of migration in the country. Aspects of health including both physical and mental health with special emphasis on occupational hazards are explored. The general status of older adults, women, and children is studied to further expand on how needs such as housing, schooling, ration, and pediatric, maternity and geriatric healthcare needs are met in their migrated land. Benefits and risk factors of migrants, as well as topics such as inequity, discrimination, resources availability, and unemployment are analyzed. A dedicated session is set that observes the impact of COVID-19 pandemic on the overall health and well-being of laborer community and investigates the exploitation they are subjected to from their host companies/agencies. The chapter is exclusively tailored to learn about the overall health and wellbeing of the migrant community, and to identify the key factors involved in determining their well-being. The discussion concludes with a few recommendations that involve the collaborative effort of all stakeholders involved in migration.

Keywords COVID-19 · Health · Migration · Migrant laborers · Well-being

Introduction

The contribution of migration to a country's development in terms of economic advancement, modernization and urban diversity is a matter of appreciation. It has reached to a point where rural–urban migration is inevitable for better economic and social progress, which is why promotion of migration is actively taking place in the

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_17

country. About two in ten people in India are internal migrants in terms of crossing the borders of districts or states (Abbas & Varma, 2014). Unemployment, natural calamities, attraction toward city life, provision for better education and healthcare facilities, marriage are the common push factors for migration. While female dominated migration is mostly the by-product of marriage, inter-state male dominated migration is seen as a result of un/under employment. Depending on the nature and duration of job availability, migration could be permanent, temporary, or seasonal in nature, with each of these having markedly different job market experience: prominent sub-sectors include construction, textile, restaurants, domestic labor, agriculture, and mining (Abbas & Varma, 2014).

However, the plight of migrant laborers takes an unfavorable turn at their work destination specifically at sending and receiving ends have strikingly different culture and language; challenges such as "restricted access to basic needs, lack of identity, social entitlements and housing, and socio-political exclusion" (Akoijam et al., 2017) are apparent. The majority of such laborers migrating out of their aspiration for better livelihood find temporary casual labor in informal settings that offer only poor wages (Akoijam et al., 2017). The very unstable nature of the jobs (Srivastava, 2011), along with low educational level, low social class affiliation, and poor economic conditions (Kusuma et al., 2014) further accentuates their vulnerability. Despite being identified as an important contributor to societal development, they had to conduct their lives out of poorly equipped houses, unhygienic environments, and deprived daily amenities. This is the multifaceted nature of their vulnerability regardless of the duration and place of stay in any city as migrant laborer. They remain affected in almost all arenas of day-to-day life including livelihood insecurity, access to state provided services, hazardous work nature, and alienation in a new environment. Inopportunely, attention paid to the needs of India's internal migrants by the government is limited and the present legislative measures for their welfare are hardly exercised and regulated.

The present chapter is a platform for discussion about the floating laborers of India who migrate from a less-developed to a more-advanced place of the country in the hope of building a better future for one selves and their families. To set the background of discussion, the chapter defines migration within Indian contexts and explores the sociodemographic variables of unskilled or semi-skilled migrant labors. It further dwells into tapping the common causes for migration. Attempts to gain an elaborate understanding about the plight of migrant laborers are made by exploring their living conditions, conditions at workplace, physical and mental health, status of education of their children and overall welfare of migrant families both with and away from the laborer. The topic of exploitation is separately discussed to elucidate the political and economic advantage gained out the same. An exclusive session on the impact of COVID-19 on the migrant laborer is provided followed by assessing the possible factors important for health and well-being of the community. The chapter also provides an overview into the existing legislative provisions and schemes enforced in the country.

Migration in Indian Terms

Migration has become an important phenomenon from economic, political, and public health points of view (Bhagat, 2008). Technically, labor migration could take form as a permanent, temporary, or a seasonal affair. As is understood from previous study findings, hardly a few proportions of migrant laborers are able to permanently move out of their place of origin to the destination location. Hence, those who lack such resources to afford for a permanent migration could be the one with insecure jobs at the destination and may have their family base at their place of origin. They are generally found to move back and forth depending upon the availability of jobs. Another subset under this could be the seasonal laborers who may have several destination locations depending upon the demand of the labor season. They are the one who scholars characterize to have "one permanent residence and changing locations of economic activity" (Abbas & Varma, 2014). Women who migrate primarily because of marriage also enter into the labor market either as domestic help or into textile subsectors.

The National Sample Survey 2007–08 has estimated the migrant population within the country to be 326 million (29% of the country's population). The survey further indicated the increase in the urban population of which 21% is contributed by rural–urban migration. As per the Economic Survey of India the inter-state migrant population between 2011 to 16 to be nearly 9 million annually (Government of India, 2018). Census 2011 identified "Uttar Pradesh and Bihar to be the biggest source states while Delhi, Maharashtra, Gujarat, Andhra Pradesh, Tamil Nadu and Kerala to be the major destination states"(Census Commissioner, 2011). Interestingly, the members of scheduled tribe community who are supposedly protected by the constitution for their socioeconomic underprivileged make the maximum representation in the internal migration (Abbas & Varma, 2014). Over 30% of these laborers indulge in precarious manual labor in unorganized market (Srivastava, 2011). An analysis based on Census of India, 2001 data indicated that, the poorer states contributed significantly to the migration flows (Bhagat & Mohanty, 2009).

Common Causes for Migration

Oftentimes, the trend of migration currently seen in Indian is connected to imagining the migration of a household or a community out of their poverty. In fact, it is true that migration does deal with addressing the issues of poverty, but the underlying causal factor of migration is the labor market inequality particularly in terms of accessibility. Communities who have been in a disadvantageous position for generations are structured to pose high barriers to their access to better segments of work" (Jain & Sharma, 2019). Inequity in wage differentials also stems from the very reason of social order. Coupled with this is the desire of the rural community for economic upliftment and urban endowments such as education and health care that

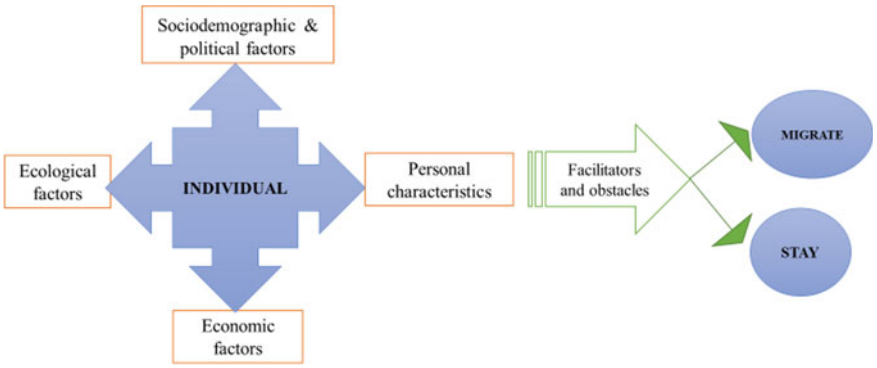

Fig. 17.1 Reasons for migration among unskilled labourers. *Source* Adapted from Islam & Shamsuddoha (2017). *Culture, adaptation and resilience. Essays on climate change Regime in South Asia*

lead to rural–urban migration. Basing on the World Bank Report, in 2010, 33.8% of rural India lives below the national rural poverty line primarily due to agrarian distress (seasonal harvest, dependence of rain and precipitation, declining market price), farmer suicide and disabling level of rural unemployment that, rural–urban gap is the most prominent reason for migration (Abbas & Varma, 2014).

As depicted in figure, the factors leading to migration could be from different directions and can be divided into four, viz. ecological factors, sociodemographic and political factors, economic factors, and personal characteristics (Fig. 17.1).

The figure represents the decision-making process for migration by an unskilled laborer and also is an apt way to analyze the possible reasons for the decision to migrate. For the ease of understanding, let us explore the general factors that come under each of these subheadings. Age, gender, marital status, languages known, physical and mental health conditions, presence/absence of disabilities as well as personality characteristics such as self-esteem, confidence, and coping skills would belong to personal characteristics that influence migration. Sociodemographic factors could be education, present and past job experiences, place of origin, role in the family, social status, and population density; political factors could be discrimination, insecurity, support, and legal provisions given by ruling party at both center and state. Monthly family income and expenditure, employment opportunism, current wage, and career prospects are the economic factors. Availability and utilization of natural resources, incidents of natural disasters or man-made calamities, exposure to environmental hazards would add up to ecological factors. Legal framework of both native and migrating state in particular and country in general, job availability, wages and living arrangements, recruitment bodies and strength of social network could be both intervening as well as facilitating the decision. Therefore, a decision to migrate arises out of multiple factors and the importance to each of these factors would vary from individual to individual.

Plight of Migrant Laborers

Migrant laborers live amidst several risk factors while they thrive for better economic upliftment. These risk factors are spread across all dimensions of their day-to-day being, affecting not just the individual, but his/her family well-being, their health, and the education of their next generation. Hence, it is important to direct our discussion toward each of these aspects in detail.

(i) **Living Conditions of the Migrants**

Recent research conducted by Akoijam et al. (2017) in 13 cities of India provides real insight into the housing conditions of migrant laborers. 43.4% of the migrant household were in non-notified slums while 11.7% were in notified slums. The sudden eviction without proper rehabilitation arrangements by the government for any developmental projects is a real crisis for such slum dwelling migrants (Abbas & Varma, 2014). Housing set up in unidentifiable locations, houses taken on rent from the localities, temporary shelter homes provided by the employer or erected by the workers themselves in or near to their worksite (e.g., construction sites or restaurants) were also found. A minority of the migrants who could make it to such locations due to high rent and unaffordable cost of living were found to live in open spaces like footpaths, bus stands, or market places. Over 70% lived in single-room shelters without separate kitchens and rely on wood, coal or cow dung (41%), kerosene (41%), and gas (28%) for their cooking. In conclusion, the general habitation facility of the laborers was that of poorly built temporary and crowded tenements mostly in unhygienic environments. Their condition continues to be poor despite the Contract Labour Act of India that entrusts the employer to provide livable accommodation to their employees (Government of India, 1996).

The study further found public taps were found to be the most common source of potable water followed by piped water and tanker supply. As is known that the water supply is intermittent, more so in summers when waiting may go up to 4 days (Y. S. Kusuma et al., 2014). Migrants also fetch water from nearby ponds or communities well to meet their requirement for water for drinking, cooking, cleaning, and sanitation. Nearly 40% of the household had absolutely no sanitation facility and used open space for defecation, while the remaining population relied on either community toilets or private toilets. The direct link between quality of sanitation to quality of health and environment requires no elaboration and it contributes to poor quality of community life as well. Only less than 20% of the sample households were not electrified. In another study Gupta et al (2009) found that the proportions of slums without electricity had dropped from 8% in 2002 to 4% in 2009, indicating that the status of migrants would be far less than the nation's general standard.

In addition, the study found that more than 75% of the household did not possess ration cards and only 15% of the people who possess ration cards were allotted below poverty line so as to be eligible to avail provisions at subsidized prices. Many of the migrant laborers from rural India would have their primary identity undocumented from their parents state itself due to their social backwardness itself. Such migrants

are largely unaware of the procedure to apply for a new ration card at their new destination, or in other cases, are unsure of how long their stay at destination would be. Hence, they remain improvised for years without being able to access secure citizenship and its benefits. This would be a hurdle in accessing health and education for children, as well as for overall security of their families, further passing down poverty to their next generation. Even the data on voter identification cards were limited, 56.6% migrants among the available data did not possess the card. In a similar study on seasonal migrants, Sharma et al (2011) found that only 22% of them neither had voter ID nor have their names enrolled in the voters list, because of which they are unable to make demand for any political and legal services.

Another repercussion of not having identity documentation is the issue with opening bank accounts. As a result of lacking a safe place to keep the money, migrants may delay their wage settlement till the time they leave for home, making them susceptible to cheating and less-payment. Others who rely on some shopkeepers or bus operators who travel to their homeland end up paying a considerable amount of money as their service charge. Those laborers who travel with the bulk of money to their home location are reported to get robbed from the trains.

(ii) **Education of Children**

As migration brings financial security, possibility of better child schooling and child health, as well as decrease in child labor is naturally expected (Antman, 2013). Before generalizing this to India, it is important to be aware that, there are two different trends here: (a) children who migrate with their parents and (b) children who are left behind. While left-behind children have higher chances of exercising the aforementioned benefits of better schooling and health, migrating children enjoy the presence of their parents. Again, education of left-behind and accompanying children of migrant laborers is as volatile as the livelihood of their families. The International Labour Organization (2010) estimated four to six million children in India migrates seasonally every year. Children who accompany their parents move with their parents from one job location to another and the question of schooling does not even stand. While children who are left behind with their mothers or grandparents at the native land would be enrolled in schools, but may not have access to education or drop-out sooner or later (Pal, 2014). The trend about the movement of children with their parents generally depends on the nature of job, for instance, in case where the father is involved in construction sites, the pattern of migration is such that the women and children get associated with the migration of the father (Pandit et al., 2011). Varied medium of instruction, barriers in getting admitted to various schools depending upon the time of migration coupled with lack of awareness further deteriorate the situation.

An interesting study conducted in the construction sites of Utter Pradesh and Bihar found that school accessibility and gender gap improves for left behind children in primary schools while accompanying children remain out-of-school/dropped out and show more vulnerability to child labor (Roy et al., 2015). Moreover, children spend their childhood in unfavourable and insecure worksites deprived of play,

leisure and schooling" (Mosse et al., 2002). Coffey (2013) suggested a causal relationship between children's migration and poor educational outcomes and ascribed it to reasons such as a break in the habit of going to school going, losing touch with the previously learnt lessons, with peers and teachers. The possibility of reverse causality was also discussed in the paper where some children were taken with their parents probably due to their poor performance in schools.

Research studies have proved similar conclusions about the poor academic performance of left-behind children as well. Antman (2012) emphasized on the negative impact that physical absence of an authority figure (father) on school readiness of the child. However, the mixed evidence proves the point that parental migration has a huge contribution to the educational attainment and career prospect of the children.

(iii) **Health**

Improved health and better accessibility to health care the positive outcomes of improved socioeconomic status brought in by migration. However, the migrants who are young and fit when they embark for their migration journey are susceptible for a wide array of health disparities. In fact, their "health vulnerabilities can occur throughout the migration cycle" (UN Migration, 2020). The detrimental effect can be on the physical and mental health of the laborer and could be viewed as occupational hazard and those due to poor working conditions.

Occupational Hazards and Ergonomic Health Conditions

Globally, the adverse occupational risks and exposure leading to poor health outcomes and high health risks are maximum among unskilled migrant laborers than any other workforce. Many a time, these laborers who work in unfavorable working conditions for less payment and for long working durations are victims of "human rights violation, abuse, human trafficking and violence" (Moyce & Schenker, 2018). As interestingly defined by Quandt et al. (Quandt, Arcury-Quandt, et al., 2013), their jobs are 3-D in nature, i.e., dirty, dangerous, and demanding, and are made to work without providing adequate training or safeguarding equipment. Recent studies have shown a notable increase in the proportion of occupational hazards among immigrant laborers in comparison with the native laborers (Flynn, 2014), indicating how such risk-involved works are now given to immigrant laborers. Depending upon the work sector, the nature of health disparities varies.

Due to Environmental Exposure

In most of the cases, occupational health hazards could develop out of risky environmental exposures or poor working conditions. Workers in sectors such as construction, mining, textiles, food production, fishing, or agriculture will have to deal

with harsh and extreme temperature either due to natural sun exposure or artificial heat/cold exposure. "Lightning strikes, sun exposure, health-related illness and death (Quandt, Kucera, et al., 2013), injury related to frequent cold/ice contact" (Gracia & Castro, 2017). Respiratory and skin infection as well as reproductive disorders as well as susceptibility to genotoxicity are the outcomes of exposure to pesticides and are commonly found among migrants involved in agriculture (García-García et al., 2016; Perumalla Venkata et al., 2017). Cancer, dermatitis, and respiratory diseases are common due to chemical exposures and are prominent among workers in dry cleaning, beauty salons, construction sites, and industries (Hsieh et al., 2016).

Due to Poor Work Environment

Occupational hazards due to poor working conditions are also many: often linked to the frequent exposure to harmful physical and chemical agents at the construction sites, migrant laborers are studied to be especially vulnerable to injuries, respiratory, and skin conditions, musculoskeletal disorders as well as gastrointestinal infection (Tiwary & Gangopadhyay, 2011); a cross-sectional study conducted among unskilled and semi-skilled construction workers further sustained these findings (Nirmala & Prasad, 2019). Muscle strain, muscular discomfort and injury potentially affect neck to foot due to repetitive and fast-paced movement, long standing and heavy lifting are reported among hotel staff (Hsieh et al., 2016). Accidents and death due to fall, machinery malfunctioning are commonplace incidents in many work setting particularly construction sites, forestry, and fishing sectors (Marsh & Fosbroke, 2015); however, injuries can be ascribed to low level of occupational health services provided at the workplace (Yu et al., 2002). Air-borne diseases resulting from working in poorly ventilated dusky, smokey and fume-filled spaces are common among workers in construction sites and textile industries (London School of Hygiene & Tropical Medicine, 2018). Immigrant workers, especially from textile industries and farming, report about the pressure to work without breaks for long hours, owing to stress and humiliation; fear of job loss and pay cut further add to the psychological health outcomes (Marín et al., 2009).

Due to Poor Living Conditions

Malaria and similar mosquito induced illness are another commonly reported health condition among the migrant community; a study based out of Gujarat substantiated this finding among all age groups and particularly among children under age 14 (Srivastava et al., 2011). Similarly, high prevalence of cardiovascular diseases and diabetes and its positive correlation with duration of stay is found (Ebrahim et al., 2010). Studies showing high prevalence of hypertension is also present in a study of Delhi-settled migrants (Kusuma et al., 2009). Health issues related to contaminated

water and unhygienic environment and poor sanitation facilities at the place of stay also leads to poor health outcomes.

Mental Health

> Usually, migration does not bring improved social well-being; rather, it often results in…squalid living conditions, exposing migrants to social stress and increased risk of mental disorders because of the absence of supportive social networks (World Health Organization, 2001, p. 13).

A plenty of recent research aligns with this opinion of WHO in India. Apart from the unfavorability stemming out of physical and logistical reasons, challenges such as living in isolation in an unknown land, culture, language and customs, and living away from their own families and culture even during familial occasions and festivities can invoke a sense of up rootedness and alienation in such individuals (Bhugra & Becker, 2005). Yadav (2019) identified the source of distress in migrant laborers to be rooted in cultural bereavement and the apathy of the legal system of the host culture that fails to protect their rights.

Stress associated with migration to a new location and difficulty to cope with the environment makes the migrants prone to various illnesses. Job insecurity, poor living conditions, meagre wage, exploitation by the employer, and inability to meet familial requirements curtails their psychological health. Unhealthy sexual practices and alcoholism are the widely reported conditions among the population (Nitika et al., 2014). Added to this is the inability to access the available healthcare service either due to lack of familiarity or due to lack of proper documentation to avail such government service. As a result of this, they consult private hospitals or unqualified medical practitioners to spend their earnings for health services (Babu et al., 2010). Post-traumatic stress disorders are also reported among them which is stemming out of lack of social status, difficult acculturation process, and separation from the family (Mucci et al., 2020). High proneness of migrants to HIV/AIDS and other sexually transmitted diseases are often reported (Nitika et al., 2014) primarily due to their risk taking behavior arising from lack of awareness. Reasons for such increased risk of HIV could be "low condom usage, multiple partners, frequent visit to sex workers, cheaper sex, pre and extramarital relationships, use of pornographic material (Shankar et al., 2017) and use of drug and alcohol before sexual act" (Rao et al., 2013; Verma et al., 2010).

Families of Migrants

(i) Spouse and Children

Migration has proven to have health risk on children in the migrated household. Stephenson et al. (2002) have identified the link between migration and child mortality in migrated families using the data of National Family Health Survey. As discussed, migrant laborers due to their inaccessibility to deserving governmental services are unable to make use of ration facilities and healthcare services leading to undernutrition and low immunization coverage (Choudhary & Parthasarathy, 2009). In a cross-sectional survey conducted among rural–urban migrant mothers in Delhi, Kusuma et al. (2010) determined immunization coverage based on factors including use of healthcare service, occupation, and family income as well as visits by health workers to find low immunization coverage among migrants (60%) and lowest among recently migrated population (39.7%).

Prenatal and delivery care service is another distressing issue among the population, which is studied to be poorly delivered. A Punjab-based study among women construction workers, Abrol et al. (2008) could estimate only 10.5% of pregnant mothers to receive more than three antenatal check-up services. It was further found that a vast majority of them had their childbirth at home and even a lesser minority had a traditional midwife to attend their delivery. Unfortunately, a recent study based on the National Family Health Surveys showed the decline in the percentage of safe child delivery as compared to the previous decade among migrant women (Singh et al., 2012).

(ii) Left-behind Parents

The impact of migration on left behind parents is comparatively untapped area of study. Rapid aging of the parents that lead to the increased reliance on children during old age marks the relevance of this issue. Of course, migration does add to the family income and therefore provides a leeway in access to better healthcare facilities to their ailing parents. Non-migrant parents also tend to obtain financial assistance from their children as well. But migration constraints their travel and physical availability. Oftentimes, parents, particularly fathers, continue to take responsibility for their children's left-behind family (wife and children) along with earning income for the family. Only very little is known and researched about the left-behind non-migrant elderly in India.

Exploitation

Generally, migration flows through an intricate network wherein the chief contractor at the destination gets in touch with a middleman for needed recruitment. The middlemen who is already part of a string finally reaches the lowest in the chain who would be a senior migrant laborer of the native locality and who aggregates

the labor force as per the requirement. Hence the contract thus reached would be an informal one without any enforceable understanding on the wages, leaves, or any other provision at work. The migrant laborers, who are completely dependent upon the middlemen, may get easily manipulated and have no provision to approach for any legal aid as they never get to know the primary employer. The exploitation takes shape is various nature such as "manipulation in wage rates and work records, non-payment or withholding of wages, long work house, abysmal working and abuse" (Abbas & Varma, 2014). Migrants are also understood to be susceptible to exploitation by police in the form of bribes and violence in return of their poor legal grounds in the destination place. Workplace abuse takes multiple forms in case of such laborers: ranging from neglect of the manager, abuse due to the mere failure in implementing safety measures, verbal abuse and humiliation by the employer and his allies, outright physical torture and harassment (Grzywacz et al., 2007), withholding of food and water, to physical, verbal, and sexual abuse (Figueiredo et al., 2018) can be regarded as workplace abuse. Women laborers working as domestic help or in construction sites are reported to undergo sexual exploitation owing to the job offers provided. Human trafficking and forced labor are also dramatically increasing and the majority are women and children. However, human trafficking for forced labor is a related topic and is beyond the scope of discussion of this chapter.

Migrant Laborers of India During COVID-19 Pandemic

The unpresidential arrival of COVID 19 pandemic has left the whole world in great distress. India, being topmost in the list of severely affected economies in the world, had the impact torrentially damaging the garment, construction, agriculture, and such similar sectors that employed unskilled/semi-skilled laborers (Londhe, 2020). The 40 million migrant workers of the country who are involved in low-paying precarious jobs in sectors such as "construction, hospitality, textile, manufacturing, transportation, services and domestic work" lost their livelihood during the months-long lockdown declared in the country (Pandey, 2020). Issues such as unemployment as well as lack of an alternate source of employment, separation from the family as well as lack of transportation facilities to reach back home, and starvation are the most unfortunate social conditions this community continues to go through even today. Over the span of a few weeks, a series of events involving migrant laborers that took place across the country threw light into the plight of poor migrant laborers in the country; the huge population size of the community led to their mismanagement during the lockdown. Since the time rumors about restarting train services began, migrant laborers staying in vicinities gathered together in unison to demand the authorities for their return to home. These gatherings that defied the norms of social distancing spread like a trend among migrants in different parts of the country and had led to protest and mishandling. The country witnessed a huge spur of reverse migration through different modes of transportation; a minority got lucky enough to avail special government-organized trains and buses. However, for almost a month

prior to these government initiatives were put in place, the only ways of transportations were those of cycling and walking. There were a large set of migrant laborers and their family, who out of sheer helplessness had walked back home putting their lives in great risk. Terrible sites of their return journeys that include starving children, minor or major injuries, heat stroke, starvation, and even deaths still continue to greatly disturb the country.

Psychological manifestations of the pandemic were identified to be depression, anxiety, panic disorder, and other psychosomatic conditions (Qiu et al., 2020; Tandon, 2020) are found to be arising out of COVID-related concerns, lack of psychosocial support, and heavy economic load (Government of India, 2020). Suicidal tendencies, serious nervous breakdown, and serious psychotic disorders are reported among the migrant workers (Shastri, 2020). Choudhari (2020) viewed the mental health condition of the Indian migrant laborers from occupational health perspective to identify the following predispositions: susceptibility for COVID-19, pre-existing mental health issues, social exclusion, per-traumatic psychological distress during the pandemic, inaccessibility to psychiatric care, huge economic load, acute and chronic effect of the SARS-CoV2 virus on the nervous system, adverse occupational health and poverty were listed.

Those laborers who stayed back in their migrated lands also had stories of exploitation and mishandling to share; these coupled with unemployment and starvation includes inaccessibility to healthcare facilities and legal rights, lack of COVID-related safety measures, congested living spaces that could lead to faster spread of the disease, limitation in number of masks and sanitizers available for their use. As the country prepares to restart its economy, the initial shortage of laborers may result in an over-exploitation of those laborers who stayed back as well as creation of a new dynamic in the job market that would enhance intra-state migration. Those migrants who are involved in key good manufacturing/processing have been at work during the wave of the pandemic in a high-risk environment in terms of vulnerabilities toward COVID-19. Many scholarly articles already predicted the exponential exploitation the laborers would face in their return to job market. Minimum wage, bare minimum necessity provisions of accommodation and stay, unsafe working environment, high health risk and xenophobia would be toppers in the list of exploitation that is awaiting the community.

Health and Well-Being of Migrant Laborers

The Sustainable Development Goals identify health and migration are two separate complex topics that together act as a catalyst for sustainable development itself. Taking into account the huge contribution of migration to a nation's development, the health and well-being of the principle contributors, who are the migrant laborers themselves, should be given paramount importance. Ironically, their health concerns are hardly attended to and their well-being fails to become any policy. Hsieh et al

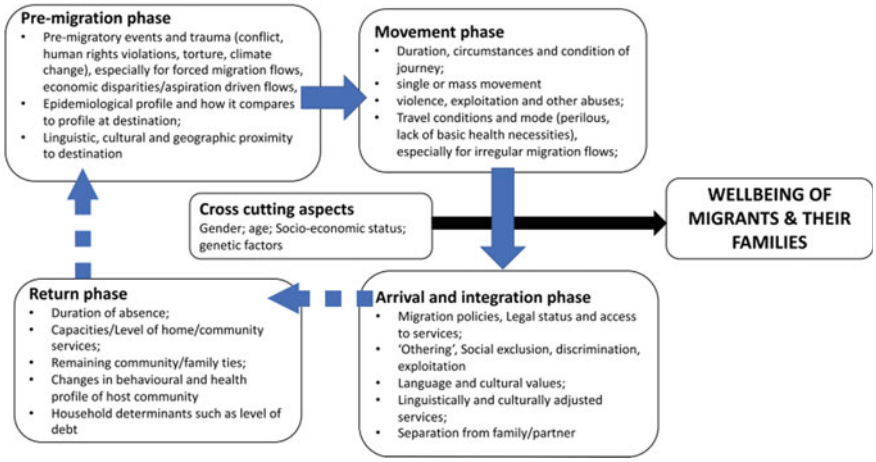

Fig. 17.2 Factors Influencing Health and Well-Being of Migrant Laborers. *Source* Hsieh et al. (2016). Work Conditions and Health and Well-Being of Latina Hotel Housekeepers. *Journal of Immigrant and Minority Health*, *18*(3), 568–581. https://doi.org/10.1007/s10903-015-0224-y

(2016) adopted a life-course approach in explaining the factors that influence health and well-being (Fig. 17.2).

Migration is depicted as a cyclic process with four stops. Pre-migration phase involves the decision-making process that is done through analysis of several factors that were elaborately discussed in session 4. Movement phase is a short space between the native land and migrated lands which would be influenced by factors such as journey conditions, social conditions like violence and exploitation as well as the trend in migration flow. During the arrival and integration phase factors such as language and cultural values, social inclusion, acculturation, migration policies and legal services, access to basic amenities and care service, as well as separation from family would be involved. This is also the deciding phase of the process where health and well-being could be assessed. The return phase would be decided based on the household requirements, remaining family ties, health and behavioral changes in the host community, and so on. However, it was understood that integration between the concept of health and migration remains untapped and improvement along those lines is imperative in ensuring the well-being of migrant communities.

Existing Policies and Programs for Migrant Laborers

The Constitution of India has several provision that directly address labor concerns: Article 14 (Equality before law), Article 15 (Prohibition of discrimination on grounds of religion, race, caste, sex or place of birth), Article 16 (Equal opportunity for public employment), Article 19 (1) (Freedom of speech and expression), 19 c (Freedom to

form associations or union), Article 23 (Prohibition of traffic in human beings for forced labor), Article 24 (Prohibition of employment of children in factories, etc.), Article 38 (State to secure social order for promotion of welfare of people), Article 41 (Right to work, to educate and to public assistance in certain cases), Article 42 (Just and humane conditions of work and for maternity relief), and Article 43 A (Participation of workers in management of industries) (Morgan & Macpherson, 1863). Moreover, India has been actively implementing provisions for various labor laws by aligning with the international labor standards (Negi, 2020). Being a founder member of International Labour Organization (ILO), our country has endorsed six fundamental conventions for ILO, namely Forced Labour Convention, Abolition of Forced Labour Convention, Equal Remuneration Convention, Discrimination Convention, Minimum Age Convention, and the Worst forms of Child Labour Convention.

Since Labour comes within the concurrent list, both the Central and State Governments have developed several legal provisions, but as it is evident, none of these are successful in ensuring even the basic protection of the migrants. "Trade Union Act 1926, The Minimum Wages Act 1948, Employees State Insurance Act 1948, Industrial Disputed Act 1949, Personal Injuries Act 1963, Maternity Benefits Act 1967, Contract Labour (Regulation and Abolition Act) 1970, Bonded Labour Systems (Abolition) Act 1976, Equal Renumeration Act 1976, Child Labour (Prohibition and Regulation) Act 1986" are a few among them (Salve, 2009). The key legislation for migrant laborers is the Inter-State Migration Workmen (Regulation of Employment and Conditions of Service) Act, 1979 which is put in place to ensure the protection of migrant laborers outside their native state. The act mandates for registration and contractors to obtain license and also provides both displacement and journey allowance. However, the act is often criticized for being a dead letter law (Swapna, 2020).

An employment scheme named "*Garib Kalyan Rojgar Abhiyaan*" is recently launched for migrant laborers affected by COVID-19 lockdown which offers to provide 125 working days for six states of the country that have the highest number of reverse migrations. COVID-19 related health services as well as health insurance were assured to the migrants through scheme "*Ayshman Bharat Pradhan Mantri Arogya Yojana"* in collaboration with National Health Authority.

Conclusion

Floating laborers immensely contribute to the growth and development of our country, however, the well-being of this community attracts least interest. As Shah and Lerche (2018) opinionated, vulnerability of the already exploited migrant laborers is further aggravated by their low social position in the capitalist economy of the country. The second in this process chain is the surplus extraction of labor by the employer through multiple means of engagements. Intensity of work that demands for challenging degree exertion, (strenuous) nature of the work, work extension by hours or day, underpayment or un-payment, poor living condition, and payment less

than that given to the local laborers would be totaled to understand the magnitude of extraction. Lack of awareness among the workers about their rights as well as poor enforcement of laws and regulations result in the community getting exploited. Changes from all corners of the society have become the need of the hour in order to ensure the health and well-being of the community.

Recommendations

Based on research and evidence as well as aiming at better health and well-being of migrant laborers, a few recommendations are made:

- The plethora of labor laws developed by various states and the center needs to be revamped based on the pragmatic needs of the laborers. Improvement should be brought in the enforcement of existing labor laws by targeting the welfare of the community.
- Accessibility to and portability of public distribution systems should be ensured in each of the states to ensure that migrants benefit out of these subsidies.
- Better framework has to be brought in regarding education of children of such floating laborers by revising the provision of admission and transfer in government schools.
- Mechanism to ensure universal registration of workers on a national platform should be installed.
- Provision of identity documents should be ensured as a first priority for any laborer in their migrant land so that they can make use of the public health facilities, banking service, and public distribution systems.
- Institution of a district facilitation office in states with high migrant inflow where documentation of both employer and worker done. This could also function as a district redressal cell through which the government can ensure that the employers meet the basic requirements of the employees as regulated by law.
- Arranging training and skill building programs for the migrant laborers based on the labor requirement of a state. This would equip them in rightly involving the job and thereby reduces occupational hazards and poor health outcomes.

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Part IV
Health and Well-Being of Elderly People

Chapter 18
Social Capital and Subjective Well-Being Contribute Happiness Among the Elderly? A Study in India

Raman Mishra and T. V. Sekher

Abstract Happiness among the aged is associated with improved physical and mental health, higher life expectancy, better compatibility with life events, and overall life satisfaction. There is a distinct difference between happiness and life satisfaction; the former is observed more as a consequence of positive experiences of significantly close and personal relationships, whereas life satisfaction is the consequence of a process including materialistic orientation and personal objectives and accomplishments. Subjective well-being is a multifactorial concept that refers to the absence of mental illness and the positive assessment of psychological functioning and experience. This study aims to disentangle the effects of social capital and subjective well-being on perceived happiness among the elderly in India. For this purpose, we used nationally representative WHO-SAGE survey data with a sample of 6560 individuals aged 50 years and above. The Sullivan method was adopted to calculate "happy life years" (H.L.Y.) for 10-year age groups of male and female respondents separately. Further, an ordered logistic regression was employed to determine the factors affecting happiness among the elderly. The analysis shows happy life years (H.L.Y.), and life expectancy decreases with increasing age. H.L.Y. was more among the women in comparison with men, while the proportion of life lived happily was higher among men. Happiness had a significant positive association with factors like education, income, activities of daily living, and quality of life. With the rise in education and income levels, happiness was increasing significantly among the elderly. Those elderly who have better access to structural and cognitive aspects of social capital are happier, suggesting that happiness correlates with a positive social environment . It is evident from our analysis that close social relations and trust

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_18

are conducive to maintain happiness. Older people with better subjective well-being and social capital are found to be happier. Interventions and policies that encourage public cooperation and equality may likely to improve the objective dimensions of well-being, i.e., life expectancy but also the subjective indicators of life such as happiness.

Keywords Social capital · Subjective well-being · Happiness · Elderly · India

Introduction

Since 2013, the United Nations has announced March 20 as the International Day of Happiness to acknowledge the importance of happiness and well-being as universal goals. According to the World Happiness Report 2020, Finland is the happiest country globally, whereas India ranked 144th among the 153 countries listed. India ranks below its neighboring countries, such as Pakistan (66), Nepal (92), China (94), Bangladesh (107), and Srilanka (130). Indians, both as individuals and as a nation, endeavor for meaningful, peaceful, and positive emotions in life. Biswas-Diener in his study suggested that India's citizens experience a predominance of constructive status and can be depicted as "mildly happy" individuals (Biswas-Diener et al., 2012).

Happiness is related to an attitude toward life that can be learned or developed. Simultaneously, happiness also belongs to the associations and activities that come under the regulation of public policies (Ho, 2011). Veenhoven and Ouweneel defined the "liveability" of a nation as "the extent to which the state provides services and infrastructure that make for a society where people can flourish, which is an essential element of collective well-being at the national level" (Veenhoven & Ouweneel, 1995). An efficient government that serves the citizen well, reduces their worries about health and expenditures related to health care, increasing employment (Di Tella et al., 2001), the financial cost of upbringing children, maintaining law and order, and employing an adequate safety net for the vulnerable (Ho, 2011). Macrosocial and political situations can also have a significant effect, especially on the happiness of citizens.

However, happiness can also be depicted as a positive feeling that initiates from the cognitive and emotional assessment of people from their lives (Argyle, 2013). There is a distinct difference between happiness and life satisfaction; the former is observed more as an outcome of positive understanding of significantly close and personal relationships. Whereas satisfaction in life is the consequence of an assessment process including materialistic orientations and personal achievements (Haller & Hadler, 2006). The happiness among elderly is multidimensional, it is influenced by individual, psychological, physical, social, economic, religious, spiritual, and cultural dimensions (Argyle, 2013), and it is one of the essential objectives of social life. Happiness is associated with enhanced physical and mental health, easier sleep, low level of stress and depression, better cardiovascular health, longer life expectancy, improved compatibility with events and quality of life, and finally,

overall satisfaction in life (Diener & Chan, 2011; Veenhoven, 2008, 2012). It is assumed that close and pleasant social relations, occupational involvement, socio-cultural orientations, and social participation are favorable to happiness (Haller & Hadler, 2006). A study shows that a U-shaped relationship exists among happiness and age as people in their older ages are happier (Frijters & Beatton, 2012).

The concept of subjective well-being (S.W.B.) refers to the absence of mental illness as well as the person's self-evaluation of their psychological functioning and experience (Ryan & Deci, 2001). It is normally believed that demographic and socioeconomic factors, health, strong social capital, and social integration are key determinants of subjective well-being (George, 2009). Subjective economic situation is crucial for happiness, and, in particular, for life satisfaction among the elderly (Haller & Hadler, 2006). A study from Finland reported that lower levels of individual and workplace social capital are related with poor self-rated health (Oksanen et al., 2008). In contrast, another study shows that high individual and community-level social capital is related to poor self-rated health (Snelgrove et al., 2009).

A recent study from Japan that researched the relationships among happiness and social capital suggests that happiness is associated with the safety of the individuals in the society (Tsuruta et al., 2019), whereas other research has investigated a positive relationship among the individual social capital and the different elements of subjective well-being (Arampatzi et al., 2018). Research from different countries has shown that living arrangement affects happiness. Married elderly and older people residing with children and kins are happier than singles. Further, structural social capital has a strong influence on happiness among the elderly. A good and close relationship with partners and spouses, children, and kin is defined as bonding social capital, whereas the relations with friends, neighbors, and acquaintances are referred to as bridging social capital. Linking social capital constitutes participation in religious and community activities. Structural social capital comprises bonding, bridging, and linking and provides a significant source of satisfaction with life and happiness (Haller & Hadler, 2006).

Similarly, cognitive social capital relates to happiness among the elderly. Studies suggest that social trust and personal trust were positively associated with happiness (Tsuruta et al., 2019). A study about the level of happiness among 268 subjects aged between 60 and 94 years found that self-reported happiness was inversely related with mortality during a 4-year follow-up (Palmore, 1969). The findings from the World Values Survey on health and happy life expectancy by age and different dimensions of attitudes suggest that individuals in Brazil and Mexico with positive inner experiences are healthier and happier and experience longer life with less morbid situations. When comparing the trends over time, it was estimated that the proportion of time to live happy and in better health has a significant contribution to mortality and morbidity (Guedes et al., 2013). Disability constraints physical and social behaviors, while subjective health influences an individual's perceptions of well-being. Whereas, happier people and those with higher levels of life satisfaction are found to be healthier (Siahpush et al., 2008). The education system segregates the people into two different segments based upon their characteristics. People with

higher levels of education are on average happier throughout life in comparison with the people having low levels of education (Easterlin, 2001).

Happiness and Happy Life Expectancy

A study conducted by modifying Veenhoven's concept of happy life years gave the notion of Happy Income. This measure is created with the concept that the socioeconomic well-being of the elderly in a region is solely dependent on their income and their subjective evaluation of their lives (Prinz & Bünger, 2009). Another study observed that the level of education is positively associated with the subjective well-being (which includes happiness, life satisfaction, and morale). This association is stronger in women than in men and among the elderly than in younger adults (Witter et al., 1984; Kutner, 2007).

Regional variation played an important role in a study conducted in the U.S. (General Social Survey) for calculating happy life expectancy (HapLE) and healthy life expectancy (H.L.E). This study found that the geographic differentials matter for happy life expectancy, and H.L.E. Early life region plays a significant role in shaping these outcomes, and happy life expectancy is essential when considering adding together "life to years" (Brown et al., 2011).

Another study conducted in the USA assessed the trends and differentials in the length of quality of life as calculated by happy life expectancy. It is evident from the study that for the progress in quality of life, happy life expectancy mostly improved in both the conditions, absolute (number of years lived in happiness) and relative (proportion of life lived in happiness) overtime for all individuals examined. An increase in longevity mainly occurred by increasing expectancy in happy years rather than unhappy years. There were substantial differences in happy life expectancy by gender and ethnic groups because of different levels of happiness (Yang, 2008).

Happiness and Subjective Well-Being

Research on happiness and health status shows that multimorbidity and physical inactivity remained as significant and robust predictors of happiness (Lukaschek et al., 2017). Happiness is positively correlated with physical and mental health, increased quality of life, and, finally, life satisfaction (Diener & Chan, 2011; Veenhoven, 2008, 2012). A study using health data reported a positive correlation among individual social capital and different components of subjective well-being, including happiness and life satisfaction (Arampatzi et al., 2018).

Happiness and Social Capital

Elderly are empowered by areas that enable physical accessibility, freedom, emotional bondings, and participation in society (Rosso et al., 2011). Elderly's happiness is influenced by the perception regarding the quality of public services. Older adults from the cities are more concerned with the availability of vital essential services, such as a safe environment, better education, and access to improved health care for vulnerable populations, the socially disadvantaged, the disabled, and the citizens living below poverty (Hogan et al., 2016). A study from Korea shows that cognitive social capital and self-rated health both are positively correlated with happiness. It is evident from the findings that social capital and health are determinants of happiness (Tsuruta et al., 2019). It was observed that structural social capital, i.e., how frequently an individual socializes with family, friends, and neighbors and participates in different activities through physical activity. Whereas, cognitive aspects of social capital including trust toward family members, neighbors, or community residents were the factors that positively influence the degree of happiness (Tsuruta et al., 2019).

Rationale of the Study

The number of older people is continuously increasing in India; it is expected to grow even more significantly in the future. Though various studies have been published about elderly in India related to their health, disease, lifestyle, gender differences, insecurity, etc., this paper is an attempt to measure their happiness quantitatively by calculating happy life years. Happiness is a subjective appreciation of life; "it measures the degree to which citizens live long and happily in a country and denotes a specific conception of quality of life in society, also called livability". The attractiveness toward long and happy life is likely to become more remarkable in the coming future.

As defined above, happiness can be assessed utilizing surveys in which a national representative sample of elderly is queried about their overall enjoyment in life. The concept of successful aging explains that the number of years spent in bad health should be less with the increase in life expectancy. This issue was taken care of by introducing the measure of "Disability Adjusted Life Years", which captures only the number of years spent in better health. Similarly, this study is also an attempt to compute "Happiness Life Years" (H.L.Y). H.L.Y is meant to be a comprehensive measure of apparent quality of life (Diener & Oishi, 2000). Further, there is a need to examine the factors associated with happiness such as subjective well-being and social capital among elderly in India.

Methodology

Data Source

The "Study on global aging and adult health (SAGE)" is a multicountry study conducted in six countries (China, Ghana, India, Mexico, Russian Federation, and South Africa). SAGE is a longitudinal health survey supported by the World Health Organization (WHO). The main objective of SAGE was to obtain reliable, valid, and comparable data on levels of health across a range of key domains. SAGE wave 1 survey in India was implemented in six states, namely Assam, Karnataka, Rajasthan, Uttar Pradesh, Maharashtra, and West Bengal (Arokiasamy et al., 2013). This survey used a systematic simple random sampling selection process, and the sampling was done in a two-stage process in rural areas and three stages in urban areas. Since the analysis is on the older population, this analysis includes 6560 individuals aged 50 years and above. SAGE survey used household, individual, and proxy questionnaires. The individual questionnaire was administered to all adult respondents aged 50-plus. This covered the overall health, risk factors, health behavior, health care, quality of life, social connection, and participation in the community.

Description of Variables

The outcome variable in this study is level of happiness—"unhappy", "neither unhappy nor happy" or moderate happy, and "happy" as reported by the elderly. The predictor variables in this study are broadly defined in three domains—background characteristics, subjective well-being, and social capital.

Happiness: SAGE used the Day Reconstruction Method (DRM) for evaluating daily life experience and subjective well-being. The DRM assesses feelings within situations and activities and therefore goes beyond asking who is happy while asking when they are happy and was used to measure the experienced well-being/happiness.

Subjective well-being: It is important to understand the elderly's perceived well-being status. Subjective well-being is composed of many variables at the individual level. This study used personal life satisfaction, self-reported health status, life satisfaction, living condition, quality of life, and financial status of the elderly as reported on a Likert scale.

Social capital: Respondents were asked about "the groups or organizations, networks, and associations to which they or any household member belong. These could be formally organized groups or just groups of people who get together regularly to do an activity or talk about things". Social capital (structural and cognitive) is a broad and multidisciplinary concept. In this study, structural social capital is categorized as bonding, bridging, and linking, whereas cognitive social capital is broadly considered in terms of personal trust, general trust, and safety (see appendix A).

Statistical Analysis

"Happy life years" (H.L.Y.) was calculated for older respondents in the 10-year age groups with four class intervals for males and females and by place of their residence separately. For calculating H.L.Y, the Sullivan method was used which observed age-specific prevalence of happiness levels in a population at a given point in time to calculate the years of life lived in the happiness state at each age by a period life table cohort. Further, the proportion of life in happiness is measured, i.e., H.L.Y and life expectancy's ratio. Graphs were presented by gender and place of residence separately for a better understanding of the events.

Tables were created for the calculated H.L.Y.s by age and gender and for showing the percentage distribution of level of happiness with other associated factors like education, income, living condition, satisfaction with life, and quality of life.

An ordered logistic regression was done by considering the ordered variable—"Happiness", where unhappy was considered as the base category, and the other two categories, "neither happy nor unhappy" or "moderately happy" and "happy", were described with reference to it in odds ratio. The confidence interval was calculated for each variable and its categories, and significance level was also shown in the table constructed through ordered logistic to find out the causal factors. The cuts are predicted by the method of maximum likelihood and reported at the end of the model. The level of happiness having three categories will have two cuts. The values below level cut-1 are predicted as lower level of happiness, values between cut-1 and cut-2 are the moderate level of happiness, and the values above cut-2 are termed as the higher level of happiness. The ordered logistic table was constructed using STATA 14 software.

Results: In Table 18.1, H.L.Y. was presented by age and sex among older respondents. This study considers older respondents from age 50 years, so the classification of H.L.Y. was made by taking age in four class intervals of ten years and by gender. It was found with increasing age, the life expectancy and H.L.Y.s decreased simultaneously. Since females have a longer life expectancy than males, H.L.Y.s among females was higher than males. Proportion of life lived happily was found to be higher in males in comparison with their female counterparts, but it was found that

Table 18.1 Happy Life Years (H.L.Y.s) among Elderly by Gender in India

	Males			Females		
Age group	L. E	H. L. Y	%Happiness	L.E	H. L. Y	%Happiness
50–59	28.58	14.62	51.15	31.50	16.17	51.32
60–69	20.63	10.08	48.86	22.91	11.28	49.23
70–79	13.80	6.19	44.87	15.37	6.77	44.01
80 and above	8.39	3.45	41.13	9.37	3.01	32.12

Note L.E.:Life Expectancy

with increasing age, the magnitude of the proportion of happy life was declining among both sexes, whereas the decline was too steep among females.

In Fig. 18.1, happy life expectancy is plotted with age. It is evident from the figure that with increasing age, happy life years are decreasing. For the 50 years age group, the happy life years for males was found to be 14.62, whereas for females, it was 16.17. Similarly, for the 80 years and above age group, the male happy life years was 3.45, whereas for the females, it was 3.01. With increase in age, the gap between male and female happy life years was reduced.

Figure 18.2 shows the proportion of life in happiness relative to life expectancy. It is evident from the figure that with increasing age the proportion of life lived happily decreases and it was found to be higher among males than females. Among

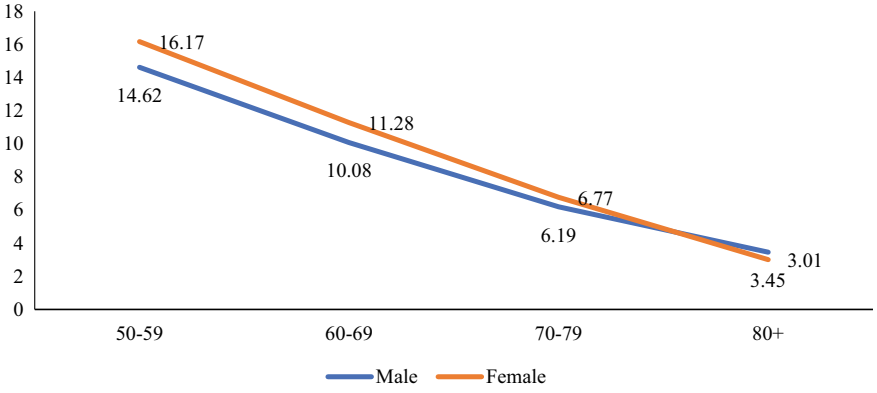

Fig. 18.1 Happy Life Years (H.L.Y.) of Males and Females, India

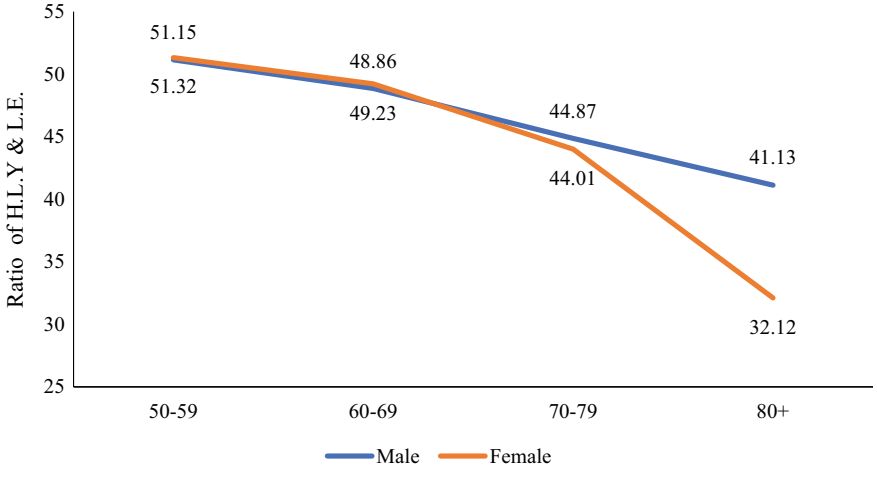

Fig. 18.2 Proportion of Life in Happiness by Gender among Older Adults

Table 18.2 Happy Life Years (H.L.Y.) among elderly by place of residence in India

	Urban			Rural		
Age	L. E	H. L. Y	%Happiness	L.E	H. L. Y	%Happiness
50–59	28.19	18.12	57.25	25.99	14.28	48.71
60–69	20.51	12.80	55.32	18.57	9.81	46.27
70–79	13.43	7.99	51.42	12.26	5.84	41.05
80 and above	7.05	3.67	39.18	6.70	3.07	35.27

Note L.E.: Life Expectancy

the elderly aged 50 years and above, the proportion for males who found to be happy was 51.2%, and for females, it was 51.3%. Similarly, for the age group 80 years and above, it was 41.1% for males and 32.1% for females.

In Table 18.2, HLYs was presented by age and place of residence among older respondents. It was found with increase in age, life expectancy, and H.L.Y.s decreased simultaneously. Since urban elderly have a longer life expectancy than rural elderly, it was also found that H.L.Y.s among them were higher than rural elderly. The proportion of life in happiness was found to be higher in urban areas in comparison with their rural counterparts, but it was observed that with increasing age, the magnitude of happy life was declining in both areas.

Figure 18.3 presents happy life years among males and females by age; with increase in age, happy life years decreases, and rural areas had a lower happy life expectancy. Happy life years in the 50–59 years age group among urban elderly is 18.1 years, and among the rural elderly, it was 14.3 years. Similarly, in the 80 years and above age group, happy life years among urban elderly was 3.7 years and 3.1 years for their rural counterparts.

Figure 18.4 shows the proportion of life in happiness relative to life expectancy by place of residence. In the age group 50–59 years, the proportion of life lived in

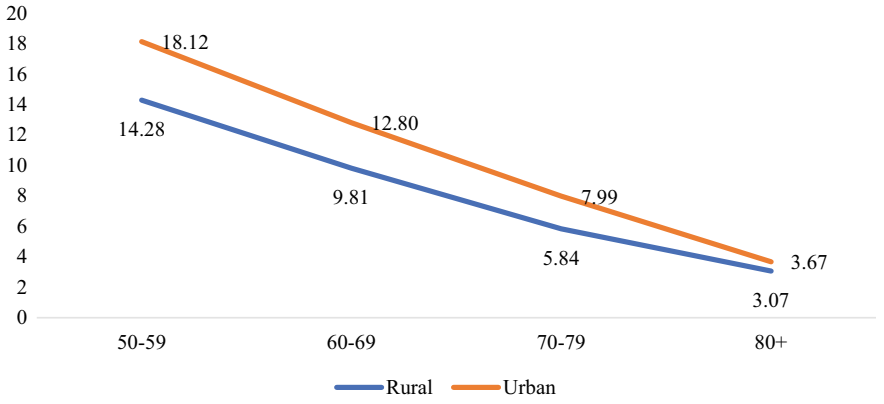

Fig. 18.3 Happy Life Years (H.L.Y.) by place of residence, India

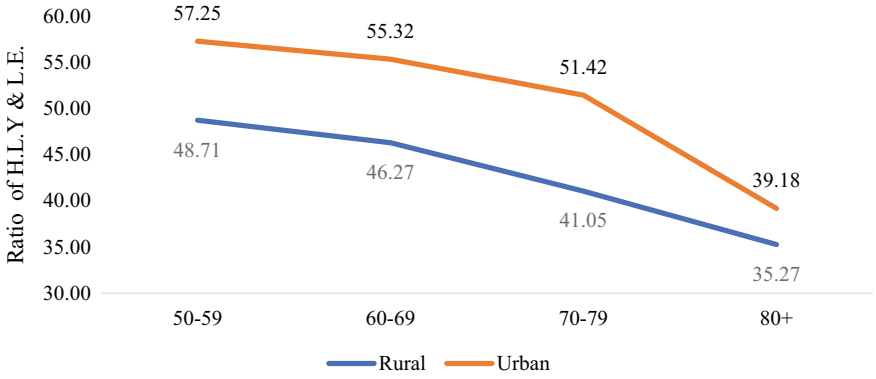

Fig. 18.4 Proportion of life in happiness by place of residence, India

happiness among urban elderly was 57.3%, and for rural elderly, it was 48.7%. In the age group 80 years and above, the proportion of life spent in happiness among urban elderly was 39.2%, and among rural elderly, it was lower, 35.3%.

Table 18.3 shows the percentage distribution and the odds of happiness by background characteristics of the elderly. With an increase in age, the odds of happiness decrease among the elderly. It is found lowest (46.2%) among the age group of 80 years and above, while the highest odds (1.1 times) was in the age group 50–59 years. Though, gender components were found almost equally distributed in all the categories of happiness. Yet, females were 1.4 times more likely to be happy than males (55.3%).

The elderly residing in urban areas are happier (61.7%) than the elderly residing in rural areas. Happiness was more prevalent among currently married elderly couples (living with spouse) (56.8%), whereas separated/widowed/divorced elderly (47.4%) were 1.6 times more likely to be happier in comparison with never-married elderly. With the increasing education and income levels, the odds of happiness increase among older respondents. Elderly with education up to secondary (62.9%) and higher (84.1%) reported more happiness than elderly with no education. Similarly, the elderly belonging to the poorer section of the society reported the highest percentage (27.0%) of unhappiness. With the increase in income level, the odds of becoming happier were found to be increasing. It was found to be highest for the richer class followed by the rich class (4.6 & 3.0), respectively. The percentage of happiness was low among the elderly belonging to scheduled castes or scheduled tribes (41.1%). The values between −0.21 to 1.92 show the moderate level of happiness, and values above 1.92 show the happiness level when values of the predicted variables were evaluated at zero (Table 18.3).

Table 18.4 shows the percentage distribution and odds of levels of happiness by subjective well-being among elderly in India. Elderly satisfied with their personal life was 40% more likely to be happier (61.6%). Around 39% of elderly who were

Table 18.3 Happiness levels by background characteristics of elderly in India (N = 6560)

Background Characteristics	Levels of Happiness			Odds Ratio (95% CI)
Age	Unhappy	Moderate	Happy	
50–59	8.55	35.6	55.85	Referent
60–69	10.69	33.52	55.78	1.08 (0.92, 1.27)
70–79	13.39	35.55	51.05	0.92 (0.70, 1.21)
80 & above	21.76	32.01	46.23	0.71 (0.50, 1.01) *
Sex				
Males	10.35	35.68	53.97	Referent
Females	10.83	33.87	55.30	1.38 (1.12, 1.69) ***
Place of residence				
Urban	7.00	31.29	61.71	Referent
Rural	12.04	36.22	51.74	1.05 (0.80, 1.38)
Marital status				
Never married	21.85	37.13	41.03	Referent
Currently married	8.84	34.32	56.84	2.17 (0.98, 4.81) *
Separated/divorced/widowed	16.23	36.34	47.43	1.56 (0.67, 3.66)
Education				
Illiterate	14.49	37.05	48.46	Referent
Up to primary	8.77	36.29	54.94	1.12 (0.91, 1.38)
Up to secondary	4.81	32.28	62.91	1.36 (1.07, 1.73) ***
College	2.18	13.72	84.1	2.89 (1.74, 4.80) ***
Wealth quintile				
Poorer	26.95	38.84	34.21	Referent
Poorer	12.02	42.52	45.45	1.82 (1.41, 2.36) ***
Medium	8.08	38.58	53.34	2.39 (1.85, 3.10) ***
Rich	5.14	34.44	60.42	3.01 (2.18, 4.16) ***
Richer	3.35	22.49	74.15	4.62 (3.30, 6.48) ***
Caste				
SC/ST	16.57	42.29	41.14	Referent
No caste or tribe	7.56	28.91	63.54	1.69 (1.26, 2.27) ***
Others	9.02	33.42	57.56	1.32 (1.06, 1.64) **
Cut 1	–	–	–	−0.21 (−1.11, 0.69)
Cut 2	–	–	–	1.92 (1.02, 2.82) ***
Total	10.53	34.77	54.7	

Note *** = p <0.01, ** = p <0.05, * = p <0.1

Table 18.4 Happiness Levels by Subjective Well-being among Elderly in India (N = 6560)

Subjective Well-being	Levels of Happiness			Odds Ratio (95% CI)
Personal life	Unhappy	Moderate	Happy	
Dissatisfied	35.75	43.76	20.49	Referent
Moderate	21.07	43.36	35.57	1.09 (0.76, 1.58)
Satisfied	6.23	32.13	61.64	1.40 (1.00, 1.98) **
Living conditions				
Dissatisfied	39.09	43.58	17.32	Referent
Moderate	21.88	48.56	29.56	1.07 (0.71, 1.61)
Satisfied	7.03	31.95	61.02	1.36 (0.90, 2.04)
Life satisfaction				
Dissatisfied	54.00	32.67	13.33	Referent
Moderate	17.19	53.99	28.83	1.88 (1.22, 2.89) ***
Satisfied	3.38	27.29	69.34	4.05 (2.68, 6.11) ***
Health				
Dissatisfied	32.09	41.86	26.04	Referent
Moderate	12.09	49.35	38.56	1.40 (1.06, 1.84) **
Satisfied	2.74	26.11	71.16	2.57 (2.02, 3.28) ***
Quality of life				
Dissatisfied	52.17	35.98	11.85	Referent
Moderate	7.98	48.18	43.84	3.99 (3.10, 5.12) ***
Satisfied	1.93	14.46	83.62	14.88 (10.32, 21.47) ***
Financial status				
Dissatisfied	23.29	42.96	33.75	Referent
Moderate	4.6	37.21	58.19	1.60 (1.24, 2.06) ***
Satisfied	2.14	18.8	79.06	2.67 (1.93, 3.69) ***
Cut 1	–	–	–	1.30 (0.81, 1.79) ***
Cut 2	–	–	–	4.20 (3.65, 4.76) ***
Total	10.58	34.79	54.62	

Note: *** = p <0.01, ** = p <0.05, * = p <0.1

dissatisfied with their living conditions were unhappy, followed by moderately satisfied with 21.9% and completely satisfied with 7.0%. It is most likely that if the elderly were satisfied with their lives, they were happier. The odds of the elderly being happy with moderate life satisfaction were 1.9 times, and completely satisfied with their life was 4.1 times more likely. Further, around 32.1% of the elderly reported unhappiness and dissatisfaction with their health status. The likelihood of the elderly being happy by being satisfied with their health status was 2.6 times more likely.

Table 18.5 Happiness levels and social capital of elderly, India ($N = 6560$)

Social capital	Levels of happiness			
Structural social capital	Unhappy	Moderate	Happy	Odds ratio (95% C I)
Bonding				
Low access	13.03	35.43	51.53	Referent
Medium access	7.87	38.57	53.57	1.06 (0.87, 1.30)
High access	9.09	30.25	60.66	1.14 (0.93, 1.38)
Bridging				
Low access	12.29	37.79	49.92	Referent
Medium access	8.12	29.77	62.11	1.52 (1.29, 1.78) ***
High access	5.28	27.51	67.21	1.90 (1.49, 2.41) ***
Linking				
Low access	11.09	35.83	53.08	Referent
Medium access	4.66	27.41	67.93	1.54 (1.19, 2.00) ***
High access	12.18	23.35	64.48	0.99 (0.58, 1.70)
Cognitive social capital				
General trust				
Low	11.32	35.02	53.66	Referent
High	9.99	34.61	55.4	1.12 (0.97, 1.28)
Personal trust				
Low	16.35	33.97	49.69	Referent
Medium	11.72	41.98	46.30	0.88 (0.70, 1.10)
High	8.48	31.73	59.80	1.31 (1.07, 1.61) ***
Safety				
Low	17.58	46.81	35.61	Referent
Medium	10.78	40.12	49.1	1.72 (1.31, 2.26) ***
High	9.6	31.59	58.81	2.29 (1.70, 3.08) ***
Cut 1	–	–	–	−1.09 (−1.45, −0.74) ***
Cut 2	–	–	–	0.93 (0.59, 1.27) ***
Total	10.58	34.79	54.62	

Note *** = p <0.01, ** = p <0.05, * = p <0.1

Similarly, respondents satisfied with their quality of life were more likely to be happy (83.6%). Likewise, having a satisfactory financial status enhances the likelihood of the elderly being happier (79.1%). The cut points were used to differentiate the adjacent levels of the happiness variable. The value less than 1.30 shows unhappiness, the value between 1.30 to 4.20 shows the moderate level of happiness, and values above 4.20 show the happiness level when values of the predicted variables were evaluated at zero.

Table 18.5 shows the percentage distribution and odds of happiness level by components of structural social capital among sampled elderly population. Elderly with high access to bonding are happier (60.7%) than those with low access to bonding (51.5%). Similarly, elderly having high access to bridging (67.2%) were 1.9 times more likely to report happiness than those having low access to bridging as social capital. A different pattern was found for linking social capital among elderly. Those elderly with moderate access to linking (67.9%) were 1.5 times more likely to be happy. Having personal trust shows a positive association with happiness among the elderly (59.8%). Elderly feeling secure and safe in the neighborhood and community were found to be happier. Elderly feeling moderately safe and completely safe were 1.72 and 2.29 times more likely to be happy. The cut points used to differentiate the adjacent levels of the happiness variable. The value less than -1.09 shows the level of unhappiness; the value between −1.09 to 0.93 shows the moderate level of happiness, and values above 0.93 show happiness when values of the predicted variables were evaluated at zero.

Discussion

Though economists argue that age and happiness are U-shaped, this study, on the contrary, shows that with increasing age, the happiness decreases. Similar to studies in the field of psychology and sociology, it is evident that happiness and age are not U-shaped. Few authors argue that there is small (Travers & Richardson, 1993) or no gender difference (Veenhoven, 1996) in reporting happiness. However, the findings from this study illustrate that elderly females are happier than elderly males. Better governance with better policies and infrastructure facilities can provide a satisfactory life, and happiness is found to be better in urban areas than in rural areas. Marriage has its own importance, and couples feel a sense of satisfaction and serenity by inducing positive experiences, compassion, love, and a sense of security, so married elderly are found to be happier than the single ones. Better socioeconomic situations are essential for fulfilling the basic needs in life. The elderly with better education and higher income levels reported more happiness than those from lower socioeconomic conditions.

Some psychologists maintain that happiness is a stable trait of some individuals and an enduring characteristic of their personality. The elderly's happiness in life is influenced by many factors, such as individual, psychological, physical, social, and economic dimensions. Elderly satisfied with their personal life and having better compatibility with life events are found to be happier. It is argued that happiness is the outcome of having a satisfactory life in older ages, this study indicates that life satisfaction is an important predictor of happiness. A better health status can help one achieve a better life free from diseases and disability. Happiness is related to increased physical and mental health, and older people reporting better health are found to be happier. Elderly with better quality of life are found to have happiness

in their life, whereas better financial status contributes to the positive feeling in the perception of happiness among the elderly.

Intimate social relations built on the basis of trust are conducive to happiness, and our findings show that elderly having high access to bonding social capital are happier. Closeness with neighbors and work partners are a major source of satisfaction for elderly. These individuals are happier than those having low access to bridging social capital. High access to linking social capital is positively associated with happiness. Thus, it can be argued that happiness comes from good and close social relationships. In line with earlier studies, this study also shows that individuals with a high degree of personal trust are happier. A sense of safety by maintaining better law and order will positively impact the happiness of elderly citizens.

Appendix A

Questions Asked for Collecting Data on Structural and Cognitive Social Capital

Questions	Response categories		
Structural social capital	Low	Medium	High
Bonding social capital			
How often in the last 12 months have you had friends over to your home?	Never/once or twice per year	Once or twice per month	Once or twice per week/daily
Bridging social capital			
How often in the last 12 months have you attended any public meeting in which there was discussion of local or school affairs?	Never/once or twice per year	Once or twice per month	Once or twice per week/daily

(continued)

(continued)

Questions	Response categories		
Structural social capital	Low	Medium	High
How often in the last 12 months have you attended any group, club, society, union, or organizational meeting?	Never/once or twice per year	Once or twice per month	Once or twice per week/daily
How often in the last 12 months have you attended religious services (not including weddings and funerals)?	Never/once or twice per year	Once or twice per month	Once or twice per week/daily
Linking Social Capital			
How often in the last 12 months have you met personally with someone you consider to be a community leader?	Never/once or twice per year	Once or twice per month	Once or twice per week/daily
Cognitive social capital			
General trust			
Generally speaking, would you say that most people can be trusted or that you can't be too careful in dealing with people?	Can't be trusted or too careful	Can be trusted	
Personal trust			
First, think about people in your neighborhood. Would you say that you could trust them?	To a very small extent/ to a small extent	Neither great nor small extent	To a great extent/To a very great extent
Now, think about people whom you work with. Generally speaking, would you say that you could trust them?	To a very small extent/ to a small extent	Neither great nor small extent	To a great extent/To a very great extent
Safety			

(continued)

(continued)

Questions	Response categories		
Structural social capital	Low	Medium	High
In general, how safe from crime and violence do you feel when you are alone at home?	Not safe at all/slightly safe	Moderately safe	very safe/Completely safe
How safe do you feel when walking down your street alone after dark?	Not safe at all/slightly safe	Moderately safe	very safe/Completely safe

Source Ng and Eriksson (2015). social capital and self-related health in older population in lower and upper middle income countries (eds) F. Nyqvist & A. K. Forsman, *Social capital as a Health Resource in Later Life: The Relevance of Context*. Vol. 11 Springer

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Chapter 19
Older Adults' Happiness and Quality of Life: Spiritualism, Social Connectedness, and Health Status

Nidup Dorji

Abstract Growing old is undeniably an inescapable process of every living being with an option to age gracefully. Life expectancy increases with advances in health care, wider access to education and economic advancement. The boom in the aging population across the world is magnified in the developing countries. The challenges of a growing aged population stress small and large systems from the family to the society. Financial, medical, and social systems require greater resources to sustain well-being and quality of life for an aging population, especially with an increased risk of health problems. Asian cultures, accounting for greater than 50% of the world's population, particularly values the traditional view of older adults' contributions of wisdom, effective mediation in conflict, and as the leader of the family. Spiritualism, close social relationships with the family, children and grandchildren, friends, and neighbors, makes up an important component of the quality of life and well-being for the older adults. The chapter explains the role of urbanization and modernization in changing the family structures, cohesion, and cooperation, as well as conflict and solidarity, which affects the support and care of older people. An effort to strengthen relationships between family members and social bonding discussed in the chapter is highly relevant to promote well-being and quality of life among the older adults.

Keywords Older adults · Quality of Life · Psychological well-being · Happiness · Spiritualism · Social connectedness · Health

Introduction

The world population is aging at a faster rate, faster now in the developing countries including Bhutan than in high-income countries (Mathers et al., 2015; Mudey et al., 2011). Growing older is an inescapable process of life. However, how a person can gracefully age in life is optional and lies in the hands of every individual. Although improved health care, better access to education and economic growth, reduced infant

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_19

and child mortality contributed to increased life expectancy (Mathers et al., 2015), factors such as biological, psychological, social, lifestyle-related, and adversities determine the acceleration of aging (Samarakoon et al., 2011). While increase in life expectancy may in one sense indicate a success story of humankind (Beaglehole et al., 2011), the steady growth of the older population presents many challenges to families, communities, and societies, particularly to the sustainability of health care, pensions and social benefits, and the preservation of quality of life (QOL) and well-being (Beard & Bloom, 2015).

Located in the eastern Himalayas, Bhutan shares a border with China and India. Bhutan is better known to the outside world for valuing Gross National Happiness (GNH) over Gross National Product (GNP). According to the 2017 population and housing census of Bhutan, Bhutanese population stands at 7, 35,553, and nearly 9% constituted of older adults 60 years and above considering a growth rate of 1.3%. GNH survey in 2015 indicated that 43.4% of the Bhutanese either extensively or deeply happy (Ura et al., 2015) is among the limited evidence to support Bhutan's claim to be one of the happiest countries in south and South–East Asia.

Traditionally, older adults in Bhutan are revered and held at a high esteem for their vast experiences in life and wisdom, being head of the family and as effective peacemakers in conflicts. A recent study by Dorji et al. (2017) revealed high QOL, especially in the social relationship domain, among the older adults in Bhutan. Urbanization and modernization continue to affect the traditional family by threatening cohesion, cooperation, conflict, and solidarity, thus affecting support of older family members (Helman, 2007). One of the male participants in the study by Dorji (2016) in Bhutan mentioned: "*With more development and progress taking place in our country, the cravings for more wealth and materialism have seriously impacted the social fabric and ties that were rich in those days. Today we alienate our bonds and relationships instantly. The values that bind the people of communities are fast declining, which I feel is a great loss to today's generation*". (p. 123). According to the GNH concept, effective time use, maintenance of health and psychological well-being, community vitality, cultural and ecological diversity and resilience, good governance, and improved living standards are believed to create and foster happiness (Burns, 2014) across the lifespan of a person. Bhutan is a spiritual country, and spiritualism and religiosity play a significant role in the daily lives of Bhutanese. In fact, a study by Dorji et al. (2019) indicated that older adults in Bhutan perceived benefits of spiritualism on their health. As health is the fundamental requirement of a person, knowledge about QOL remains critical to understand the consequences of illnesses, treatment and its modification, care and improvement, and rehabilitation of the patients.

Quality of Life

Quality of life, though a broadly studied topic, has little unanimity in definition, leaving the interpretation to vary between and within disciplines including in the

field of health and medicine (Haraldstad et al., 2019). QOL is defined by the World Health Organization, as "an individual's perception of his/her position in life in the context of the culture and value systems in which he/she lives and in relation to his/her goals, expectations, standard and concerns". This description highlights the multidimensional, multifaceted complexity of a subjective assessment of environmental, physical, psychological, and social well-being (World Health Organization, 1995, p. 1405). Although QOL is highly subjective, QOL for older adults and its maintenance is increasingly becoming an important issue for public health resource evaluation and distribution (Van Leeuwen et al., 2019). Attitude, autonomy, relationships, spirituality, financial security, home and neighborhood, health conditions, roles, and meaningful activities are regarded as important components of QOL especially in the Western countries (Van Leeuwen et al., 2019).

Well-Being

Similar to QOL, there is no single consensus definition for well-being, and the question of how it should be defined still remains unanswered due to its complexities (Dodge et al., 2012; Marsh et al., 2020). Broadly speaking, well-being refers to the perception of life's wellness (Marsh et al., 2020). Marsh et al. (2020) pointed out that researchers have used the word well-being generally to include measurable factors (e.g., economic and social conditions) as well as subjective experiences beyond neutral levels of mental illnesses. Two theoretically grounded modern perspectives on the positive psychological components of well-being include a hedonic approach that focuses more on maximizing one's feeling of pleasure and life satisfaction and eudaimonic approach that emphasizes actualizing individual human potentials and positive human functioning (Zhang & Chen, 2019). In the latter perspective, autonomy, personal growth, environmental mastery, positive relationships, self-acceptance, and purposeful life are the main domains of psychological well-being (Ryff, 1989). Irrespective of the approaches, most scholars believe that well-being is a multidimensional construct (Dodge et al., 2012) and that true well-being requires a combination of both hedonic (positive affect) and eudaimonic components, a framework that has been adopted by the Organization for Economic Cooperation and Development (OECD) who regularly undertakes cross-national well-being surveys (Marsh et al., 2020). According to a systematic approach by Marsh et al. (2020), competency, positive emotions and stability, positive relationships and optimism, resilience, self-esteem, and vitality positively influence well-being.

Well-being is also used interchangeably with "quality of life" in a variety of disciplines (Dodge et al., 2012) making the task of defining well-being "conceptually muddy" although it has become pervasive (Morrow & Mayall, 2009, p. 221). However, Dodge et al. (2012) argued that the narrow emphasis on QOL cannot adequately help define well-being as QOL relatively appears to be a dimension of well-being. Well-being factors such as optimism, resilience, and emotional stability

are negatively associated with negative life events in contrast to positive relationships between positive life events experience and well-being (Marsh et al., 2020). A multidimensional approach to the study of well-being is highly valuable (Marsh et al., 2020).

Happiness

The concept of happiness is mostly used in the context of pleasant or positive mental or emotional states ranging from contentment to intense joy. It can also be used in the context of life satisfaction and subjective well-being. Although some philosophers argue, when a person is said to be happy, it could mean the person has the right sorts of subjective feeling: a high level of a positive and low level of negative affect and a greater sense of life satisfaction (Yang et al., 2020). In the context of Bhutan, guided by the philosophy of "Gross National Happiness", the concept of happiness signifies neither monistic nor purely subjective, picks out pleasant experiences, or fulfilled desires, but happiness is used to pick out a pluralistic, principally objective conception of a desirable life (Metz, 2014).

In a Spanish study, balanced life and satisfaction significantly predicted current happiness, and the sense of autonomy and independence sources one's happiness (Godoy-Izquierdo et al., 2013). For the centenarians, satisfaction with life in the past was directly linked to present happiness (Bishop et al., 2010). Furthermore, better quality of social interactions, improved standards of living, and being satisfied with one's' health conditions significantly influence happiness (Didino et al., 2018). Common to most existing literature, life satisfaction remains as a common correlate of happiness for older adults. The state of happiness also largely depends on what people do and how active they are in their daily life. More active the older adults are, the happier they are (Kavčič & Avsec, 2018). Social activities are believed to satisfy people's need for relatedness; physical activities enhance physiological and psychological well-being by gaining a sense of mastery; cognitive activities help meet the need for competence or curiosity (Kavčič & Avsec, 2018). In a cross-cultural study (Italy and Cuba), morality and value-based aspects for happiness included values, faith, and feeling of selflessness (Sotgiu et al., 2011). Although being happy is generally viewed in seeking the company of others, development of bonding and strengthening relationships between people, happiness, and its relationship with social behavior still remains complex (Quoidbach et al., 2019).

Why Aging Matters?

One can opt to age gracefully although growing older is an inescapable process of a living being. Aging is a part of the life journey from birth to death (Noronha, 2015). The world population is aging rapidly with other continents joining Europe

and North America (Au et al., 2019). With increased in aging population, chronic diseases are more of a concern than previously focused on the cause of preventable premature death (Beaglehole et al., 2011). Globally, the shift in the leading cause of death to chronic non-communicable diseases mainly cardiovascular diseases (CVD), cancers, diabetes, and chronic obstructive lung diseases is highly concentrated in the older population (Au et al., 2019). These chronic health conditions are the leading causes of death and disabilities among the older adults (Beard & Bloom, 2015), diminish well-being and QOL of a person, and pose a constant challenge to "aging well". Furthermore, the prevalence and the burden of chronic health conditions in aging impose substantial economic toll through medical expenses and loss of income (Suzman et al., 2015). Although increase in the aging population increases the burden of chronic health conditions (Joshi et al., 2003), the relationship is not always unidirectional as metabolic diseases such as obesity and diabetes accelerate biological aging (Burton & Faragher, 2018). Whether human ages normally or prematurely, adoption and promotion of a healthy lifestyle and healthy living, and prevention of health risks and disease conditions remain crucial.

Aging Perspectives: Prevent Ageism and Promote Successful Aging

Aging relates to "living in a new reality" (Romo et al., 2013). Perception of aging influences societal behaviors and expectations toward older adults, their well-being, and coping with the aging process (Löckenhoff et al., 2009). Societal discourses shape the perceptions on aging (Hausknecht et al., 2019). How individuals or society frame aging can impact perceptions on aging and contribute toward maintaining a positive or negative environment for the older adults to live in the community (Busso et al., 2019). A decline in the health status, loss of loved ones, retirement, slowing of pace are inherent to aging, and the acceptance, adaptations, and coping with life changes remain critical to older adults (Van Leeuwen et al., 2019). Acceptance is a strategy that helps contribute to inner peace and tranquility (Prigerson & Maciejewski, 2008). Although aging is considered as an inevitable aspect of life of a person (Hausknecht et al., 2019), aging is generally framed within the biomedical model of health care as the phase of decline in life (Vincent, 2006). Researchers and policymakers are increasingly aware and shifting the thinking of aging from the time of decline to prioritizing QOL and well-being (Bowling, 2008) which requires new framework inclusive of active, positive, or successful aging (Bowling, 2008; López-López & Sánchez, 2020).

Ageism is a prejudice, stereotyping, and discrimination against aging is still prevalent in the modern societies (Kavčič & Avsec, 2018), and when directed toward older adult, it negatively influences their physical and mental health, well-being, and QOL care received (Burnes et al., 2019). Ageism also promotes other discriminatory acts such as the social exclusion of older adults from engaging in meaningful roles and

relationships, which then affect their health. Inter-cultural study on the perception toward aging indicated that participants from the Eastern countries view aging more positively than those from the Western countries (Löckenhoff et al., 2009). Older adults perceiving greater negative age stereotypes and discrimination are associated with low-esteem and heightened old feeling (Marquet et al., 2019). A study on the positive aging views from eight countries in Europe revealed a significant prediction in better cognitive performance (Smith et al., 2019). In a study in the US, higher ageism predicted higher chronic health conditions and subsequently greater health-care cost (Levy et al., 2020). Levy et al. (2020) suggested that a comprehensive approach to address the societal source of injurious images and behavior toward old, even if the impact on ageism could be limited, would reduce the financial burden and enhance the lives of old people. A systematic review by Burnes et al. (2019) revealed that education, inter-generational contacts, and combined program interventions greatly reduced self-reported ageism and provided generalizable benefits.

Ageism has become an important issue in the modern world due to a significant effect of modernization on the demographic structure and its transformation. Migration and urbanization, decline in the marriage and fertility rate, surge in the age of first marriage and first child, increase in the adoption of nuclear families over the practice of extended family system, and increase in divorces are some of the many outcomes of modernization that influences the perceptions, behaviors, lifestyles, cohesion and cooperation, and conflict and solidarity (Kalaycı & Ozkul, 2020). One of the outcomes of modernization processes which is of grave concern is the manifestation of distrust in different cultures lowering life satisfaction and sociability, which are important components of social well-being (Aupers, 2012).

Social Death Versus Biological Death

Biological death refers to the process by which critical organ systems permanently cease to function and physical decay begins (Joralemon, 2013). On the other hand, loss in the social identity, connectedness, and losses linked to the degeneration of the body is broadly considered social death (Králová, 2015).The notion of social death is more abstract, less familiar, and equally complicated. It refers to the disintegration and disappearance of a person's social identity, loss of social connectedness, agency, and relationships that compromise the well-being of a person (Borgstrom, 2016; Joralemon, 2013). Social rejection hurts, and most importantly, rejection affects self-worth and identity and fuels one's sense of meaningless existence (Steele et al., 2015).

Throughout most human history, biological death preceded social death since most people died young and prematurely. Nonetheless, the pattern of death reversed in the twentieth century especially in the affluent countries where social death precedes biological death and is becoming a trend that is rapidly affecting the aging population. Prolonged dying at advanced ages results in the separation of people from their social networks well in advance of biological death (Joralemon, 2013). In the contemporary

materialistic times, social death is apparent ahead of the biological death. Many psychological theories suggest the sense of belonging, and social connectedness is central to the physical and psychological well-being of a person (Steele et al., 2015).

In Bhutan, higher QOL was reported among older adults who perceived good relationships with children, which is an indication that support from family members remains crucial for their QOL and well-being. Despite this, the practice of the traditional extended family system remains a concern for older Bhutanese adults which is seemingly getting eroded with urbanization and modernization (Dorji, 2016)**.** The maintenance and sustenance of a congenial and respectful relationship between older and younger generations remain ever critical amidst challenges in the contemporary world. Investing in social connection would play a significant role in keeping existential anxiety and death thoughts at bay (Steele et al., 2015).

What Quality of Life and Well-Being Depends on?

The research reflects complex findings of the elements of well-being and QOL among older adults around the world.

Health is a Matter for Well-Being, QOL, and Happiness

Talking about well-being and QOL cannot be independent of health. Aging has a consequence on the pattern of diseases and its chronicity in the population (Beaglehole et al., 2011). The definition of health by the World Health Organization as a state dependent on the presence or absence of disease since 1948, still widely used, invited many critiques that health can no longer be defined simply in terms of physical, absence of disease or disability, but also includes mental and social dimensions (Larson, 1996). Since researchers have established relationships between religious participation and well-being, the definition of health is criticized for failing to incorporate the spiritual and/or religious aspects of well-being (Noronha, 2015). Noronha (2015) claims that the integration of spirituality and religious resources and the knowledge and wisdom of human psychology into the treatment plan especially for the older adults is critical.

Health is a prominent component of aging well (Au et al., 2019) and is a paramount element of QOL that facilitates the ability to self-care, perform household chores, and communicate and participate in carrying out meaningful activities (Van Leeuwen et al., 2019). The ability to manage self, held autonomy, and dignity is an important aspect of QOL for the older adults. Being able to self-govern facilitates older adults to socialize, enjoy, and carry out what they want and experience freedom (Van Leeuwen et al., 2019). A study in the Netherlands among older adults emphasized the significance of health to their well-being since health enables them to pursue things that contribute to their well-being (Hackert et al., 2019). Likewise, older adults in

Bhutan expressed that good health and its maintenance is critical to attain happiness and satisfaction in life (Dorji, 2016). One of the older Bhutanese adults mentioned, "*There is no one who can be so dear other than me to care for my own body, mind, and speech. […] I have the sole responsibility to take care and maintain my own health. Good health is the basis for a person doing anything worthy in life. Therefore, health is very important in life*". (Dorji, 2016, p. 103). Existing literature supporting public health reorientation from treatment to prevention and promotion of health by identifying health risk factors can effectively avert diseases and foster better well-being and QOL. For instance, initiatives to stop smoking have been pivotal in reducing morbidity in many countries (Au et al., 2019). However, hurdles still exist in the implementation of prevention strategies to transform into reality.

In the Netherland-based study, older adults regarded health, financial security, family and social contacts and support, autonomy, helping others, religion, living environment, and adaptations significant for their well-being (Hackert et al., 2019). Most studies support the positive relationship between physical activity and psychological well-being (Zhang & Chen, 2019). The status of health is one of the most influential predictors of happiness (Angner et al., 2013). In a cross-cultural study between Italy and Cuba, health was the most frequently cited component of happiness and education best predicted the overall happiness for old age (Sotgiu et al., 2011).

Social Connectedness/support is a Significant Correlate of QOL and Well-Being

Quality of life, both physical and emotional, is increased through intimate platonic, romantic, or familial relationships because of the desire to feel a sense of belonging and attachment (Myers, 2003). Increased psychological well-being has been shown with social network, especially family, satisfaction, and therefore a positive effect on QOL (Mudey et al., 2011) and happiness for older adults (Tse et al., 2012). Strong social connections, leading to feeling of safety, are the building blocks of a strong society and well-being (Ura, Alkire, Zangmo, & Wangdi, 2012).

Having close relationships makes the person feel physically and mentally supported and enables the feeling of being worthy to others, which helps avoid loneliness (Van Leeuwen et al., 2019). The pervasive nature of loneliness (Masi et al., 2011) has a strong negative impact on the QOL of older adults (Van Leeuwen et al., 2019). QOL and happiness among older people have been shown in many studies to be associated with supportive social connections (Chen et al., 2013; Liao & Brunner, 2016). Receiving social support and closer relationships are potential sources of love, affection, and appreciation, which are keys to life satisfaction and are the predictive factors of QOL (Liao & Brunner, 2016; Oh et al., 2014; Van Leeuwen et al., 2019). As better QOL was reported among those perceiving stronger social support (Khan &

Tahir, 2014), social relationships and contacts may be among the most important modifiable factors of QOL of older adults (Nguyen et al., 2012; Puts et al., 2007).

A better QOL was found among the joint families (Kumar et al., 2014). A family relationship may be the most important correlate of well-being in Asian societies (Li & Cheng, 2015). The physical, psychological, social, and spiritual needs of the elderly are believed to be met when they live with their family members (Khan & Tahir, 2014). Nonetheless, change in the level of respect for older people, especially in Asian society, was observed in the recent past (Bansod, 2011). An elderly Bhutanese male participant who perceives decline in the cultural practices of respecting elderly mentioned, *"I would feel happier if the tradition of respecting our elders by juniors and the elderly loving our juniors be continued. I sense change in the situation and degradation of our cultural values"*. (Dorji, 2016, p. 137). Families bring and demand resources such as time, money, goods, and services and offer emotional support, information, and connections to others (Waite & Das, 2010). A greater sense of psychological well-being is associated with greater emotional support received from the family members (Thanakwang, 2015). However, a decline in close family ties negatively influence health and well-being in particular for the older adults (Helman, 2007). The dwindling of the quality and quantity of social relationships is observed especially in the developed world due to greater social mobility, delayed marriage, increased age-related disabilities, or reduced inter-generational living (Holt-Lunstad et al., 2010).

People living in good neighborhoods report better QOL as neighborhood resources or neighborhood social capital provides a sense of security including reassurance and support. Close relationships with neighbors are critical to older people particularly who are ill (Gabriel & Bowling, 2004). Involvement in the loved activities was important for sustaining interest in life and is associated with better health status and well-being. For instance, by participating in art and craft activities, older women may find more purpose in their lives and better subjective well-being (Liddle et al., 2013). Lack or loss of close social contacts is one of the main predictors for depression among older populations (Djernes, 2006). Buckley and McCarthy (2009) pointed out that prevention of social isolation among older people is important and suggested that any older adults' services should be shaped to maintain connectedness. Perceived social support may be an important resource that predicts emotional stability, extraversion, agreeableness, openness, and conscientiousness (Udayar et al., 2020).

In the existing literature, especially in the medical and health researches, well-being and QOL are studied as an outcome (Haraldstad et al., 2019) and are dependent on several influencing factors including social connection and support. However, there is a lack of evidence about how the state of psychological well-being and QOL of a being affects a person's social connection and support. The existence of this gap requires further exploration.

Spirituality/religiosity and Its Benefits

While spirituality focuses more on the existential and experience of an individual's faith, values, beliefs, and their influence on daily life, religiosity is more often referred to as commitment to religious faith and affiliation, participation in activities associated with faith (Moberg, 2005). Self-reflective and development exercises, like meditation, that can but are not necessarily a part of religion, can be classified as spiritual activity. Evidence suggests that spirituality and religiosity are among many of the modifiable factors that concern the improvement of health in later life (Zimmer et al., 2016). Spirituality is positively linked to various dimensions of life satisfaction, health, and well-being (Moberg, 2005; Noronha, 2015). Having a spiritual or religious framework gives a lens to which distress, illness can be understood and interpreted. Purpose and meaning are often defined through faith towards higher beings (such as God) gives older adults meaning (Dorji et al., 2019; Van Leeuwen et al., 2019). One of the older Bhutanese female participants, who expressed the benefit of spirituality, mentioned, "*Besides helping pave the road for after life, it also helps to discover self and become more aware, explore more of our own potentials, discover hell and heaven within self and teaches the law of cause, conditions and effects*". (Dorji, 2016, p. 104). Studies have also revealed mixed findings of spirituality and religiosity depending on the characteristics of it measured in the study (Koenig, 2012). Therefore, whether spiritualism comforts and afflicted or afflicts the comforted is debatable. Religious people are more oriented and committed toward a healthy lifestyle, exhibit less smoking, alcohol consumption and substance abuse, and less risky sexual behavior (Mishra et al., 2017; Zimmer et al., 2016). Religious individuals tend to demonstrate the experience of more positive affect and greater level of satisfaction in life (Vishkin et al., 2019). Vishkin et al. (2019) argued that religiosity associated with frequent use of cognitive adjustments contributes to greater life satisfaction and well-being. Investing in religiosity and spirituality could promote emotion-focused coping in the context.

Looking on the Brighter Side of Life

A positive perception of aging has a direct effect on the well-being and QOL of older adults (Ingrand et al., 2018). Having a positive attitude toward life and adopting life philosophies such as staying positive, being happy and enjoying life, maintaining humor, optimism and curiosity, and making the best of life are essential for a good QOL (Van Leeuwen et al., 2019). A positive self-perception of aging also reported better health outcomes and predicted greater longevity (Moser et al., 2011) as much as negative perception predicted persistence of depression and anxiety (Freeman et al., 2016).

Conclusion

Quality of life, well-being, and happiness is a subjective and multifaceted concept that depends on multiple factors including the perception of aging, health conditions, social connectedness and support, and spiritualism.

A comprehensive approach toward addressing societal sources of injurious images, ill behavior, and treatment toward old could substantially benefit in mitigating the burden of healthcare costs from a higher prevalence of chronic health conditions, which are significantly associated with ageism. Ageism needs to be recognized as an important modifiable risk factor to address and promote human health (Burnes et al., 2019) through the promotion of attainable inter-generational contacts and social support. As stressed by Marquet et al. (2019), the negative perception on aging and discrimination affects well-being and QOL, and interventions emphasizing the improvement in the sense of feeling worthy and acceptance of the reality of aging among older adults could enhance their psychosocial well-being. As social rejection hurts and often affects self-worth and identity (Steele et al., 2015), efforts toward meaningful social engagements could promote older adults' sense of meaningful existence. In addition, efforts to enhance the relationship between family members, social connections and bonding, and health could be more relevant to promote QOL and well-being among the older people.

Promotion and the maintenance of happiness, well-being, and QOL remain crucial to older adults for their longevity and life enjoyment. Besides, strengthening the roles and activity and relationships, promotion of spiritualism and its consolidation in daily living, the elevation of positive attitude toward their health conditions and adaptations, and emotional comfort would enhance QOL, well-being, and happiness for older adults (Van Leeuwen et al., 2019). Although the change in the family system is inevitable in the modern age, every effort could be made to make older people feel part of the family and meet their physical, psychological, social, and spiritual needs.

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Part V
Well-Being of Marginalized Population

Chapter 20
An Ecological–Contextual Model of the Development of Executive Functions: Identifying Target Areas for Its Promotion in Children in Socially Disadvantaged Contexts

Celina Korzeniowski

Abstract Children growing up in socially disadvantaged conditions are exposed to numerous risk factors that impact their cognitive development. Neurosciences have identified executive functions (EFs) to be some of the cognitive systems that are the most sensitive to environmental influence. EFs involve a set of high-order cognitive functions that control and regulate behaviors, emotions, and cognitions necessary to reach goals and solve problems. EFs are essential for self-regulation and play a key role in children's cognitive, emotional, and social development. EFs are significant predictors of health, quality of life, and well-being throughout the life cycle. EFs' development is lengthy, multi-staged, and extends from early childhood to adulthood. Various sensitive periods in the EFs' development have been identified, which creates different time windows in which the experience has a maximum impact on brain maturation. Research studies have identified factors in the child's family, school, and community context as possible modulators. For family, they are rearing practices, cognitive stimulation, stress, and caregiving. For school, they are classroom management, classroom climate, and teacher scaffolding. For the community, they are cultural norms, ethical values, and social practices. However, these factors have not been integrated into an ecological model that allows visualizing their differential weight within the set. The goal of this study is to present an ecological and contextual model of EFs' development that integrates the most significant research studies on the topic published in the last 20 years. In conducting this study, 50 peer-reviewed academic publications, issued between 2000 and 2020, were selected for review. Identifying and understanding the differential weight of the modulatory factors of the EFs' development help to identify target areas of intervention aimed at promoting their development, which is of particular interest for the design of programs aimed at improving the developmental trajectory, health, and well-being of children growing up in socially disadvantaged contexts.

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_20

Keywords Executive functions · Development · Ecological–contextual model · Children · Socially disadvantaged contexts

Introduction

Executive Functions: Its Implication in Healthy Development

Executive functions (EFs) constitute one of the most distinctive aspects of the human being, as they enable the ability to act with purpose and in a self-regulating manner in the various contexts of social interaction (Blair & Raver, 2014; Walk et al., 2018). Executive functions describe a set of high-order cognitive abilities that control and regulate the behaviors, emotions, and cognitions necessary to achieve goals, solve problems, and provide adaptive responses to novel or complex situations (Diamond, 2013).

Three core EFs have been identified: inhibitory control, working memory, and cognitive flexibility. Inhibitory control involves mental operations aimed at suppressing inappropriate behavior, or an attention tendency toward irrelevant or distracting stimuli that can interfere with the deliberate resolution of a problem (Friedman & Miyake, 2004). Working memory refers to the ability to keep information online and to operate on it, beyond distractions or despite carrying out another task (Davidson et al., 2006; Diamond, 2013). Finally, cognitive flexibility compromises the ability to shift attention, adapting mental activity, and behavior according to the demands of the environment (Diamond, 2013; Fine et al., 2009). During the development process, these three basic executive functions mature, differentiate, and enable the development of more complex ones, such as planning, organization, metacognition, monitoring, fluency, and decision making (Diamond, 2013; Miyake et al., 2000). These functions act in an interrelated way, enabling flexible, pro-positive, and self-regulated behavior.

EFs are implemented in a wide variety of situations, in essence those that are characterized by being novel and complex, their competence being crucial for an optimal functioning and socially adapted to the changing demands of the environment (Lezak, 1982). The essence of EFs is cognitive control, which involves a set of interconnected neural networks that operate in a coordinated way across an integration zone located in prefrontal areas (Fuster, 2001; Koechlin & Summerfield, 2007). EFs have a hierarchical place in human cognition, from which they orchestrate the necessary resources for the achievement of a goal or the resolution of a problem. The "cold" EFs are involved in reasoning and efficient information processing. However, the "hot" EFs play a key role in emotional competence, as they enable the regulation of emotional expression, the knowledge of one's own emotions and others, and their monitoring and adjustment to the situations of the context (Hongwanishkul et al., 2005).

EFs play a critical role in cognitive, social, and emotional development of children and predict many life outcomes. Their adequate performance in childhood is

associated with good school performance, purposeful social relationships, emotional well-being, and behavioral self-regulation (Diamond, 2013; Walk et al., 2018).

Children who show a greater capacity for self-regulation are better able to regulate their emotions, establish positive relationships with peers and adults, tolerate frustrations, expect rewards, adjust their behavior to the demands of the context, be more creative, be flexible, and present a better school performance. EFs are considered critical for school readiness, future academic performance, and successful learning (Nyroos et al., 2018).

EFs are considered resources for learning. Over the last 20 years, a body of research has documented its involvement in different subject areas, such as Literature, Mathematics, and Science, (i.e., Best et al., 2011; Fuhs et al., 2014; Welsh et al., 2010). EFs help children to set goals, initiate and complete tasks, direct and sustain their attention on relevant aspects of tasks, plan and organize activities, sustain cognitive effort and persevere in the face of difficulties, detect errors, recognize new perspectives, formulate alternative plans when atypical events occur, and reflect on thoughts and actions (Blair & Raver, 2014; Hodgkinson & Parks, 2016; Korzeniowski et al., 2016; McKinnon & Blair, 2018; Nyroos et al., 2018). In addition, they are involved in contributing to monitoring and reflection on learning processes, promoting emotional self-regulation, and enabling self-regulating behavior (Korzeniowski et al., 2020). For these reasons, EFs play a critical role both in self-regulated learning processes and for children's adjustment in the classroom setting (Fitzpatrick et al., 2014).

These achievements in childhood predict better health, better quality of life, greater academic success, better employment status, and a lower incidence of conduct problems, in adolescence and adulthood (Diamond, 2013; Moffitt et al., 2011). A longitudinal study (Moffitt et al., 2011) observed that self-control in early childhood predicts many life outcomes in adulthood, after controlling for the effect of IQ and socioeconomic status. This study reported that children with difficulties in self-control presented, in adolescence, a higher frequency of risk behaviors, such as greater consumption of tobacco, alcohol, school dropout, and teen parenthood. In adulthood, they presented: health problems, such as higher prevalence of metabolic syndrome, substance dependence, and sexually transmitted diseases; economic difficulties, such as financial planning problems, credit and savings difficulties; higher prevalence of single parenting; and, conduct disorders, such as disruptive social behavior and problems with the law. These data underscore the role of children's self-regulatory capacities in health and quality of life in human development, and identify them as a target of early intervention and prevention programs.

In sum, the adequate development of executive functions in childhood is a key factor for healthy development, well-being, and quality of life. From there, the importance of identifying the factors that shape their development arises, especially in children who grow up in socially vulnerable conditions.

Executive Functioning Development

Executive functions emerge in early childhood and present a protracted development that continues into adulthood. Its development is sequential, multi-staged and is associated with the late maturation of a set of neural networks coordinated by the prefrontal cortex (Fuster, 2001). The prefrontal regions show a late development in contrast to the early maturation of other cortical regions. This maturational pattern reflects the hierarchical organization of the brain (Koechlin & Summerfield, 2007), within which the prefrontal cortex is one of the structures that shows the most connections with the rest of the cortical and subcortical regions.

The gradual changes in the morphology and physiology of the prefrontal areas and their connections are associated with the emergence and maturation of EFs. Specifically, it has been suggested that EF development is closely related to myelination and synaptic pruning, which are the two events that are considered most responsible for brain maturation (Korzeniowski et al., 2021).

Myelination of the frontal lobes increases linearly from 4 to 13 years of age, which is associated with an increase in the speed of nerve impulse conduction between the connections of the prefrontal cortex and other regions of the brain. Synaptic pruning sculpts the neural connections of the prefrontal cortex with other cortical and subcortical areas, selectively removing non-functional synapses. This process is continuous from ages 5 to 16, leading to a decrease in synaptic density and changes in gray matter during childhood and adolescence (Sowell et al., 2001).

Morphological maturation of the prefrontal cortex is reached at puberty, but anatomical and functional changes continue for years to come. In this stage, the increase in gonadal hormone secretion plays an organizing effect on the neural mechanisms that support cognitive processing (Davies & Rose, cited in Hughes, 2011). Adolescence is characterized by a sustained increase in myelination, which is associated with faster and more efficient processing of information in the frontostriatal network (Giedd et al., 1999; Paus, 2010), and by a reduction in the gray matter, which is associated with the specialization of the neural networks involved in executive functioning. On the other hand, changes in interhemispheric connections, neurotransmission mechanisms, and increases in brain metabolism have been reported. An increase in dopamine and serotonin, as well as a modification in the biosynthesis of neurotransmitters and peptides, have been documented, affecting cognitive functioning and being associated with gains in EFs in adolescence (Tau & Peterson, 2010).

The extensive development of the neural networks that make up cognitive control is considered a facilitating factor of cognition as it creates time windows, in which the plasticity of the brain is increased and it is more susceptible to the environmental experience. This refers to the existence of sensitive periods (Armstrong et al., 2006), in which the development of executive functioning can be promoted and stimulated through appropriate experiences. Consequently, gains in children's executive abilities should be interpreted as resulting from the delicate and sustained interaction between brain maturation and the influence of the environment. The literature reports that an

adequate development of executive functions is reflected in the milestones described below.

In early infancy, around 6–8 months of age, the emergence of executive functions is recorded. The milestone of "permanence and recovery of the object" signals the emergence of behavioral inhibition, working memory, attention, and rudimentary problem solving (Korzeniowski et al., 2021). Later, between 3 and 5 years of age, important achievements and rapid advancement in EFs are observed. At this stage, children acquire the skills to keep more than one thing in mind, flexibly shift focus, inhibit a dominant response tendency, detect errors, begin to regulate the expression of their negative emotions, and have metacognition (Diamond & Kirkham, 2005; Hughes, 2011; Korzeniowski et al., 2021; Roebers et al., 2012).

During middle childhood and adolescence, EFs register a peak of intense growth between 6 and 10 years of age, after which EFs continue to develop more slowly. In this stage, EFs follow a process of sequential and multi-staged development, in which some functions, such as attentional control and inhibitory control, mature earlier, while others, such as planning, metacognition, working memory, show gains in adolescence and early adulthood. Advances in the development of EFs in this vital stage allow children to process and manipulate a greater amount of information, understand the most relevant conditions of the tasks, an efficient use of memory strategies, greater flexibility to solve problems and progress in the organization and planning of its activities (Flores-Lazaro et al., 2014).

EF development has an additive and systematic effect on the control of cognition. The maturation of each executive function makes a specific and selective contribution to the cognitive control process, which is associated with a greater capacity to create mental schemas, greater mental flexibility, greater planning of cognitive and behavioral activity, and greater cognitive fluency and creativity (Flores-Lázaro et al., 2014; Korzeniowski et al., 2021). These achievements will have a significant impact on the school, social and emotional environment of children.

Executive Functioning Development and Socially Vulnerable Contexts

EFs can be negatively affected by stressful environments and by the lack of quality and proactive interactions with adult caregivers. However, environments that promote healthy child development can help children to strengthen their EFs (Hackman et al., 2010).

Social vulnerability is a risky social condition that makes it difficult, in the present or future, to satisfy well-being in terms of subsistence and quality of life (Korzeniowski et al., 2020). It is a complex, multi-causal phenomenon that includes aspects such as helplessness, insecurity, exposure to risks and stress due to traumatic

socioeconomic events. However, it also involves, to deal with these events, the availability of resources and strategies that may arise from within the group itself or from external support (Golovanesky, 2007).

Children who grow up in socio-vulnerable conditions are exposed to numerous risk factors that impact their physical, social, emotional, and cognitive development (Hackman & Farah, 2009; Lipina et al., 2011; Noble & Farah, 2013). It has been documented that, compared to children from more favored socioeconomic strata, these children present: a higher percentage of physical and psychological health problems, such as depression and anxiety; more behavior problems, such as aggressiveness and impulsiveness; and, lower school and intellectual performance (Arán Filippetti & Richaud de Minzi, 2012; Farah et al., 2006; Noble et al., 2007).

Unfortunately, the socio-environmental conditions of the homes of children who grow up in socially disadvantaged conditions are different from those who live in better socioeconomic conditions. The former are exposed to a greater number of stressors, family instability, less cognitive stimulation, and more inconsistent parental discipline guidelines. Such children have poorer diets, are exposed to more toxins in the water and air, have less read to them and attend poorer schools (Evans, 2004). They are more likely to be victims of abuse and neglect and are often exposed to greater violence in their homes (Fitzpatrick, 2014). The cumulative experience of these factors negatively affects neurocognitive development.

Educational and cognitive differences between children from more affluent backgrounds than those growing up in socially disadvantaged conditions are evident in early childhood and widen even more with the passage of time. In early childhood, children from disadvantaged contexts have a lower vocabulary and have lower performance in cognitive and executive functioning tasks (Fitzpatrick, 2014). During the preschool and school stage, studies in developed countries (i.e., Crook & Evans, 2014; Fitzpatrick et al., 2014; Hackman et al., 2010; Noble et al., 2007) and developing countries (i.e., Ison et al., 2015; Korzeniowski et al., 2016; Lipina et al., 2011; Musso, 2010; Piccolo et al., 2016) have reported, for children from disadvantaged contexts, in comparison with their peers from more advantageous social contexts, a lower performance in: attention, working memory, cognitive flexibility, planning, overcoming difficulties in self-regulating emotions and resolving conflicts. These difficulties become apparent as children enter school, persist in elementary school, and generate greater differences in secondary school completion rates (Fitzpatrick, 2014).

Based on these reports, neurosciences have attempted to specify the factors that mediate the impact of the environment on children's cognitive development. During the last two decades, environmental factors that model the EF development have been studied, identifying factors from the family, school, and community.

Family Factors That Model Executive Functioning Development

Research focused on understanding the characteristics of early childhood development environments that could impact child cognitive development. Pioneering studies focused on the family, and identified environmental factors, health conditions, and social interactions, as predictors of EF development (i.e., Deater-Deckard, 2014; Hackam et al., 2010; Landry et al., 2002; Bibok et al., 2009).

At first, the home environmental and health conditions of children growing up in socially- disadvantaged conditions were addressed. The home environment determines access to learning opportunities and resources necessary to stimulate cognitive development. A study carried out in Argentina observed that exposure to lead, the quality of nutrition, the child's health status, and the environmental conditions of the home all modeled the development of executive functions in children (Arán Filippetti & Richaud de Minzi, 2012). The environmental conditions of the home that negatively affected the cognitive development of children were reported as: noisy, crowded environments, with inadequate sanitary conditions and limited space development (Arán Filippetti & Richaud de Minzi, 2012). In line with this report, a study observed differences in attention, planning, and verbal working memory in children based on characteristics of the home environment (Hackman et al., 2010).

Subsequently, it was analyzed whether the quality of the bounds between caregivers and children could model the impact of socially disadvantaged conditions on the development of self-regulatory capacities in children. Hackman et al. (2010) identified three mediating factors: prenatal factors, parental care, and cognitive stimulation.

During pregnancy, mothers who are in disadvantaged socioeconomic situations are often exposed to stressful events which compromise their health and that of their child. They tend to have high levels of stress, lower nutritional quality, and higher risks of infection, which is associated with higher chances of abnormal fetal growth and premature birth (Farah et al., 2006; Hackman et al., 2010; Noble & Farah, 2013). In particular, stress can increase cortisol levels in the fetus, which has been related to a delay in neuronal maturation, myelination, and synaptogenesis, thus affecting neurocognitive development (Lupien et al., 2001). Low birth weight and alterations in fetal development have been associated with a greater probability of suffering from mental illness and presenting a lower school performance (Hackman et al., 2010).

After birth, a high level of stress in the parents or caregivers of the children decreases the involvement, the sensitivity to the needs of the children, resulting in a lower quality of parental care (Blair et al., 2011). The presence of irritability, depression, anxiety in parents compromises the quality of interactions with their children. Likewise, the presence of stress in parents has been linked to the use of punitive and inconsistent parenting strategies, greater neglect, greater frequency of family conflicts, family violence, which promotes emotional and behavioral problems in children (i.e., Fitzpatrick, 2014; Hackman et al., 2010). Parents with high

levels of stress are less predisposed to interact and communicate with their children, which negatively affects the development of children's cognitive and emotional self-regulation abilities.

However, it is important to stop here and analyze the results of research that indicate that it is not possible to think of a linear relationship between poverty and lower quality of parental care. A research reported that proactive interactions between parents and children have been associated with resilient behavior in children living in impoverished environments (Orozco-Hormaza et al., 2012). In line with this result, parental education programs that aim to improve parenting practices in families at risk, improve social and emotional functioning in children. Together these results denote that the quality of care that children receive at home and the type of interactions they establish with their parents or caregivers constitute family resources that can reduce the impact of socially unfavorable conditions on child cognitive development.

Another variable of interest is the variety and quality of cognitive stimulation that children receive at home (Hackman & Farah, 2009). Cognitive stimulation is a broad concept that includes both the availability of material resources, number of books in the home, learning materials, internet access, computers, travel, as well as cultural and educational resources of the family, the educational level of parents, socioeconomic status, collaborative interactions between parents and children, parenting practices, communication between parents and children.

From the variables mentioned, the educational level of the parents constitutes the factor that has been consistently associated with differences in executive functions in children and adolescents (i.e., Ardila et al., 2005; Farah et al., 2006; Matute et al., 2009; Noble & Farah, 2013). Parents with a high educational level create a more intellectually stimulating environment for their children and generate richer formats of interaction in relation to the use of language (Ardilla et al., 2005; Hoff, 2003). It has been observed that university-educated mothers use a richer vocabulary when interacting with their children, dialogue with them more, and read more books to them (Hoff, 2003). These children tend to have faster language development and better cognitive performance.

Based on these results, the researchers began to investigate the type of collaborative interactions between parents and children in order to understand what types of scaffolds promoted a greater EF development (Bernier et al., 2010, 2012; Bibok et al., 2009; Roskam et al., 2014; Spruijt et al., 2018). Scaffolding is a metaphor that captures the idea of an adjustable and transitory support that enables the child to solve a problem that they could not achieve without receiving help (Brown & Palincsar, 1989). Through scaffolding, parents or caregivers plan and organize children's activity so children can perform a task that is beyond their current skill level. Consequently, parents need to adjust support to the children's cognitive level.

Some processes have been identified by which adults provide this help to children, such as (a) focusing attention on the requirements of the task; (b) maintenance of the goal; (c) frustration control; (d) decrease in the degree of difficulty of the task; (e) highlight the main characteristics of the task; and (f) modeling the ideal strategies to solve the task. In this context of social and emotional support that parents provide children, they develop the necessary skills to solve task independently, which traces

their cognitive development. However, the effectiveness of scaffolds is mediated by two factors, the use of language and timing (Bibok et al., 2009).

- The use of language in the construction of the scaffolding affects the EF development (Hoff, 2003; Landry et al., 2002). Two types of scaffolds have been identified, elaborative and directive. Expressly telling the child what to do, reducing the complexity of the tasks, that is, reducing the size of the problem, blocking the difficulties that the child must face, is what characterizes directive scaffolds. These are functional in early childhood, but then produce a counterproductive effect (Bibok et al., 2009). On the other hand, in elaborative interactions, parents provide the child with external and auxiliary resources, which allow him to face a challenging problem that requires partial constructions of new knowledge (Bibok et al., 2009). It has been observed that parents' who offer the child advanced linguistic models to represent problems and their possible solutions, predict the child development of language and EFs (Bernier et al., 2010; Hoff, 2003; Landry et al., 2002).
- Timing as to when it is offered to the child is the second factor that mediates the effectiveness of scaffolds. To be effective, the moment must be contingent on the child's cognitive construction activity. In a study with two-year-olds, the use of contingent directive and elaborative interactions was compared to solving a puzzle. The results indicated that only elaborative interactions contingent on the child's activity predicted improvements in child attention spans (Bibok et al., 2009).

Therefore, cognitive stimulation is not limited to the availability of material resources in the home, but finds its essence in the quality of interactions between children and their caregivers. Enriching the daily life of children with playful, recreational, and educational activities mediated by a caregiver, in which the caregiver organizes the activity in a way that facilitates its solving by the child and encourages him to reflect on their actions, is a way to create opportunities to promote EF development.

In summary, research in neuroscience and cognitive neuropsychology has collected empirical evidence that allows identifying factors and characteristics of the most disadvantaged family contexts that can negatively or positively impact the cognitive development of children. These data point out valuable areas of intervention and prevention to promote better development in children.

School Factors That Model Executive Functioning Development

The literature reports that the schooling experience is a factor that contributes to the promotion of EFs (Burrage et al., 2008; Fuhs et al., 2014). Entering the school offers children new learning experiences that boost the development of executive

functions. Recent research has documented bidirectional relationships between EFs and reading, writing, and math skills, indicating a mutual influence between both processes (McKinnon & Blair, 2018; Van der Ven et al., 2012). Furthermore, it has been documented that children who learn school content and skills more quickly are more willing to participate in increasingly demanding academic activities, which stimulate the development of EFs (Fuhs et al., 2014). Therefore, children's gains in school learning will lead to improvements in their self-regulation abilities.

On the other hand, it has been observed that the EF development is sensitive to the conditions of the school and classroom environment. The type of school, the availability of material resources for learning, the school climate, classroom management, the instructional and organizational support of the class, peer relationships, and the interactions between teacher and student are some of the factors that can modulate the self-regulatory capacities of students (Bardack & Obradović, 2019; Hu et al., 2020; Korinek & deFur, 2016; Nyroos et al., 2018; Rosen et al., 2014; Suntheimer & Wolf, 2020; Spilt et al., 2018; Vandenbrouck et al., 2018; Weiland et al., 2013).

In relation to the availability of material resources for learning, some studies have reported that schools from disadvantaged contexts have less resource in relation to those from more affluent contexts. These differences impact the learning of schoolchildren and reproduce the initial socio-cultural differences of children (Krüger, 2013). Although the material conditions and the availability of resources for learning shape the schooling experiences of children, there are other factors with greater explanatory force about the learning processes of children. The quality of teaching is one of the most important school variables influencing student achievement (Organisation for Economic Co-operation and Development [OECD], 2015).

Numerous studies document the relationship between the quality of teaching and children's school learning processes; however, few have asked how the teaching process shapes the cognitive development of students (i.e., Weiland et al., 2013). Initial studies analyzed this relationship in a broad way and indicated that the school climate, class management, and the structuring of teaching activities are factors that modulate the cognitive and emotional self-regulation capacities of schoolchildren. However, these studies did not detail the specific mechanisms by which schooling impacts children's performance of executive functions.

In an effort to provide clarity to this question, a body of recent research has focused on analyzing the role of the teacher as a mediator of the cognitive development of students (Bardack & Obradovic, 2019; Keenan et al., 2019; Korinek & deFur, 2016). Two ways have been identified by which educators promote the development of students' EFs: one, implicit, from modeling the use of EFs in daily school activities; and, the other, explicit, through scaffolding the development of the students' self-regulatory capacities (Bardack & Obradovic, 2019; Korinek & deFur, 2016).

Human beings learn by observing the behavior of others. Teachers model EFs for their students when they: organize content, plan and sequence the steps of learning tasks; use time productively; resist distractions; shift their focus of attention to serve diverse stimuli; control frustrations by maintaining a good school climate; or, use their cognitive flexibility to seek different solutions to problems (Badarack & Obradovic,

2019; Hodgkinson & Parks, 2016; Korinek & deFur, 2016; Nyroos et al. al., 2018; Rosen et al., 2014; Walk et al., 2018).

Research shows that the emotional and cognitive self-regulation of teachers plays a critical role in promoting and maintaining positive educational practices that contribute to students' EF development. A greater capacity for self-regulation of teachers, emotional support, instructional and class organization, and establishment of clear and consistent routines are associated with better stress management, better school climate, better class management, and greater students' EF development (Andersen et al., 2019; Badarack & Obradovic, 2019; Diamond & Lee, 2011; Hodgkinson & Parks, 2016; Rosen et al., 2014).

Furthermore, it has been observed that teachers who denote greater self-regulation capacities are more likely to use educational practices that explicitly support or scaffold students in the acquisition of self-regulatory capacities (Anderson et al., 2020; Korinek & deFur, 2016; Raver et al., 2012; Rosen et al., 2014).

In one study, it was observed that the scaffolding of planning-organization skills and cognitive flexibility offered by educators was associated with improvements in students' EFs six months later (Badarack & Obradovic, 2019). Among the strategies used by educators to scaffold EFs were: instructing students how to use time or how to keep materials organized; allowing students to choose topics or projects; communicating trust and respect; establishing clear routines; considering multiple perspectives; switching between perspectives; and, frequently using positive feedback (Badarack & Obradovic, 2019). The sustained practice of these strategies helps students take ownership of them, and use them to regulate their learning processes.

In sum, the school context is an environment with multiple resources and opportunities to promote the development of the self-regulatory capacities of its students, especially for those from vulnerable contexts.

Cultural Practices Within the Community, and Child Executive Functioning Development

EFs develop in social interaction. The socio-historical theory of development (Vygotsky, 1978) postulates that higher mental functions, such as self-regulation, develop within the context of interpersonal activity.

In order to analyze how social interaction directly influences children's behaviors that require executive control, Morguichi et al. (2007) examined whether children's executive control might be influenced by learning from another person's actions. They proposed an interference task and a card-sorting task to children, in a context of social interaction, in which an adult modeled the execution of the task in a wrong way (Moriguchi, 2012; Moriguchi et al., 2012). The finding indicated that children imitate adult behavior in solving executive functioning tasks, especially if they observed a confident adult model. Interpersonal interaction may facilitate internalizing some

views of another person's perspective on reality, which shape the development of EFs (Moriguchi, 2014).

These results provide evidence of the importance of social modeling in cognitive development, and raise the question of whether cultural differences can mediate the influence of social modeling on EF development. Morguichi et al. (2012) replicated their study on social imitation, with 3- and 4-year-olds in Canada and Japan, and observed a greater sensitivity to adult modeling in Japanese children than in Canadians. They interpreted these differences in terms of cultural psychology theories. They postulated that the differences between Canadian and Japanese children are probably due to the fact that the former may be more likely to separate themselves from another person, and, consequently, act more independently of the others (Morguichi et al., 2012). However, more studies are necessary to support this postulation.

A review study set out to examine the evidence for cross-cultural variation in socialization and children's self-regulation, based on a contextual-developmental perspective (LeCuyer & Zhang, 2015). The contextual–developmental perspective proposes that social values, beliefs, cultural norms and ethical values, shape the socialization process and the behavior of people, and consequently, they can affect the development of self-regulatory capacities in children (Bronfenbrenner, 1979, 1992). The analysis of comparative and correlational studies indicated coherent patterns of sociocultural influence on children's attention, compliance, delay of gratification, effortful control, and executive function (LeCuyer & Zhang, 2015). These findings postulate the importance of incorporating a socio-contextual view, to understand how the differences in parenting can distinctively shape the development of executive functions.

The social practices, cultural norms, values, and attitudes of socio-cultural context affect parents' rearing practices, their behaviors, and the interaction between parents and children. Parents from different cultures and communities will offer children distinctive learning experiences and opportunities, which will distinctly shape children's cognitive development. Likewise, culture and social values will shape children's schooling, the quality of teaching, and collaborative interactions between teachers and students. Considering that, schooling may affect, in a distinctive way, the development of students' self-regulatory capacities, perhaps strengthening certain executive functions more than others.

In a study carried out with a large and representative sample of 55,000 Argentine schoolchildren (Korzeniowski & Ison, 2019), in which the students' EFs were evaluated, cognitive flexibility was identified by teachers' reports as the strongest EF in the children. These data could be associated with learning opportunities and practices, in their homes and schools that often stimulate cognitive flexibility in children. Furthermore, these results could be associated with the practices reported by the Argentine teachers in another study (Korzeniowski & Ison, 2020), who use guidelines and strategies with high frequency to strengthen students' cognitive flexibility. However, future studies are necessary to test these associations directly and predictively, and to compare these findings with other sociocultural contexts.

In sum, the review carried out indicates that it is not possible to interpret the impact of social interaction on the development of executive functions without considering cultural differences. It is necessary to adopt a contextual perspective of development that allows understanding of the associations between differences in cultural norms and values, socializing behaviors, and children's self-regulation, in order to comprehend diversity in children's EF development.

An Ecological–Contextual Model of the Development of Executive Functions

From a contextual–developmental perspective (Bronfenbrenner, 1979, 1992), and to integrate the contributions of the environmental factors that model the development of executive functions, an ecological model is proposed that synthesizes variables from child, family, school, and community (see Fig. 20.1). The proposed model is flexible, and it is hoped that it can be enriched with future research.

Ecological Interventions for Improving Executive Functions in Children from Socially Vulnerable Contexts

The study of the environmental factors that shape EF development in children from socially vulnerable contexts has allowed us to identify areas of intervention. In recent decades, there has been a growing interest in designing ecological interventions aimed at enriching family and school resources in order to enhance the cognitive and socio-emotional development of children in conditions of social vulnerability (Diamond & Lee, 2011; Diamond & Ling, 2016).

One of the strengths of intervention methods in neuroscience is that they enable articulation with other intervention proposals and their application in natural contexts where the child grows up, such as school, home, and community (Lipina et al., 2011). Based on this postulate, two types of interventions have been developed: enriched curricula and psychoeducational workshops for parents.

Enriched curricula refer to cognitive training activities that are integrated into the school curriculum, forming part of the daily activities that children carry out at school. These interventions are accessible to more children, can be started early, and can be sustained longer. Its application is in charge of educators, and consequently, it is necessary to train them with knowledge and strategies aimed at promoting students' EFs (Andersen et al., 2019; Bardack & Obradovic, 2019; Keenan et al., 2019; Korinek & deFur, 2016). Enriched curriculum programs, such as Tools of Mind (Diamond et al., 2007), have generated promising results, indicating that participating children improve their self-regulatory capacities and school competencies. Likewise, these experiences promote the active participation of children, reduce stress in the

Fig. 20.1 An ecological–contextual model of the development of executive functions

classroom, and cultivate play, self-confidence, social and emotional development, accompanied by a greater EF development and school performance (Anderson et al., 2020; Cabanes Flores et al., 2018; Diamond & Lee, 2011; Domitrovich et al., 2007; Janz et al., 2019; Korzeniowski et al., 2017; Walk et al., 2018; Zelazo et al., 2018).

In order to improve family resources, training for parents has been implemented. Workshop for parents has focused on assisting parents in improving communication with their children, promoting the development of critical thinking skills, and providing techniques for family stress management and guidelines to enhance child development and learning (Diamond & Lee, 2011; Korzeniowski et al., 2017).

In one study, a series of workshops were carried out to train parents from socioeconomically vulnerable backgrounds (Stevens & Neville, 2011). Over eight weeks, parents learned strategies to improve communication with their children, reduce stress, and promote the use of critical thinking in children. The results indicated that the parents who participated in the intervention exhibited a decrease in stress in the face of parenting challenges and increased opportunities for dialogue and verbal

communication with their children. These changes were associated with children's improvements in language, memory, and attention.

The strengths of these interventions are several. Training caregivers is a way to enrich family educational resources, favor a climate of positive interaction, and promote better stress management, which results in benefits for parents, children, and the whole family.

The promising results of ecological interventions provide evidence of the importance of enriching the daily activities of children who grow up in socially vulnerable conditions, in order to promote their development. Ultimately, the aim of these interventions is to increase children's resources to cope with disadvantaged environments.

Conclusion

Executive functions play a key role in the cognitive, social, and emotional development of children. Their adequate performance in childhood is associated with self-regulated behavior, proactive social relationships, emotional well-being, and successful school learning in childhood. These childhood achievements predict better health, well-being, and quality of life in adolescence and adulthood.

Children who grow up in socially vulnerable contexts are exposed to numerous risk factors that impact their cognitive development. They present educational and cognitive disadvantages that are appreciated upon entering the educational system and are accentuated during the school career, due to the summative effect of risk factors.

EFs can be negatively affected by stressful environments and by the lack of quality and proactive interactions with adult caregivers. However, environments that promote healthy child development can help children to strengthen their EFs. Considering that the family and the school are the two social institutions that most shape the development of children (Gerrard & Soriano, 2020), the characteristics of these contexts that modulate child EF development have been studied. For family, the following factors have been identified: parents' educational level, prenatal and postnatal stress level, family socioeconomic level, rearing practices, cognitive stimulation, and quality of mother–child interactions. For the school context, these factors have been pointed out: school climate, classroom management, teacher's emotional support, and collaborative interactions between teacher and students that scaffold EF development. However, the impact of the family and the school on children's cognitive development should be understood and analyzed within the framework of their sociocultural context. The contextual–developmental perspective postulates that cultural norms and social values shape the socialization practices of children, and, by this path, the EF development. Based on that, it is necessary to adopt a contextual–developmental perspective, in order to comprehend diversity in children's EF development.

Knowing the explanatory value of these factors in the child cognitive development has made it possible to identify specific areas of intervention. The current challenge

is the design of ecological interventions aimed at increasing resources for family, school, and community, in order to promote child EF development. The experiences carried out provide promising results and underline the importance of training parents and teachers.

Interventions in the family indicate the need to transfer resources to the parents or caregivers of children, aimed at promoting the quality of parental care, increasing sensitivity to the needs of children, improving communication, and train them in using techniques and activities designed to promote the EF development. Through short, simple and playful activities, caregivers can create meaningful learning experiences for children to strengthen their self-regulatory capacities. The challenge for researchers and practitioners will be to create these resources and find the best strategies to bring them closer to less favored households.

In school, the key is the quality of teaching, which underscores the importance of revaluing the role of the teacher as a mediator of the cognitive development of students. This underlines the need to transfer knowledge and strategies to educators, so that they become able to create new and better educational practices aimed at promoting students' learning and EF development. The challenge for educators and researchers is to create bridges between neuroscience and education. Both must overcome barriers, articulate objectives and share perspectives and languages to create enriched educational practices.

The evidence gathered indicates that the cumulative and summative effect of enriched practices at home and at school is a possible way to reverse, or at least compensate for, the educational and cognitive gap between the most and least favored children. Ecological interventions for home and school can benefit many children. It is necessary to articulate efforts between researchers, educators, governors, and community leaders to extend these interventions to more children, families, and schools. The more bridges that can be established between these sectors, the greater the chances of providing children with better opportunities for healthy development and a better quality of life.

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Chapter 21
Mental Health of Children with Physical Disabilities: A Concern for All

E. T. Phakula and Jace Pillay

Abstract Most research in the field of education and health studies focuses on the physical health of children with disabilities, often neglecting their mental health, which should be a concern for all. Hence, the focus of this chapter is on the mental health of children with physical disabilities, living in child-headed households (CHHs) in Johannesburg, South Africa. Qualitative data was collected from six children who had been diagnosed with a physical disability and who attend a special school catering for their needs. The researchers used a combination of individual and focus group interviews and collages. Through thematic analysis, several psychological, educational, and social factors were identified as contributors to the poor mental health of the participants. The findings and their implications are discussed in relation to the capability theory of human development.

Keywords Children · Mental health · Disability · Johannesburg · South Africa

Introduction

This chapter commences with a description of the situation of children with physical disabilities living in child-headed households (CHHs), which is aligned to the capability theory of development. The challenges faced by children with physical disabilities become more intense in child-headed households. This is because the responsibility of looking after the emotional, physical, and social well-being of the physically disabled child now falls on a minor. The child head, a minor, does not have the psychological, physical, or social maturity to assume such huge responsibilities.

In this chapter, CHHs refer to households where all members are children under the age of 18 years (Meintjes, 2009). CHHs are increasingly prevalent in South Africa. Parents may be absent because of illness, death, divorce, or employment

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_21

elsewhere. Children with physical disabilities living in child-headed households are more likely to be orphaned than their non-disabled peers.

Children with physical disabilities may utilize wheelchairs, canes, crutches, or walkers to move around (Brault, 2012). These children may experience difficulties in covering short distances, climbing a flight of stairs, or getting in and out of bed. The World Health Organization (2011) reported that these children may suffer from arthritis or rheumatism, back or spine problems, broken bones or fractures, cancer, cerebral palsy, diabetes, epilepsy, head or spinal cord injuries, heart trouble or atherosclerosis, hernia or ruptured hernia, high blood pressure, kidney problems, lung or respiratory problems, missing limbs, paralysis, stiffness or deformity of limbs, stomach/digestive problems, stroke, thyroid problems, or tumors/cysts/growths as a condition contributing to limited activity.

In the context of this chapter, physical disability is seen as the deprivation of the ability to live a good life at full capacity. Development refers to the expansion of capability. The capability theory is defined by its choice to focus upon the moral significance of individuals' ability to achieve the kind of lives they value. A person's capability to live a good life is defined in terms of a set of values, such as being in good health or being able to have loving relationships with others. This poses a challenge for children from CHHs living with physical disability as they also experience psychological problems, such as having to fit into the community. As a result, children with physical disabilities living in CHHs are discriminated against by the community because of their disability, and their educational needs and general outcomes fall short of expectations. The deprivation of one's access to a good life reflects the failure of the societal system to respect human dignity.

Nationwide, one in four children living with physical disabilities has lost one or both parents, compared to one in five among non-disabled children. Sub-Saharan Africa has been identified as the world's poorest region with the largest proportion of vulnerable children in the world (Pillay, 2014; Sewpaul & Mathias, 2013). There is a clear indication that children with physical disabilities living in child-headed households are often neglected. Research has been done on physical disability, and on CHHs in South Africa, but a search of the available literature shows that there are no studies reported on both physical disability and CHHs. Not much is known about the psychological, educational, and social experiences of children living with physical disabilities in CHHs in Johannesburg. For a deeper understanding of this issue, this chapter has been divided into subsections, including an introduction, background, and theoretical framework. This is followed by a brief description of the research methodology used in the study and the psychological, educational, and social findings that emerged through the data analysis process. Issues of concern are raised, followed by discussion, and recommendations to address the issues raised.

Background of Children with Physical Disabilities Living in CHHs

CHHs are increasingly prevalent in South Africa. This is largely because of socioeconomic circumstances (for instance, divorces and employment away from the home) leading to absent parents, and parental deaths, particularly from diseases, such as HIV/AIDS and other related illnesses (Pillay, 2012). Fleming (2015) pointed out that orphans and vulnerable children in countries with many cases of HIV/AIDS experienced discrimination in accessing education and health care as orphanhood was associated with HIV/AIDS. Fleming further argued that maternal and double orphans are more discriminated against in accessing education than paternal orphans (Fleming, 2015).

According to the General Household Survey of 2006, only 0.67% of all children in South Africa lived in CHHs, which represented about 122,000 children (Meintjes, 2010). The current prevalence (in 2020) of children living with physical disability and from CHHs is unknown. In South Africa in 2012, about 150,000 children were believed to be living in CHHs (UNICEF, 2014), which meant that they lived without an adult parent or guardian. In 2006, 55% of children in CHHs were 14 years or older, with 88% of CHHs including at least one child who was 15 or older (De Lannoy et al., 2015; Kellerman, 2014). Sub-Saharan Africa has been identified as the world's poorest region, with the largest proportion of vulnerable children in the world (Pillay, 2014; Sewpaul & Mathias, 2013).

According to the mid-year estimates of Statistics SA (2010), there were 18.6 million children under the age of 18 years in South Africa. Of these, 45% were in the age group 10–17 years, with 49% of these children who were females living with physical disability. Children living with physical disability in CHHs suffer the double jeopardy of disability and the absence of parents (Herbert, 2012; UNICEF, 2014). According to Healey et al. (2011) and Venter et al. (2012), the lack of appropriate and adequate provisions for learners with disabilities at institutions of learning in South Africa unfavorably affects their education. This was the case for children with physical disabilities living in CHHs, where they were faced with challenges academically, in terms of teaching them how to read and write, and socially. In CHHs, those opportunities were not accessible. This affects children living with physical disability from child-headed households socially, psychologically, personally, and emotionally.

The African Child Policy Forum (2011) argued that schools needed to pay specific attention to children in the community who were living with physical disability. People who were infected with HIV/AIDS received home-based support from the community, while this was not the case for children from CHHs who are living with physical disability. Even more recently, challenges experienced by children in CHHs clearly reflect their social disempowerment and devastating experiences of poverty, which are further exacerbated by the lack of adequate social support from their families and communities (Pillay, 2016).

According to Stats SA (2014), only eight percent of children living in CHHs were HIV/AIDS orphans, whereas 80% had a living mother; some parents had abandoned their children and remarried after a death or divorce and had abandoned the children of a previous marriage. The perception that CHHs mainly comprise orphans from families suffering with HIV/AIDS has been shown to be erroneous (Stats SA, 2014). Meintjes and Hall (2009) further confirmed that CHHs are not only the result of the HIV/AIDS pandemic but also due to economic circumstances that force parents to work away from home, leaving the children to their own devices, or as a result of one parent remarrying after the death of a spouse or divorce. CHHs are a rising phenomenon, which has increased at an alarming rate.

In 2016, about 25.73 million people were estimated to be living with HIV/AIDS in Africa, among which 741,000 died due to HIV/AIDS-related illness (Odugbesan & Rjoub, 2019). UNAIDS (2018) has indicated that higher prevalence of HIV/AIDS within a country could lead to decrease in life expectancy, higher mortality rate, lower birth rates, lower human capital, and low job productivity. In recent years, the phenomenon of child-headed households has generated interest and research (Kapesa, 2015; Kurebwa & Kurebwa, 2014; Mothapo, 2016; Magwa & Magwa, 2016), but there is little literature available on the nature and scale of support that community structures assume in escaping poverty for this type of household.

Moreover, 25 326 divorces were granted in South Africa in 2016 (Stats SA, 2018). In 2014, approximately 61.3% of registered births were to single mothers across South Africa and 24% of these were from KwaZulu-Natal (Stats SA, 2015). In 2017, about 44% of children in South Africa lived with their mothers only (Hall & Sambu, 2018). This increased the children's vulnerability to food insecurity as they were forced to assist with parental responsibilities of looking after their siblings, running the household, and providing food (UNICEF, 2014). A slight improvement was noted in 2017, when 57% of children in CHHs were 15 years old and above, with only about six% under six years old (Hall & Sambu, 2018).

In 2015, Stats SA's General Household Survey showed that there were about 90,000 children in 50,000 child-headed households. The country has approximately 3.7 million orphans, about half of whom had lost both parents to AIDS-related illness (UNICEF, 2014). The number of maternal, paternal, and double orphans was expected to rise to about five million in 2020 (Statistics SA, 2015; UNICEF, 2014). While this figure is not large in relation to the total number of children in the country, this is still a cause for concern.

Children with physical disabilities living in CHHs are at risk of having to cope without parental care or regular income and are situated in areas where services are poor. Child-headed households face diverse socioeconomic hardships, academic, and psychosocial quagmires that include the disruption of their normal childhood (Agere & Tanga, 2017). In addition, this vulnerable group needs to deal with emotional strain and is more likely to be abused and exploited. A search of available literature has revealed that studies have been conducted separately on physical disability and on CHHs, but not on both physical disability and CHHs together. Not

much is known about the psychological, educational and social experiences of children with physical disabilities living in CHHs in Johannesburg. Hence, there was a need to carry out the present study.

Theoretical Framework

This study was guided by Amartya Sen's Capability Theory of Development (2005), since the main concern was to explore the psychological, educational, and social experiences of children with physical disabilities living in CHHs in Johannesburg, South Africa. Sen's capability theory of human development focused on the ability of individuals to achieve well-being and to develop valuable lives and healthy living standards. This theory explains the well-being of people living with or without disability.

The capability theory was chosen as it focuses on the capacity of a human being to live a good life, or create a set of valuable and desirable living conditions, such as being in good health or having loving relationships with others, and to have real access to resources (Sen, 2005). However, when evaluating how well people are doing, one must seek to be as open-minded as possible. For example, one needs to be able to step outside of one's comfort zone and consider other perspectives and ideas. This was an important concern when studying these children from CHHs in Johannesburg who were living with physical disability.

According to Sen (2005), a lack of freedom limits people's capability in different ways, which was a concern for the children in question. The freedom that Sen refers to is not given on paper by a constitution nor is it the right to vote in elections. It is the kind of freedom that can be enjoyed by individuals, enabling them to live their lives in a fulfilling manner. As for children with physical disabilities living in CHHs, freedom of education and other freedoms were explored to evaluate their psychological well-being. People need an environment where they have the freedom to speak in public without fear, raise their voices, associate with others, and influence external factors that affect their lives. These all seemed to be problems for many children with physical disabilities living in CHHs. The capability theory points to the importance of fostering institutional participation, public debates, democratic practices, and empowering policies (Sen, 2005). These are all non-monetary dimensions of life and particularly important for poverty alleviation. They include the expansion of capability.

Methods

A qualitative research method was used to gain an in-depth understanding of the psychological, educational, and social experiences of children with physical disabilities living in CHHs in a natural or real-world setting (Sitienei & Pillay, 2019). A qualitative method was chosen for this chapter because it is structured, which helped

the researcher and the participants to work together during interviews to ensure clarity and elaborate where necessary. A social constructivist paradigm was used in the research, since the study focused on the knowledge the children constructed about their psychological, educational, and social experiences of being physically disabled and living in CHHs.

As part of a multiple case study design, six participants were purposely selected from a Learners with Special Education Needs (LSEN) School for involvement in the study. The criteria for selection were that they had to be physically disabled, aged between 14 and 15 years old, representative of gender (three males and three females), and they had to be living in CHHs. This method of purposive sampling was easier, quicker, and cheaper than other types of sampling. The sample therefore comprised six children aged 14 and 15, who had a physical disability, and lived in CHHs. Data was collected through individual interviews, a focus group discussion and collages. These were analyzed for themes depicting their psychological, educational, and social experiences.

All ethical protocols were rigorously followed during the research process to ensure that the rights of the learners were fully protected. Written permission to conduct the study was obtained from relevant committees. Each participant was requested to complete an assent form prior to data collection. From the commencement of the study, all participants were informed that their participation was voluntary and that they were free to withdraw at any point without any consequences. Participants were informed that only pseudonyms would be used regarding data collection to ensure confidentiality and anonymity throughout and after the study. A psychologist was present at the research site to assist participants should, any of them, experience distress during the study.

This study focused on the psychological, educational, and social experiences of children from CHHs living with physical disability. Since no previous work has been conducted on this topic, the objective of the researcher was to describe the experiences of this target group to address the gap in the literature. This study is crucial to understanding the difficulties the participants encounter and the strategies they have adopted to enable them to cope with their challenges. The developmental implications of their experiences are also considered here. As mentioned earlier, qualitative data analysis methods were employed to extrapolate themes that arose from the data in terms of the experiences of children from CHHs living with physical disability.

Trustworthiness was maintained by ensuring credibility, dependability, transferability, and confirmability of the study (Lincoln & Guba, 1985). These four criteria are recommended by Lincoln and Guba (1985) to explore the trustworthiness of qualitative research. Credibility was achieved through flexibility (field notes were taken) and triangulation. Interviews were conducted both individually and in focus groups, each with six participants. Videos and field notes were transcribed word for word and combined for data. Dependability was established through a dense description of research methods, analysis of data, and triangulation for consistent findings. Transferability refers to the extent to which the findings can be applied in other areas with similar contexts (Guba & Lincoln, 1985). Confirmability was achieved through

auditing the findings and checking with the participants that what they said had been accurately captured and also by using triangulation of data collection methods (Pillay, 1996).

Findings

The findings presented in this chapter demonstrate the type of psychological, educational, and social experiences that children with physical disabilities living in CHHs encounter daily.

Psychological Experiences

The psychological experiences of the participants were characterized by fear of being left alone, abuse and exploitation, longing for parents or caregivers, and a lack of confidence. (See Fig. 21.1). To enhance potential capability of such children, it

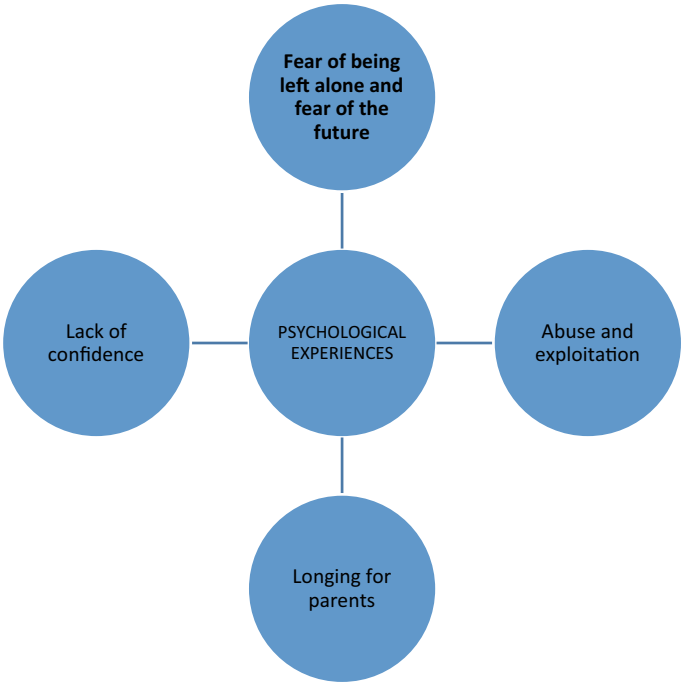

Fig. 21.1 Visual representation of psychological experiences

would be crucial that the government and communities get involved with efforts to aid children living with physical disability from CHHs as these children are prone to sexual abuse and other exploitation.

Fear of Being Left Alone and Fear of the Future

The first psychological challenge of children with physical disabilities living in CHHs is the fear of being left alone without assistance. This was evident during the individual interviews, when participants mentioned that they were very scared and felt alone after the death of their parents. The other children in the family, especially the eldest child (who assumed the responsibility of child head), also worried about fending for themselves and looking after their physically disabled sibling. These children have every reason to be afraid, as noted by other studies. They are exposed to an increased risk of exploitative child labor practices, with lower wages, life on the street, sexual exploitation, exposure to drugs and HIV/AIDS infection, and increased discrimination (Nicholson & Jefferson, 2008).

Children with physical disabilities and living in CHHs frequently experience deep fear for their future. The participants' experiences were lived against the backdrop of great, basic, and physical needs. Children with physical disabilities and living in CHHs had the added disadvantage of not having their parents to look out for them or to help them obtain certain opportunities that could improve their lives. For instance, children with physical disabilities living in CHHs may find it difficult to access funding or a bursary after matric because they may not be able to access information to apply for the funding, and have neither parents nor friends to assist them. In addition, the child head may not have the capacity to access this information. These factors are part of the evidence that children with physical disabilities living in CHHs have access to less information about the future than others.

Abuse and Exploitation

Children with physical disabilities living in CHHs are subjected to various forms of abuse and exploitation, such as bullying by other children, sexual abuse, stigmatization, community violence, and assault (Kanyamurwa & Tumuhimbise, 2007). This was blatantly evident in this study when participants shared their experiences of being victims of such abuse. Similar findings were noted in previous studies, where most of the participants became reclusive in response to societal alienation (Kanyamurwa & Tumuhimbise, 2007). These children experience a range of emotional responses, including depression, anger, anxiety, and fear, all of which raise their psychosocial vulnerability. Many of these children are unable to attend schools like other children their age, or even be sent to special schools for children living with physical

disability. They also experience low food security and are malnourished. In addition, The National Association for People Abused in Childhood (2012) recorded that children who are sexually abused experience a range of short- and long-term symptoms which are not limited to physical effects, but also psychological and emotional challenges.

Some of the children from CHHs may become disruptive and display dysfunctional behaviors, ranging from mild to severe in scope (Kanyamurwa & Tumuhimbise, 2007). Because of abuse and neglect, these children become sad, hurt, and angry. This was evident in the responses of most of the research participants. The responses may eventually culminate in antithetical behavior toward self and, to a larger extent, hostility toward others and society in later life.

Longing for Parents or Caregivers

It was overwhelmingly evident from the colleges and interviews that children with physical disabilities living in CHHs long for the deceased or absent parent(s) and better family relationships. This demonstrated that children from CHHs, like all children, want to love and be loved. This is in line with the capability theory of Sen (2005). Children with physical disabilities living in CHHs expressed their need for parental presence and believed that their lives would have been better if they had one or both parents in their lives. Those that had been abandoned by living parents expressed the hope that their parents would return one day.

Some of the children, despite the emotional turmoil of their physical disability, had the added strain of having to take care of their own physical and psychological needs and those of siblings. For instance, one of the research participants had to cuddle her little sister who would wake at night, crying, and calling out for their absent mother. All these psychological and emotional issues made the children feel helpless and hopeless.

Lack of Confidence

Lack of confidence was a common psychological challenge encountered by children with physical disabilities living in CHHs. This lack of confidence emanates from people's perceptions of the physically disabled child (stigma), especially those from CHHs (UNICEF, 2013). In the absence of parents or adult role models to boost their self-confidence, disabled children from CHHs begin to perceive themselves in the same way that their immediate society does (Sen, 2005). Children with physical disabilities living in CHHs were unable to relate to others and gain self-confidence. Mutual empathy was more important than it is usually in all relationships. Moreover, children living with physical disability from CHHs are usually in the adolescent stage of their lives and are also dealing with the challenges that come with physiological

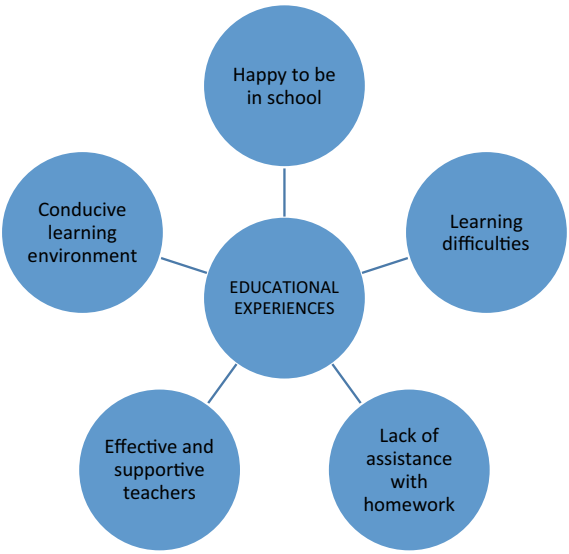

Fig. 21.2 Visual representation of educational experiences

and physical changes in their bodies. As there are no adults around them to help them to understand and deal with these changes, they become even more confused and inept (Munyai, 2013). This may greatly affect their self-confidence. Figure 21.1 represents the negative psychological experiences of children with physical disability living in CHHs.

Educational Experiences: The participants in this study experienced both positive and negative educational experiences. The positive ones were related to their being happy to be in school, especially in a school tailored to meet their needs, and where they had effective and supportive teachers. Negative experiences were related to difficulties doing homework and to learning difficulties (See Fig. 21.2). The positive experiences relate to Sen's capability approach (2005). Of the three factors, psychological, educational, and sociological, the protective factors were most evident in this study in the educational area as the participants had been placed in a suitable special school.

Conducive Learning Environment

The participants in this study were pleased to be placed in a school that catered for their needs. They all expressed great happiness at being moved from mainstream schools and placed in a special school for children living with physical disability. Mainstream schools are generally staffed by teachers with inadequate training in inclusive methodologies and not able to deal with the range of needs of children with physical disabilities (Zirima, 2012). These needs were addressed in special schools.

Limited awareness of disability among teachers and general school staff in mainstream schools is one of the challenges faced by children living with physical disability. Poor school support systems, overcrowded classes, and limited or no suitable resources, are contributory factors leading to high dropout rates among children from child-headed households living with physical disability (Marongwe et al., 2016). Their special needs are provided for at special schools, unlike in mainstream schools. Resources for children with disabilities tend to be allocated to limited schools rather than inclusive mainstream schools (UNICEF, 2013). In the case of the participants of this study, they benefited from being in a special school.

Happy to Be in School

The participants felt comfortable in their schools as they felt that they were accepted in the school environment and were able to make many friends. This was clear from the responses of all participants involved in the group interviews. This feeling of comfort and acceptance is most likely to go a long way to determine whether the children can stay in school and, to some extent, improve their academic performance. Such an outcome could eventually culminate in their finishing school with opportunities for gainful employment and living good lives to full capacity, which is in line with the Capability Theory postulated by Sen (2005).

Effective and Supportive Teachers

In the LSEN schools, the teachers have a clear understanding of special education and a commitment to teaching children with special needs within an inclusive education framework. This is in line with UNESCO (1994), where the Salamanca Statement recognized the need to create an enabling learning environment for children living with physical disabilities and other learning barriers. Teachers need to have a clear understanding of the special educational needs of disabled learners and a commitment to teaching them. Teachers at special schools possess the appropriate training to teach and manage children with physical disabilities, unlike in regular schools, and this contributed to the participants' stated comfort and happiness in attending the participating school. When asked whether they found their teachers more effective and supportive than in mainstream schools, the participants confirmed that these teachers had more experience in working with children who have their needs. The positive educational experiences of the children were, however, often marred by negative experiences, as noted below.

Lack of Assistance with Homework

Education in South Africa is a gateway out of poverty. However, both children with physical disabilities living in CHHs and the child heads of these households are faced with the tragically overwhelming situation of pervasive poverty that leads to their being deprived of adequate education. Virtually all the participants in this study pointed out the absence of adults at home to assist them with homework, which contributed to their poor academic performance and the likelihood of their dropping out of school. Lack of support hindered their educational performance and development, and as a result, some of the participants gradually lost the drive to succeed in their studies (Darling-Hammond et al., 2020). This corroborates the findings of studies in South Africa that showed that children with physical disability living in CHHs have lower educational attainment than able-bodied children and are more likely to leave school earlier, with fewer qualifications (Stats SA, 2017).

Learning Difficulties

Most of the difficulties that children with physical disabilities living in CHHs experience, and which lead to their leaving school, emanate from the absence of any adult to assist and encourage them with their schoolwork. This became evident during the individual interviews in this study. It was observed that the male participants had more learning difficulties than female participants. All male participants were struggling, especially in Maths and Science. Children living with physical disabilities have lower educational attainment than other children, which leads to lower economic status (Stats SA, 2014). In addition, Mabetoa (2014) argues that orphaned children are at risk of dropping out of school due to continuous disruptions experienced when their parents fall ill and eventually die. Figure 21.2 represents both the positive, protective factors, and the negative educational experiences of the participants.

Social Experiences

Stigmatization, marginalization, and lack of a social support system were the hallmarks of the children's social experiences (See Fig. 21.3).

Stigmatization and Marginalization

The stigma attached to disability is heart breaking, especially when children living with physical disability are made to feel ashamed because of factors they had no

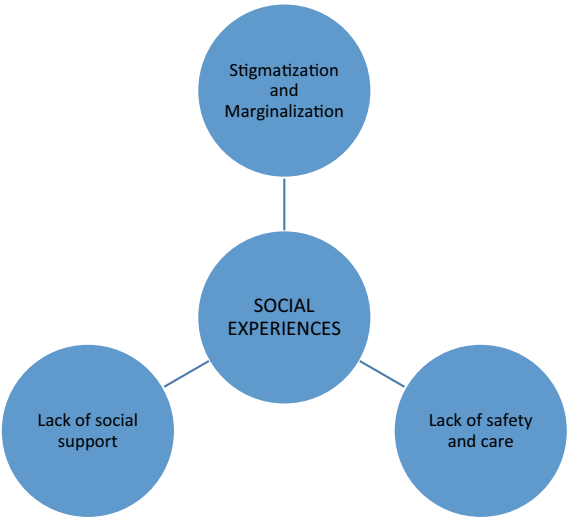

Fig. 21.3 Visual representation of social experiences

hand in and could not change. Children with physical disabilities living in CHHs feel humiliated and, without a caring adult to boost their self-esteem, may become reclusive and stay away from people. Risk factors that impact on children and youth orphaned due to AIDS and children with physical disabilities living in CHHs include bullying, stigma, community violence, and lack of opportunities for positive recreational activities (UNICEF, 2013).

Children with physical disabilities living in CHHs are also marginalized regarding access to social amenities, education, and other social services. This is not just because they are a minority group with few people who are ready to represent their interests and advocate for them. Our contemporary social system does not generally consider them important. In addition, they do not have access to funds to pay for these services. Even those in authority who are given the responsibility of assisting them need to be prompted. The absence of both parents (through death or other reasons), societal stigmatization, rejection, and marginalization, combines to make physically disabled children living in CHHs feel despondent and abandoned (Tessemma, 2012).

Lack of Social Support

Lack of social support for children from CHHs living with physical disabilities was evident in the findings. The participants stated that they suffer social stigma in their communities. Most disabled persons lack mobility, or their muscles cannot handle the amount of strain taken by those of able-bodied individuals (UNICEF, 2013). This means that they cannot participate in intensive sports or contact sports, such as soccer, rugby, hockey, and boxing. Besides, they may be restricted from participating in many

activities, such as running, playing, and other recreational activities due to lack of amenities. However, protective factors which may reduce the psychosocial stress and cumulative risk effects include factors within each child, from their caregiver and in their caregiving environment.

Lack of Safety and Care

For children who head families, life is challenging due to the absence of an adult figure or parent who can guarantee safety. Children with physical disabilities living in CHHs, the child heads of the households and the other children from the CHHs, may feel insecure, anxious, and mistrustful of others. Children living with disability become demotivated along the path of personal growth, as safety is a primary source of motivation. In accordance with the *Constitution of the Republic of South Africa 1996* and the *Children's Act No. 38 of 2005* as amended, the rights of children living in CHHs are compromised. The loss of a traditional family environment diminishes the child's safety net against abuse, exploitation, and violence. Significantly, the child head's rights to education, rest, play, and recreation are compromised by having to assume adult responsibilities prematurely, having to take sole charge of the household, the disabled, and younger siblings.

Children everywhere should be cared for by adults and one another within the family, kinship and clan network. This is most importantly required at a time of stress, illness, or challenges, especially in the life of children from child-headed households living with physical disability. Family care is our species-specific cultural adaptation to ensure children's growth, learning, and socialization. Figure 21.3 represents the negative aspects of social experiences of children with physical disability in CHHs.

The Capability Approach Relating to Psychological, Educational, and Social Factors

Despite these challenges, the theoretical framework underpinning this study also emphasizes a person's capability to live a good life (Sen, 2005). Protective factors which reduce the psychosocial stress and cumulative risk effects include factors within each child, from their caregiver and in their caregiving environment. Individual factors include a sense of belonging in the family, hope, and confidence (Sen, 2005). Caregiver factors include having a consistent, caring caregiver, good quality care, and positive child–caregiver interactions. These include frequent praise for the child, follow up and support from the caregiver, and equal sharing of resources within the family. Environmental factors related to caregiving include food, security, and minimal exposure to stigma, discrimination, and bullying. Other factors involve child-friendly essential services, emotionally responsive relationships from adults,

such as careers and educators, and engagement in sport, family outings, and positive activities at their special school.

The African notion of Ubuntu and the belief that no child should be abandoned should be made relevant to people's relationships with children living with physical disabilities in CHHs. Ubuntu can be described as personhood, selfhood, and humaneness, This view is reinforced by Mugumbate and Chereni (2019), who posit that Ubuntu exists in different spheres and contexts. Ubuntu as humaneness places the emphasis on human solidarity, empathy, human dignity, and the humanity in every person. These qualities should be applied to children with physical disabilities living in CHHs. Moreover, the old African adage, that it takes a village to raise a child, should be prioritized in people's relationships with disabled children from CHHs. Where households have been affected by AIDS-related or other losses, hope may be found in rebuilding the village by strengthening the resilient traditional social network system, which is the African kinship system.

Implications of Findings

Based on the findings, the implications for mental health support strategies for children with physical disabilities living in CHHs are discussed. Adopting the capability theory of human development, the authors emphasized that the human rights of children with physical disabilities should be a concern for all. The intention is to help create more positive mental health experiences that would enable the children to live meaningful, enjoyable, productive, and beneficial lives. Government has made efforts to lessen negative psychological experiences such as sadness and loneliness. For example, there are different sporting codes and facilities in their school for social entertainment. More can be done in terms of offering specialized services to counsel the participants to reduce the sadness and hurt they feel. In the context of the COVID-19 pandemic, children with physical disabilities living in CHHs face even greater barriers to accessing essential health services and hygiene facilities. This is due to environmental barriers such as lack of accessible public transit systems, limited capacity of health workers to communicate and work with persons with disabilities, and high costs of health care, exacerbated by lockdown restrictions.

Recommendations

Building Capacity

Examples of physically disabled people around the world who have surmounted the challenges of their disability to become leaders in their chosen careers with the cooperation of their school system (e.g., principal and school-based support team

in South Africa) could be incorporated into the content of the school curriculum. Inviting adults with physical disability who are successful in their chosen careers to speak at all schools could help provide relevant role models. This would help to build self-confidence, alleviate the children's fear for their future, and make them understand that they have every right to have been born. This is consistent with the theoretical framework of Sen (1979), which explores the ability of individuals to achieve the desired valuable lives and living standards.

Children with physical disabilities living in CHHs should therefore be guided in terms of career options in their respective schools, and this should include career counseling. Funding for their education options should also be explored, and higher education institutions should collaborate with schools to identify and empower the children. Special fund schemes may also be established by the government to assist children with physical disabilities living in CHHs.

In terms of educational experiences, it is recommended that children with physical disabilities living in CHHs be provided with extra support through psycho-educational counseling to enhance their development and understanding of the impact of their experiences. Their extended families or guardians should be included in this learning too.

Children with physical disabilities living in CHHs could also be provided with more after school help, including for the skills people need to be employed. Where possible, computers with internet could be obtained from the public or private sector to assist with homework and improve the learning processes of the children in question. The value the participants place on education and their being comfortable and happy in their school environment indicates that schools can play an important role in their overall empowerment.

Capable teachers, helpful teaching materials, and teaching aids should be provided, particularly in English language and mathematics. Competence in the English language assists in understanding other subjects taught in that medium and increases children's writing skills. Although the participants were encouraged to write freely, it was evident from their essays that their writing skills were below average. The participants' grammar and punctuation were also not at the appropriate level for their age. This could be a hindrance as they will also require these language skills to further their academic careers.

Capacity can be built by using community interventions. These would be advantageous to bridge the gap caused by marginalization. For example, community home-based care could be part of family support systems and needs for the children with physical disabilities living in CHHs. Community interventions may be necessary in educating community members about the existence of these households. It is also important to address the stigma that community members frequently attach to children with disabilities in CHHs. This way, their peer group could also be educated about how best to alleviate the plight of the children in CHHs. Extended family members (guardian or community home-based careers) should become part of these interventions regarding the needs of these households and their roles in supporting them.

An effective response to the challenges we face in South Africa must include rebuilding and strengthening relationships between family members and extended families, and psychological and social care, which are vital to human development. The most powerful and important form of psychosocial support is in the positive regard and affirmation that children are given in everyday care and support provided by families, households, friends, teachers, and community members. Children affected by adversity are less likely to develop serious symptoms that require specialized therapy if they are given family-based and community-based care and support and are helped to maintain or resume a sense of normality in their lives. These may often be lacking in the case of children from CHHs living with physical disability. In addition, religious organizations could be brought in to provide spiritual, psychological, educational, and social support.

Conclusion

Information regarding child-headed households living with physical disability is scarce in South Africa; not much is known about the psychological, educational, and social experiences of children with physical disabilities living in CHHs. The increasing morbidity and mortality rate of children living with physical disabilities from CHHs was considered in evaluating the findings. It is evident that the extremely high number of orphans and destitution among children living with disability makes it difficult for families and communities to respond in a traditional manner, such as taking these children into extended families. The situation has led to the emergence of a new form of family structure. These are families headed by children.

The focus of this chapter was to explore and describe the mental health of children with physical disabilities living in child-headed households. The human capability approach of Sen underpins the study, which explores the well-being and capability of individuals to achieve desired and valuable lives and living standards. These ideas were used to understand the psychological, educational, and social experiences and challenges of the participants in relation to their educational development. The children's appreciation of the positive aspects of their special school shows their ability to make the most of opportunities to build capability.

The findings revealed how children with physical disabilities living in child-headed households were affected by psychological, educational, and social challenges in their everyday life. These children carry a burden of family responsibilities and perform roles much greater than children in adult-headed households. These responsibilities deprive the children in question of much needed educational and social opportunities. The recommendations indicate different areas of support that could be used to help the children enhance their own capacity to live valuable lives and contribute to society in the way that Sen has envisaged regarding capability and human development.

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Chapter 22
Community-Based Intervention for Differently Abled People

Anjali Gireesan and Jeshtha Angrish

Abstract Disability has been accepted to be a global phenomenon and a condition that requires effort and attention from the different parts of the society. Community, in which a person with disability lives, can play an effective role by a participative attitude as well as by being aware of their significant role. In this chapter, we discuss evolution of disability as a concept, the magnitude of disability in Indian context, the ways and procedures adopted in disability assessment (both general and specific procedures), the nuances of community-based rehabilitation program, the role of different parts of community in managing disability, the challenges that the community may face in imparting effective services to the persons with disability, and the legislations that emphasize the role community in this context. In each section, an attempt has been made to bring out the variety of roles that the community can play in bringing about effective mainstreaming of this population. We conclude the chapter with a list of recommendations as care and support services to persons with disabilities involve resources and revisions at multiple levels. This needs help from many stakeholders, apart from the main caregivers like communities around, local bodies of the government and other organizations that can provide infrastructural, economical, and legal aids to these people.

Keyword Disability · Assessment · Management · Community-based rehabilitation

Defining Disability

Disability is an umbrella term covering impairments, activity limitations, and participation restrictions (WHO, 2009).

(1) *Impairment* is a problem in body function or structure.
(2) *Activity limitation* is a difficulty encountered by an individual in executing a task or action.

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_22

(3) *Participation restriction* is a problem experienced by an individual in involvement in life situation

International Labour Organization (ILO) looks at a disabled person as an individual "whose prospects of securing, retaining, and advancing in suitable employment are substantially reduced as a result of a duly recognized physical or mental impairment". Definition of disability, according to Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995, includes seven broad categories related to blindness, low vision, hearing impairment, mental retardation and mental illness, and locomotor disability; whereas mental illness means any mental disorder other than mental retardation, mental retardation means a condition of arrested or incomplete development of the mind of a person, which is specially characterized by subnormality of intelligence.

More often than not the definitions of disability are based on the perspective with which the disability is viewed. Thus, disability as a concept has evolved as models of disability have been modified (Retief & Letsosa, 2018). We will discuss some of the models in this section.

Medical Model: This model treats disability as a disease and advocates that the nature of disability is individualistic as the problem lies in the functioning of a particular body system within a person. It demarcates differences between a disabled person and able-bodied person wherein the latter is projected to be a better-equipped individual. The intervention module thus adopted focuses on eliminating the disability and the person to change rather than changing the environment that the person is living in. Also, in this model, the person with disability is expected to play a "sick role" that may or may not be true in reality.

Social Model: According to this model, disability is a social construct shaped by the notions and attitudes of the society that a person is residing in. People have impairments, but the attitude and the meaning ascribed by the society to these impairments is what constructs disability. Thus, the physical and social environment poses limitations on persons with disabilities, and this is what needs to be changed so that the disability can be managed effectively. This model has significant implications for enacting and reforming policies that can improve the life experiences of persons with disability.

Identity Model: According to this model, the impairment forms an important part of the identity of the person that needs to be embraced and positively acknowledged. This model allows persons with disabilities to identify as a group that has the freedom to choose to be a part of the mainstream society or to exist as an independent community.

Human Rights Model: This model goes beyond social model in terms of establishing the dignity of persons with disability providing a blueprint for the policies based on theories and facts associated with the living conditions of these people. It helps to establish both cultural and political identities of the person with disability. It offers solutions for the challenges faced by these individuals rather than just describing them.

Limits Model of Disability: This model proposes the concept of "Limitness" where disability is perceived as one of the variety of limits that all human beings have but still live a regular life. It emphasizes on similarity of experiences that an able-bodied person shares with a disabled person, thus collecting evidence that all human beings with limits are a part of the society. All of us have the freedom to choose the actions to overcome the limitness possessed in varying degrees.

Magnitude of the Problem

India is a part of many International Commitments that emphasize on regulating and managing disability. These are as follows:

(1) *Declaration on the Full Participation and Equality of People with Disabilities in the Asia Pacific Region' (2000).*
(2) *UN Convention on the rights of Persons with Disabilities' (2008).*
(3) *Biwako Millennium Framework' (2002).*
(4) *The Sustainable Development Goals (2015).*

These initiatives require the foundation of comprehensive statistics to build on and reach the maximum number of persons with disability. The survey to understand these statistics is carried out by the Decennial Population Census (Office of the Registrar General and Census Commissioner) and National Sample Survey Office (NSSO). In Census 2011, the data was collected on eight types of disability. It showed that 20% of the disabled persons are having disability in movement, 19% are with disability in seeing, and another 19% are with disability in hearing. About 8% have multiple disabilities. Males are more in number among the affected for all the types of disability. 17% of the disabled population is in the age group 10–19 years, and 16% of them are in the age group 20–29 years. The Census 2011 showed that, in India, 20.42 lakhs children aged 0–6 years are disabled. This figure is a matter of concern and needs to be paid special attention to. Among the total disabled persons, 45% are illiterates. 13% of the disabled population has matric/secondary education but are not graduates and 5% are graduates and above. Nearly 8.5% among the disabled literates are graduates. One in every two disabled non-workers is dependent on their respective families. Among the male disabled non-workers, nearly 33% are students, while the same among the corresponding category of females is 22%. In totality, Uttar Pradesh has the highest number of disabled population, whereas Bihar has the highest number disabled population when it comes to children (Chandramouli and General, 2011). The States of Kerala and Goa have the highest literacy rate among the disabled persons (70%). The lowest literacy rate among the disabled persons is reported from Arunachal Pradesh (38.75%) followed by Rajasthan (40.16%) (Census, 2011). There have been many independent researches in India to understand the population dynamics when it comes to disability. For example, Kumar et al., (2008) conducted a community-based cross-sectional study to understand the pattern of mental disability in rural Karnataka. The prevalence of mental disability was found to be 2.3%. The

prevalence was higher among females (3.1%) than among males (1.5%). Kumar et al. (2012) in their systematic review contended that disability in India follows an iceberg phenomenon where there is more to the problem than the numbers that are actually presented in front of us. The variation in prevalence of disability is observed due to social attitudes and stigma, international evidence, gap driven by mental retardation, and mental health measurement.

In fine, disability is an umbrella term covering impairments, activity limitations, and participation restrictions. More often than not the definitions of disability are based on the perspective with which the disability is viewed. These are medical model, social model, identity model, human rights model, and the limits model. India is a part of many International Commitments that emphasize regulating and managing disability. The variation in prevalence of disability is observed due to social attitudes and stigma, international evidence, gap driven by mental retardation, and mental health measurement.

Developmental Disorders

Developmental disorders are a heterogeneous group of conditions that show its effect in one or more areas of developmental patterns whether it be physical, cognitive, or social in nature. DSM V has renamed this group of conditions as neurodevelopmental disorders. This is an umbrella term that includes intellectual disability, learning disability, autism spectrum disorder, attention deficit hyperactive disorder, and developmental coordination disorder.

(1) *Intellectual disability* is a term used to refer to a condition where the individual has compromised cognitive development and is lower than that of their counterparts of the same age.
(2) *Learning disability* is a group of conditions where the problem lies in specific areas of language like reading, writing, spellings, and mathematics.
(3) *Autism spectrum disorders* are a group of conditions where the social communication and development of an individual is compromised and is characterized by behavioral difficulties.
(4) *Attention deficit hyperactive disorder* is a condition where an individual is impulsive, not able to focus attention and hyperactive in nature. These three conditions might occur simultaneously or in isolation in the individual.
(5) *Developmental and coordination disorder* is motor disability where the problems occur in integrated motor movements, and thus, the individual might experience problems in both gross and fine motor skill development.

All developmental disabilities have both organic and social basis. In order to manage these in an effective manner, it is imperative that both of these are considered and included in the diagnosis as well as the intervention procedures. As observed, the developmental disorders are different in terms of the developmental areas affected in a person. But there are some commonalities between them. Though two individuals

might be diagnosed with the same disability, their diagnosis and intervention will be different because of the difference in the degree of severity and the nature of comorbidity might be varied. These are lifelong conditions and can be managed but cannot be cured completely.

Disability Assessment

Disability is an area if managed at the correct and appropriate time can have a good prognosis. A very important part of this procedure is the assessment phase. Testing and assessment are many times used interchangeably, but there is a basic difference between the two terms. While testing gives one a measurement of a particular trait or entity, assessment is more holistic in nature. It is a battery of different methods undertaken to understand the problem and hence arrive at a solution. There are basically three categories of initial assessment followed when looking at disability. These are interviews, psychometric testing, and situational and functional assessment. All of them have their own advantages and disadvantages, and more often than not, they are used in combination with each other. Assessment becomes important in the following ways:

- Behavioral prediction.
- Helps in acquiring the knowledge of personality and support systems.
- To gauge the existing potential and abilities in an individual.
- To understand the organic basis of the condition.
- To evaluate the efficacy of an intervention.

The efficacy of these different types of assessment does not only depend on their robustness, but on the professionals involved in the administration and interpretation of these tests as well. A well-established test if handled by a not so equipped professional will not be beneficial to understand the condition of individuals. An ability to understand the condition involves theoretical understanding of disability, expertise to individualize the assessment procedures and sensitivity to cultural and social factors that surround this individual. Only a combination of the above mentioned factors can lead to successful and efficient assessment. Most studies used semi-structured questionnaires for measurement of disability.

IQ Assessment: This is basically done to understand the current level of cognitive functioning of the individuals. The IQ scores not only indicate the intelligence level but gap in the underlying process like lack of fluency in processing abilities and a slower automaticity of different perceptual activities (Geary et al., 2012). All this necessitates the requirement of a thorough IQ assessment which can include both verbal and non-verbal assessments.

Behavioral Therapy: Some persons with disability face a lot of behavioral problems ranging from physiological ill effects like reduced sleep to social problems like lack of self-confidence and inadequate communication patterns (Hamid, 2015). For

example, about 24–52% of children with learning disorders present behavioral problems which can result from anxiety/stress, social isolation and can result in aggressive behavior (Diakakis et al., 2008). The root cause of such behavioral problems needs to be identified so that the prognosis for these people is more positive. Behavioral therapy, for children, is practiced on many levels in terms of classroom management and how effective and desirable behavior can be introduced and inculcated in the child.

Observation and Interview: Observation and interview are basically used as complementary procedures in order to understand the non-verbal behavior as well as the communication pattern of an individual. It proves to be powerful tool and can help in the subtle discrimination of the different disorders that are prevalent in children. These also provide the baseline data that can later be helpful in bridging the gaps that might remain unexplored in the other procedure utilized for diagnosis. These methods are not only done with persons with disability (PWD) but with primary caregivers and the other service providers of the PWD as well in order to get a holistic picture of the condition of the individual.

Screening and Psychometric Tests: Screening and psychometric tests are done to arrive at a universal score that will be interpreted in a similar fashion across different service providers. Choosing a psychometric test based on the baseline data and provisional diagnosis entails the expertise of a service provider, and the subsequent analysis and interpretation of the scores that can facilitate further steps to be initiated in the management of disability also involves professional skills. The screening and psychometric tests involve various areas for exploration. All these tests together can provide for a holistic picture of the condition of the person and help in providing quality services.

For disability assessment and management, various tools have been used. Some studies have used Barthel Index for Activity of Daily Living, Instrumental Activities of Daily Living, Indian Disability Evaluation and Assessment Schedule, Rapid Assessment of Disability scale, and Standard Health Assessment Questionnaire (Ramadass et al., 2018). Studies that used the International Classification of Functioning, Disability and Health concept for measuring disability reported prevalence ranging from 70.0% to 93.2%. The more popular ones are as follows:

- **International Classification of Functioning, Disability, and Health**: This is a global disability assessment schedule that includes information on the functioning and disability. It is approved by the World Health Organization (WHO). According to the ICF model, functioning and disability include broad areas of body functions and structures, the activities of people, participation of people in all areas of life, and environmental factors that affect these experiences. This tool is thus based on the biopsychosocial model of disability. Functioning is defined as "an umbrella term for body function, body structures, activities, and participation. It denotes the positive or neutral aspects of the interaction between a person's health condition and that individual's contextual factors". Disability is defined as "an umbrella term for impairments, activity limitations, and participation restrictions.". The

ICF has eight components which are further arranged into hierarchical domains. These are as follows:

- **Body Functions**: The physiological functions of body systems (including psychological functions).
- **Body Structures**: Anatomical parts of the body such as organs, limbs, and their components.
- **Impairments**: Problems in body function and structure such as significant deviation or loss.
- **Activity**: The execution of a task or action by an individual.
- **Participation**: Involvement in a life situation.
- **Activity Limitations**: Difficulties an individual may have in executing activities.
- **Participation Restrictions**: Problems an individual may experience in involvement in life situations.
- **Environmental Factors**: The physical, social, and attitudinal environment in which people live and conduct their lives. These are either barriers to or facilitators of the person's functioning.

The broad framework puts assessment in context and provides the focus for selecting relevant aspects of functioning and disability for assessment. Qualifiers are codes used to record the extent of functioning or disability in a domain or category or the extent to which an environmental factor is a facilitator or barrier. A uniform or "generic" qualifier scale is provided to record the extent of the "problem" in relation to impairment, activity limitation, and participation restriction as shown in Box 2. The environmental factors qualifier uses both a positive and negative scale, to indicate the extent to which an environmental factor acts as either a facilitator or barrier to functioning. Measurement is an area for further development, and it is recognized that the generic qualifier requires calibration to relate its scale to existing measurement tools (Table 22.1).

Table 22.1 ICF qualifier scales

Generic qualifier	Qualifier for environmental Factors	
	Negative	Positive
0. No problem	0. No barrier	0. No facilitator
1. Mild problem	1. Mild barrier	+ 1. Mild facilitator
2. Moderate problem	2. Moderate barrier	+ 2. Moderate facilitator
3. Severe problem	3. Severe barrier	+ 3. Severe facilitator
4. Complete problem	4. Complete barrier	+ 4. Complete facilitator
8. Not specified	8. Not specified	+ 8. Not specified
9. Not applicable	9. Not applicable	+ 9. Not applicable

- **Barthel Index for Activity of Daily Living**: This scale is basically used to monitor the progress of people with disability undergoing rehabilitation. Clients receive numerical scores based on whether they require physical assistance to perform the task or can complete it independently. Items are weighted according to the professional judgment of the developers. A client scoring 0 points would be dependent on all assessed activities of daily living, whereas a score of 100 would reflect independence in these activities.
- **Indian Disability Evaluation and Assessment Schedule (IDEAS)**: IDEAS is widely used to measure and certify disability in our country. It has four items: self-care, interpersonal activities (social relationships), communication and understanding, and work. Each item is scored between 0 to 4, i.e., from no to profound disability, and adding scores on four items gives the "total disability score". Global disability score is calculated by adding the "total disability score" and MI2Y score (months in two years—a score ranging between 1 and 4, depending on the number of months in the last two years the patient exhibited symptoms). Global disability score of 0 (i.e., 0%) corresponds to "no disability", a score between 1 to 7 (i.e., <40%) corresponds to "mild disability", and a score of 8 and above corresponds to >40 percent corresponds to moderate to profound disability (Mohan et al., 2005).
- **Rapid Assessment of Disability Scale**: This questionnaire was designed to ascertain the prevalence of disability in the target population and hence design intervention modules according to the identified needs. It is based on the conceptual frameworks of disability the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and the International Classification of Functioning, Disability and Health (ICF). It has five Sects. (1) Demographic information, (2) Assessment of functioning, (3) Awareness of rights of people with disability, (4) Well-being and quality of life, (5) Participation in the community (Huq et al., 2013).

Developmental disorders are a heterogeneous group of conditions that show its effect in one or more areas of developmental patterns whether it be physical, cognitive, or social in nature. DSM V has renamed this group of conditions as neurodevelopmental disorders. It includes intellectual disability, learning disability, autism spectrum disorder, attention deficit hyperactive disorder, and developmental coordination disorder. Disability is an area if managed at the correct and appropriate time can have a good prognosis. A very important part of this procedure is the assessment phase. There are basically three categories of initial assessment followed when looking at disability. These are interviews, psychometric testing, and situational and functional assessment. For disability assessment and management various tools have been used. Some studies have used Barthel Index for Activity of Daily Living, Instrumental Activities of Daily Living, Indian Disability Evaluation and Assessment Schedule, Rapid Assessment of Disability scale, and Standard Health Assessment Questionnaire.

Key Stakeholders and Their Role in Disability Management

Role of Parents: When dealing with children with disabilities and their parents, it is important on the part of service providers to understand the culture that surrounds, the parenting practices adopted and understand the dynamics between the parent and the child. More often than not, primary caregivers are not aware of the support systems they already engage with. This perception consequently led to their lack of trust in their surroundings for social support (Washington, 2009). Parents have often emphasized that while accessing services for their children, they would like to receive information on good support practices for children at home, the physical and psychological health difficulties for themselves and their child, lack of social support experienced needs to be addressed, and they also experience hostility from their surroundings if they involve themselves in giving support facilities to their children with the service providers. These problems of parents are often unnoticed by the service providers (Chien & Lee, 2013). Indian parents also report a similar experience when it comes to taking care of a child with a disability. There is an increased burden on the care providers of children with intellectual disability because of very limited social support from family as well as the surroundings. There are a lot of misconceptions regarding children with intellect that further tends to isolate them from society. In order to minimize these observations, public awareness programs and community-based interventions have been suggested (Edwardraj et al., 2010). Also, those mothers who perceived more support reported better adjustment, and this adjustment was lower if the severity of the disability is higher. Thus, if the parents are able to find effective support in their surroundings they would be able to manage with disability in a more constructive manner (Pal et al., 2002). Thus, social support is one of the important factors that can mediate the frustration of parents and result in better care of their children.

Role of Service Providers: The antecedent factors which influence the role components include the demographic factors of the community and as well as the dynamics of the institution that the professionals work in. The other factors considered important were the professional expertise of the service providers, the family characteristics, and type of relationship between the service providers and the family. The circumstance and the environment in which these care coordinators work need to be taken into consideration when designing an intervention program, and also, the nature of interaction between these professionals and families needs to be explored (Hills et al., 2016). A transdisciplinary approach of care for PWD is effective, but lack of enough therapists, lack of psychological and professional family or social support, and lack of resources and equipment have been observed to be a barrier in this regard (Weatherill et al., 2012). In order to understand these, one needs to facilitate feedback and design strategies to facilitate better communication between all the stakeholders. In order for services to become effective, objective measures and their implementation need to be standardized, and community support needs to be encouraged (Darrah et al., 2012). The relationship with the community is important in terms of providing

effective social support as well the support of service providers is required to successfully implement family-centered care. The role of service providers is very important in translating a framework into a significant contributor of quality care and support services to children attending early intervention programs (Fordham et al., 2012). Family-centered care has a lot of positive outcomes for service providers, children, and the parents. There are very few studies which include all the stakeholders in one study to understand the perception of family-centered care from all the perspectives. Family-centered care has not been explored in India in the context of disability. For a successful implementation of family-centered care, a trans-discipline care coordination is essential which will eventually benefit the quality of services offered to children with disability.

Role of Teachers: Though we have different systems of education available, up to 95% of children with disabilities are devoid of basic education. Most of the organizations that have special education are run privately, but the emphasis for the same comes from the government. Those disabilities that are considered low incidence disabilities in developed Countries are high incidence in developing countries because of how these are defined and the stigmatization surrounding these disabilities where a child with intellectual disability tends to be hidden. As a result of all these factors, misrepresentation of children with disabilities happens in India, and there is lack of reliable statistics (Kalyanpur, 2008). A combination of positive beliefs with behavioral control was observed to have positive outcomes in the context of practicing inclusive education. Also, teachers who believed that inclusive education is a part of school curriculum had higher chances of engaging in the same (MacFarlane & Woolfson, 2013). Pre-service teachers' who had training, were aware of different intervention programs, had knowledge of policies and legislations and who were taught to deal with their concerns have better and positive attitudes towards including children with disability in Regular classrooms (Sharma et al., 2009) . Variations in school systems across different states, the inadequate spending of funds in educational reforms by both state and central governments, disparities in education across different groups of children, and the enrollment of these children continue to be low in regular schools despite government initiatives. She observes that constructive work is being done in the field of inclusive education but the inadequacies have to be brought into light as well as persons with disabilities lack the support of effective policies. The focus on the child and not the system has been pointed as one of the reasons for this observation (Singal, 2006). Preparation is needed at different levels like preparing the children for getting included in regular classrooms like formulating bridge courses, preparing the mainstream schools for receiving children with disability like giving specialized training to teachers and preparing the parents for the same. These facilities are limited and have been imposed in only some states like Uttar Pradesh and Andhra Pradesh. The resources in the organizations, where inclusive education is functional, are scarce and poor. Hence, constructive work is needed to address these issues (Sanjeev & Kumar, 2007). Programs like District Primary education Program, Janshala, and Sarva Shiksha Abhiyaan suffer from problems like lack of effective data, lack of disability indicators, and ineffectiveness in addressing their proposed objectives as well as financial constraints. Though some

schools advocate that they have inclusive education, an examination of the same was found to be contrary and very different from that of the conventional concept of inclusive education. The infrastructural constraints that schools have also interfere with the perception of including children in the regular school setups.

Role of Non-Governmental Organization: NGOs work in close association with the government for providing services to people with disabilities, technical assistance, and training of effective personnel for management of disability. However, their role in policy development has been observed to be minimal and under-explored. This is prevalent at both the central as well as the state level. The same has been the case with NGOs led by persons with disabilities. In this context, community-based rehabilitation programs can act as mediators between the NGOs and the general public. Development organizations like Poorest Area Civil Society (PACS) Program and World Bank are also showing interests in collaboration with disability NGOs for identifying and addressing the economic needs of people with disabilities in rural areas and helping in their rehabilitation. A combined effort of the NGOs can ensure a stable and continued implementation of the various initiatives provided by the government. This would further strengthen the disability movement. Another area where the role of NGOs is significant is in terms of interaction with communities. For example, Mamta Punarvas Kendra NGO in Shri Ganganagar district of Rajasthan NGO has worked in one block to sensitize sarpanchs, GP members, patwaris, and gram sevaks on disability issues, with field work for this report indicating that these efforts are already showing positive impact in implementation of poverty alleviation schemes.

Disability For a in Tamil Nadu

There is evidence of good collaboration among NGOS and between NGOS and the state in Tamil Nadu:

Vellore District Disability Network: 12 disability-related organizations meet quarterly to share resources for the rehabilitation of persons with disabilities. The District Disability Rehabilitation Officer is present and occasionally the Disability Commissioner

Disability Forum: A disability forum of 23 NGOs (disability-specific and development) is facilitated by the Organization for Development Action (ODA). This forum shares information, knowledge, and referrals between NGOs. There is reluctance by some organizations in this forum to lobby for change as they receive government support and are concerned about what impact their involvement may have on access to state resources. Hence, issues identified in this forum are used for lobbying the government directly by ODA and other interested parties

In August 2005, a **State Resource Training Centre for PWD** was set up in Chennai under the National Program for Rehabilitation of Persons with Disabilities (NPRPD). Different NGOs with disability-specific expertise are

providing their voluntary services for training of persons with disabilities. The center will showcase good NGOS practices

A weekly radio program call **Thiramaiyin Thisayil** (In the Direction of Your Abilities) is broadcast by Ability Foundation in association with all-India radio. It focuses on issues and policies which affect the rights of PWD. Other NGOs also use the show as a vehicle for spreading information on vocational training programs and to publicize events such as job fairs. Letters and responses from remote rural towns of TN indicate significant penetration

Source Officer (2005)

Challenges at the Community Level

An individual cannot function in isolation. There has been countless research on the benefits of social support for development of various psychosocial factors. Thus, involving community which is often perceived to play a neutral role in management of disability can be effectively involved. The different roles in which community members can be involved are non-administrative staff of a special school, logistical arrangements of awareness campaigns, procuring of materials that help children with disability for facilitating different therapies as well as door to door campaigns. Most of the special schools inducted in the present study were located in suburban areas where not everyone is involved in everyday occupation. Their familiarity with the locality and basic literacy can be streamlined and capitalized to equip them with spreading awareness. This might in turn make them more empathetic toward the situation and increase their support in accordance. Some of the challenges at community level in delivering effective services to people with disability are as follows (Kumar et al., 2012):

- **Understanding the Concept of Disability:** Disability is a broad term that is applicable to only part of a population. The specificity associated with it makes it a topic of varied understanding. Lack of support from the community poses many challenges like isolation and stigmatization experienced by the children and their families. This isolation and stigmatization can lead to many future problems like low self-esteem, aggressive behavior in children, and manifestation of psychological disorders like conduct disorders.
- **Prioritization of Available Resources:** Disability management capitalizes on the resources that are available in the environment. Certain disabilities require infrastructural amendments (physical disabilities) more than the other resources, whereas certain others require availability of health resources (multiple disabilities). Thus, depending on the prevalence, the prioritization of the resources is a necessary step. Lack of the knowledge of available resources and dearth of reliable statistics poses challenges on this front.

- **Adopting a Multisectoral Approach:** Primary healthcare system must play a major role both as a provider and supporter and should engage with initiatives such as early identification of impairments and providing basic interventions, referrals to specialized services such as physical, occupational, and speech therapies, prosthetics and orthotics, and corrective surgeries. The educational sector should be more inclusive by adapting newer techniques with respect to content of the curriculum, methods of teaching and ensuring that classrooms, facilities, and educational materials more accessible. Collaboration with the employment and labor sectors is essential to ensure that both youth and adults with disabilities have access to training and work opportunities at community level.
- **Monitoring and Evaluation of the System:** The legislative framework and other services available for people with disability will be effective only when the community as a whole is aware and equipped. Therefore, there needs to be machinery in place that ensures information dissemination and consequent community mobilization that may help in the process of rehabilitation. Other positive outcomes of a monitoring system include opportunity for education, opportunity for work, transfer skills to community level, program activities, and involvement of disabled people.

The First Step

In the Adaama province of Ethiopia, a CBR worker noticed a bridge across a river was broken. This was making the mobility of persons with disabilities a very difficult job. The personnel initiated communication with the local school and government in order to do something about this issue. A local committee was thus formed. A community mobilization process was started by this committee, which encouraged economical and physical support of the community in building the new bridge. After the bridge was completed, the local government was motivated to take up more such activities that will improve the living conditions of persons with disabilities

Source: https://www.ncbi.nlm.nih.gov/books/NBK310937/

Stakeholders of disability management are parents, service providers, and teachers NGOs. More often than not, primary caregivers are not aware of the support systems they already engage with. This perception consequently led to their lack of trust in their surroundings for social support. Social support is one of the important factors that can mediate the frustration of parents and result in better care of their children. In case of service provider's professional expertise of the service providers, the family characteristics and type of relationship between the service providers and the family are considered important. Teachers who believe that inclusive education is a part of school curriculum have higher chances of engaging in the same. Preparation is needed at different levels like preparing the children for getting included in regular classrooms like formulating bridge courses, preparing the mainstream schools for

receiving children with disability like giving specialized training to teachers and preparing the parents for the same. Community-based rehabilitation programs can act as mediators between the NGOs and the general public. Challenges encountered at community level are understanding the concept of disability, prioritization of available resources, adopting a multisectoral approach, and monitoring and evaluation of the system.

Community-Based Rehabilitation

The resources available at the community level may be effectively used for rehabilitation persons with disability. This approach is effective at a primary health level. The community has a two-pronged role in managing disability. In one, it takes an active stage in imparting skills to the persons with disability, and the other is in the capacity of decision maker when it comes to planning, decision making, and evaluation of the program with multisectoral coordination. WHO has developed guidelines for effective community-based rehabilitation based on the objectives to be achieved according to the Convention on Rights of Persons with Disabilities. These guidelines were concentrated on the components of health, education, livelihood, social, and empowerment (Khasnabis et al., 2010).

Health: The key concepts here include health promotion, identifying barriers to health promotion, health promotion for family members, and developing health promotion action. The suggested activities include supporting health promotion campaigns, strengthening personal knowledge and skills, linking people to self-help groups, educating healthcare providers, and creating supportive environments.

Education: The key concepts under this component are early childhood care and education, primary education, secondary and higher education, non-formal education, and the process of lifelong learning. CBR programs pay special attention in promotion of inclusive education, integrated education, and special education. They also concentrate on identifying various barriers related to education of the disabled like poverty and gender.

Livelihood: The key concepts under this component are enhancing the different types of skills essential for work, providing opportunities for self-employment and wage employment, offering financial services, and ensuring social protection. Informal provision at the community level is through community-based organizations and, especially, self-help groups.

Social: Social roles are the positions people hold in society that are associated with certain responsibilities and activities. Different types of social roles include those related to relationships, work, daily routine, recreation and sport, and community). The social roles people hold are influenced by factors such as age, gender, culture, and disability. The elements in this component are providing personal assistance, ensuring enjoyments of relationships and family, participation in cultural activities as well as in recreational and leisure activities. Added to this is the element of justice that can be facilitated by the CBR workers.

Empowerment: The key elements of this component are facilitating advocacy and communication, community mobilization for change and action, promoting political participation of persons with disability, and coming together and forming disability organizations and participation in self-help groups which increases their visibility and helps them acquire mutual support.

Impact India Foundation and Community Health Initiative

Impact India Foundation is an organization situated in the Thane district of Maharashtra. It has brought into practice various initiatives that are based on the community's contribution

Community Health Initiative (CHI) covers 1.5 million backward tribals in the state. CHI aims at the reduction of existing disabilities and incidence of future disabilities through prevention and cure using existing delivery systems and available infrastructure, in partnership with government, NGOS, and local community. To reduce disability, a model project in close partnership with the government needed to be introduced whose success could be replicated. A leading social work agency was commissioned to undertake a participatory baseline survey, understand the community's needs and priorities, and enlist support. The government appointed a senior Deputy Director, Health Services, as a Liaison Officer for the Community Health Initiative, so that the government health infrastructure and personnel worked with IIF to identify the lacunae necessary to bridge the gap. IIF appealed to the Corporate Social Responsibility components of the private sector to provide funding support and donation of professional skills. IIF swung into action recruiting 40 staff, mainly locals, oriented to act as change agents to coordinate activities covering 1.5 million tribals and mobilizing the community to avail of health services. Meetings were held with self-help groups, Anganwadi (crèche) workers, Bhagats (Traditional Medicine practitioners), Suhinis (Traditional Birth Attendants), and partnerships were fostered with referral hospitals for free-of-cost treatment. While the government and private sector representatives will support with funding, IIF and other Non-Government Organisations in the area will make efforts to ensure the community is mobilized to create a demand on the public health system to ensure its effective functioning. Capacity building of the community assumes greater importance than ever

Source https://www.impactindia.org/

National Policies on Disability

Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (PWD Act)

Passed in 1995, the Persons with Disabilities Act covers the seven categories of disabilities. This act was often hailed as landmark legislation when it comes to the disability movement. The person with a disability should be certified as having no less than 40 percent of any disability as certified by a medical authority to avail the benefits provided under this legislation. The disabilities covered are as follows:

(1) **Blindness**—It is the total absence of sight or visual acuity not exceeding 6/60 or 20/200 (Snellen chart) in the better eye with corrective lenses. A limited field of vision is also included in this definition.
(2) **Low Vision:** It includes the visual capacity to execute a task with appropriate devices.
(3) **Leprosy cured:** Leprosy is a contagious bacterial infection that affects eyes, skin, nose, and peripheral nerves. In the PWD act, people with three stages of the disease have been considered. These are a person who has been cured of leprosy but has lost sensation, a person who manifests deformity but has just adequate mobility and a person with severe physical deformity that affects engagement in employment.
(4) **Locomotor Disability**: Restriction in the limb movement of a person has also been considered under this act. The etiology mainly consists of disability of bones, muscles, or joints. The provisions have been given keeping in view a substantial capability decided by the person's involvement in routine jobs and normal functioning.
(5) **Hearing Impairment:** A person who loses the ability to hear the sounds of 60 decibels or less in the better ear has hearing impairment and can avail the measures under this act.
(6) **Mental Retardation:** This category specially considers those persons who have their range of intelligence below the normal. The normal range as defined by the IQ score is 90–110. Any person who has an IQ less than 90 is considered to be subnormally intelligent.
(7) **Mental Illness:** This is an umbrella term that takes into account any mental health issue that is apart from mental retardation.

The major areas of focus, where protection of rights, equal opportunities, and full participation by appropriate governments and local authorities for the disabled have been provided, are as follows:

- **Education**: Education is taken to be a key in promoting the rights and opportunities for the persons with disabilities. Hence, this act provides for free and compulsory education till 18 years of age, promotion of inclusive as well as integrated education in regular schools and promotion of setting up of special

schools and associated programs for those who cannot be included in the regular schools. The severity of disability being considered, vocational training has also been considered for these children so that they may attain gainful employment later. Provisions for both formal education and education through open universities have been implemented. Also, there is three percent reservation for people with disabilities in educational institutes. Modifications have been made in the existing curriculum and examination system so that their representation can be encouraged and enhanced.

- **Public Accessibility:** The act ensures that there will be no discrimination of persons with disabilities in transport facilities, traffic signals, or in built environments. State Governments within the limit of their economic capacities are to install auditory signals at red lights and have barrier-free environments to ensure access to all. Construction of ramps is one measure that may be included easily to accommodate people with locomotor disabilities. A barrier-free environment is the key to ensure the independence and streamlining of persons with disability in the society.
- **Employment:** Benefits like reservation, posts of convenience according to the disability, ensuring promotion even if the disability is acquired during the job, and appropriate pay scales and services that are at par with other employees have been provided here. This provision also ensures that a person with disability does not remain isolated and can maintain his or her sense of purpose in the society at large.
- **Health:** The act provides measures at both preventive and management level when it comes to health of persons with disabilities. There are benefits when it comes to screening in prenatal and postnatal stages to ensure early detection and thus more effective management. The institutes that play a significant role in identification and management of the conditions are given recognition under this act. Many research initiatives that may throw light on better rehabilitation of person with disability have been sponsored under this act as well as State Governments are to ensure implementation of "Government Schemes and Individual Benefits/Concessions for Persons with disabilities".

The Lok Sabha passed "**The Rights of Persons with Disabilities Bill—2016**". The Bill will replace the existing PwD Act, 1995, which was enacted 21 years back. The types of disabilities have been increased from existing 7 to 21, and the Central Government will have the power to add more types of disabilities. Speech and Language Disability and Specific Learning Disability have been added for the first time. Acid Attack Victims have been included. Dwarfism, muscular dystrophy has been indicated as a separate class of specified disability. The new categories of disabilities also included three blood disorders, namely thalassemia, hemophilia, and sickle cell disease. In addition, the government has been authorized to notify any other category of specified disability. The New Act will bring our law in line with the United National Convention on the Rights of Persons with Disabilities (UNCRPD), to which India is a signatory. This will fulfill the obligations on the part of India in

terms of UNCRD. Further, the new law will not only enhance the rights and entitlements but also provide an effective mechanism for ensuring their empowerment and true inclusion into the society in a satisfactory manner.

National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999

The National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act was passed by Parliament in 1999. This act covers the following disability areas and is defined by the National Trust as follows:

- "*Autism* means a condition of uneven skill development primarily affecting the communication and social abilities of a person, marked by repetitive and ritualistic behavior".
- *Cerebral Palsy* means a group of non-progressive conditions of a person characterized by abnormal motor control posture resulting from brain insult or injuries occurring in the prenatal, perinatal, or infant period of development".
- *Multiple disabilities* means a combination of two or more disabilities
- *Severe disability* means disability with eighty percent or more of one or more multiple disabilities.

Objectives of the Trust: The major aim of this act is to make people with disabilities self-sufficient and prevent their isolation from society by making the community more supportive physically, emotionally, and financially. The family support is ensured by making them empowered to care for these people as well as appointment of guardians in case there is no family or the guardians are deceased. Ancillary support is provided by recognizing registered organizations that provide need-based services to families of persons with disabilities.

- **Powers and Duties of the Board:** The primary aim of the board is to receive the financial funds allocated by Central Government for the disability sector, and then, they further distribute the resources to implement the approved programs. These programs are often channelized through registered organizations. All allocations work on the basis of priority. In the majority of situations, preference shall be given to women with disability or to persons with severe disability and to senior citizens with disability (i.e., persons above the age of 65 years). An *approved program* has the following characteristics:
  - Promotion of independent living in the community.
  - Facilitating care and support services like respite care, foster care, or day care services.
  - Ensuring a proper shelter of permanent or temporary nature.

  - Increasing social support by networking and other methods.
  - Constituting bodies that can ensure effective and appropriate guardianship.

- **Procedure for Registration:** An application needs to be filled and filed for a welfare trust to be established. The major aim of this trust should be promotion of welfare of persons with disability. Any association of persons with disability or any association of parents of persons with disability or any voluntary organization can choose to undergo this registration.
- **Guardianship:** A guardian is generally appointed for a person with disability with their due consent. The application for the choice of person is submitted to the local committee. If the person is not able to do so, then any registered organization may make an application to the local committee for appointment of guardian for a person with disability. This guardianship is to look after the needs of the person with disability and also to monitor the property that the person may own. The guardian thus appointed then has to deliver the details to the authority within a period of six months. These details include a list of immovable property and financial assets and liabilities incurred due to disability. Removal of guardians is also possible on the account of neglect or misappropriation of property.
- **Accountability and Monitoring:** Any registered organization can submit a written requisition to the board to access any book or document maintained by them.

Going Beyond Boundaries

Mobility India is a foundation that looks after the prosthesis and orthosis needs of people with physical disabilities. Through its various community-based rehabilitation approaches, they have succeeded in highlighting the role of community to take care of physical as well as emotional needs of the disabled. Swarnapriya was identified by Mobility India's community facilitator for the community-based rehabilitation (CBR) programme. In order to improve Swarnapriya's mobility, a wheelchair was provided to her. She also had a strong inclination for dancing. A dance studio "Swing n Sway Innovative" approached MI to take part in a cultural program to promote dance as a medium which has no boundaries. Through the platform, she was able to live her dream, and her performance was highly appreciated. Apart from providing such opportunities, mobility India has completed community rehabilitation initiatives in Rural Karnataka for and promoted programs like home-based education

Source mobility-india.org/

Rehabilitation Council of India Act, 1992

This act came into being to regulate the training of rehabilitation professionals and to maintain a Central Rehabilitation Register to certify rehabilitation professionals. Thus, by this act, the Rehabilitation Council of India has become the apex body to further professional development of those in the field of disability rehabilitation. According to this act, the term "**rehabilitation professionals**" refers to audiologists and speech therapists, clinical psychologists, hearing aid and earmold technicians, special educators, vocational counselors, and multipurpose rehabilitation therapists.

Objectives of the Council: Rehabilitation council mainly works for ensuring quality training for the service providers of the persons with disabilities. This is mainly done through implantation of training policies, ensuring credibility of service providers by standardizing training courses, eliciting their required qualifications as well as giving appropriate recognition to the institutes and universities which impart the necessary expertise to these potential service providers. Also, a Central Rehabilitation Register of Institutions possessing the recognized rehabilitation qualification is maintained with the council.

National Policy for Disability

National Policy for Disability (NPD) ensures equal opportunities and effective access to rehabilitation measures. It also endeavors to provide social rehabilitation. The National Policy recognizes that Persons with Disabilities are valuable human resources for the country and seeks to create an environment that provides them equal opportunities, protection of their rights and full participation in society. The focus of the policy shall be on the following:

Physical, educational, and economic rehabilitation measures: The measures to be adopted to provide effective services to the persons with disability need to cater them in a holistic manner. For this purpose, NPD proposes physical and educational resources that include counseling services provided by Accredited Social Health Activist (ASHA) addresses at the grassroot level, provision of assistive devices as prostheses and orthoses, tricycles, wheelchair, surgical footwear and devices for activities of daily living, and quality education through *Sarva Shiksha Abhiyaan.* This program effectively addresses the educational needs of students with disabilities. This includes education through an open learning system and open schools, alternative schooling, distance education, special schools, wherever necessary home-based education, itinerant teacher model, remedial teaching, part-time classes, community-based rehabilitation (CBR), and vocational education. Economic needs are addressed through the IEDC scheme which provides financial assistance for development and dissemination of resources like hostel allowance, production of instructional material training of general teachers, and equipment for resource rooms.

Human Resource development: Human resources will be trained to meet the requirement of education for children with disabilities under inclusive education, special education, home-based education, preschool education, etc. The training programs target teachers who are willing to be a part of inclusive education, enhancing the curriculum of special education

training and training of caregivers for home-based education, and care services for disabled adults/ senior citizens, etc.

Education of persons with disabilities: Education of persons with disabilities has been provided with special attention under the NPD. This is so because education is considered to be instrumental in effectively empowering the person with disability, and it is a right-based issue for them. Our society and its tangible and intangible resources are structured in a stereotypic manner that often compromises on the right to education for this population. Hence, NPD provides for rehabilitation measures under the following categories:

- *Curriculum revision*s like devising a convenient medium of teaching, provision of learning tools, financial assistance to build up additional resources, and implementation of better interpersonal communication methods as well as a tailor-made evaluation system according to the abilities of the children are promoted under this policy.
- *Legal provisions* like reservation in government as well as private educational institutes, promotion of disability centers in universities, making the education campus more accessible and encouraging adoption of inclusive education.
- *Training of educators* includes a myriad of measures like organizing awareness camps for school teachers with the purpose of educating them regarding the problems and capabilities of children with disabilities, promotion of adult learning centers, and imparting of skills that will help in management of disabilities

Employment: A gainful employment is necessary for fulfilling the basic needs of an individual. Though there are reservations for the disabled in government sectors, their problems require more concrete steps. Under this legislation, the employment opportunities have been extended to the private sector as well as home-based income generation programs, imparting skills that ensure employment and accessible work environment have been ensured. Also, for those who are self-employed, assistance is provided through appropriate agencies like Marketing Boards, District Rural Development Agencies (DRDAs), private agencies, and Non-Governmental Organizations in marketing of goods and services produced by persons with disabilities.

Barrier-free environment: Public buildings (functional or recreational), transport amenities including roads, subways and pavements, railway platforms, bus-stops/terminals, ports, airports, modes of transports (bus, train, plane, and waterways), playgrounds, open space, etc., will be made accessible. Modification of Curriculum of Architects and Civil engineers will be undertaken to include issues relating to construction of barrier-free buildings. In service, training will be provided on these issues to the government architects and engineers. State Transport Undertakings will ensure disabled-friendly features in their vehicles. Railways will provide barrier coaches in a phased manner. They will also make the platforms buildings, toilets, and other facilities barrier-free coaches in a phased manner. They will also make the platforms buildings, toilets, and other facilities barrier-free. Communication needs of the persons with disabilities will be met by making information service and public documents accessible. Braille, tape-service, large print, and other appropriate technologies will be used to provide information for the persons with visual disability.

Social Protection: Social security measures ensure that a person is protected in the society and feels that he or she may live adequately. This policy covers issues like tax relief benefit, amount of pension and unemployment allowance, and support by Life Insurance cooperation without exception for persons with disabilities.

Sports recreation and cultural activities: Sports and cultural activities give an opportunity to the person with disability to explore and strengthen their abilities. Hence, under the policy, accessibility to the services and the travel opportunities have been emphasized upon. Identification of talent among persons with disabilities in different sports shall be made with the assistance of local NGOs. The representation of persons with disability will be enhanced by formation of sports organizations and cultural societies. Participation in the sports and recreational activities would be encouraged and thereafter reinforced with a national award for excellence in sports for persons with disabilities

United Nations Convention on the Rights of the Persons with Disabilities

Convention on the rights of the person with disabilities was adopted by the UN General Assembly in 2007. It has been signed by 158 countries and ratified by 138. It was brought into force as a result of the increasing prevalence of disability globally. It emphasizes on the implementation of the entire existing legislative framework for persons with disabilities. It has a total of 50 articles. *Article 1* states the purpose of the convention, *Article 2* gives out the key definitions of the constructs included in the convention, *Articles 3–9* correspond to activities that require general application, *Articles 10–30* elaborate on substantive rights, and *Articles 41–50* describe the steps to be adopted for implementation and monitoring of these rights. The general principles on which the convention is based are as follows:

- Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons.
- Non-discrimination which includes the concept of reasonable accommodation which is the "necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms".
- Full and effective participation and inclusion in society.
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity.
- Equality of opportunity.
- Accessibility.
- Equality between men and women.
- Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

In order to ensure the monitoring and implementation of the rights of the persons with disabilities, National Human Rights institutions play an important role. It provides for coordination between different parts of the government which requires multisectoral involvement. The purpose of such synergy is to reach a maximum number of national stakeholders that include civil society organizations, academic institutions, and the private sector.

In Sum

Persons with Disabilities Act, covers the seven categories of disabilities. This act was often hailed as a landmark legislation when it comes to the disability movement for education, public accessibility, health, and employment opportunities. The Lok Sabha passed "The Rights of Persons with Disabilities Bill—2016". The types of disabilities have been increased from existing 7–21, and the Central Government will have the power to add more types of disabilities. The National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act was passed by Parliament in 1999. This act mainly covers the measures of guardianship for persons with disabilities. Rehabilitation Council of India Act into being to regulate the training of rehabilitation professionals and to maintain a Central Rehabilitation Register to certify rehabilitation professionals. National Policy for Disability (NPD) ensures equal opportunities and effective access to rehabilitation measures. It also endeavors to provide social rehabilitation. Convention on the rights of the person with disabilities was adopted by the UN General Assembly in 2007. It has been signed by 158 countries and ratified by 138. It emphasizes on the implementation of all the existing legislative framework for persons with disabilities. The purpose of such synergy is to reach a maximum number of national stakeholders that include civil society organizations, academic institutions, and the private sector.

Conclusion and Recommendations

Care and support services to persons with disabilities involve resources and revisions at multiple levels. This needs help from many stakeholders, apart from the main caregivers like communities around, local bodies of the government, and other organizations that can provide infrastructural, economical, and legal aids to these people.

1. Accessibility to the services needs to be improved. We have come a long way in bringing out and understanding the problems of persons with disabilities and addressing them with appropriate solutions. But there is a strong requirement of connecting them to these solutions as well.
2. Institutions that offer multiple services in close proximity need to be increased in number.
3. A procedure that connects health professionals from different sectors needs to be encouraged so that problems and their solution can be brought out on a common platform.

4. Representation of persons with disabilities while formulating and implementing a respective legislation needs to be ensured.
5. A periodic evaluation of the already existing services has to be in place. This requires a dynamic system where the population for which these services are meant for are in touch with the authority. A smooth communication channel has to be procedurally implemented for the same.
6. Persons with disabilities are an important part of the population. They need to be empowered and streamlined into the society. Thus, the community that they live in should also be aware of their problems and participate actively in this process.

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Part VI
Role of Family, Teachers and Mental Health Professionals in Well-Being

Chapter 23
Promoting Child, Family, and School Well-Being: A School-Based Family Counseling Approach

Brian A. Gerrard

Abstract This chapter describes how School-Based Family Counseling (SBFC) may be used by mental health practitioners and educators to promote well-being in children, families, and schools. SBFC is defined and its historical roots in the work of Dr. Alfred Adler explained. Research describing the need for the SBFC approach is provided. The chapter explores the significant impact that both families and schools—the two most important social institutions affecting children—have on children's well-being with specific reference to mental health and academic success. The nine strengths of SBFC are outlined: (1) school and family focus, (2) systems orientation, (3) educational focus, (4) parent partnership, (5) multicultural sensitivity, (6) child advocacy, (7) promotion of school transformation, (8) interdisciplinary focus, and (9) evidence-based support. SBFC theoretical models, such as Bronfenbrenner's Ecological model, the SBFC metamodel, and the Circumplex Model, are described. Evidence-based support for SBFC, mainly in the form of randomized control group studies, is provided. The chapter provides examples of how SBFC is a global movement. The chapter concludes with a discussion of challenges experienced by SBFC and solutions that can be implemented.

Keywords Child · Family · School · Well-being · Family counseling

Introduction

School-Based Family Counseling (SBFC) is an integrated, systems approach designed to help children succeed academically and personally through mental health approaches that link school and family (Gerrard & Soriano, 2019). The fundamental premise behind SBFC is that the family and school are the two most important social systems affecting children and that by working simultaneously with both systems mental health practitioners are better able to enhance the well-being of children.

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_23

Origins of School-Based Family Counseling

The earliest large-scale application of SBFC was practiced by the psychiatrist Alfred Adler in Vienna in the 1920s. Adler believed that an especially effective way to help children was through conducting demonstration interviews with them, their teacher, and their parents, in front of an audience of mental health practitioners, parents, and teachers. Adler described his approach as follows:

> The purpose of these clinics is to put the knowledge of modern psychology at the service of the educational system. A competent psychologist who understands not only psychology, but the life of the teachers and parents as well, joins with the teachers and holds a consultation clinic on a certain day. On that day the teachers will have a meeting, and each one will bring up his particular cases of problem children. They will be cases of lazy children, children who corrupt the class, children who steal, etc. The teacher describes his particular cases, and then the psychologist will contribute his own experiences. Then the discussion starts. What are the causes? When did the situation develop? What should be done? The family life of the child and his whole psychological development is analyzed. With their combined knowledge, the group comes to a decision as to what should be done with a particular child.
>
> At the next session the child and the mother are both present. The mother will be called in first…Then the mother tells her side of the story, and a discussion starts between the mother and the psychologist…..When, finally, the method of influencing the child is agreed upon, the child enters the room. He sees the teacher and the psychologist, and the psychologist talks to him but not about his mistakes. The psychologist speaks as in a lecture, analyzing objectively - but in a manner that the child can grasp - the problems and the reasons and the ideas that are responsible for the failure to develop properly….
>
> This summary account will give an indication of the possibilities that can be realized from the fusion of psychology and education. Psychology and education are two phases of the same reality and the same problem. (Adler, 1930, pp. 187–189)

The clinics that Adler referred to were 30 child guidance centers that he established throughout Venna. Each was attached to a school. At these clinics children, referred by teachers or parents, were seen by psychologists or psychiatrists trained by Adler. The mental health practitioners would work with the teachers and the parents to help children overcome their problems. These clinics, which Adler called "Advisory Clinics," provided remedial assistance for children with existing problems. In addition, the clinics provided preventive work through demonstrations in an auditorium before an audience of mental health practitioners, teachers, and parents. This innovative linking of school and family is the essence of a School-Based Family Counseling approach.

During World War II, the Vienna guidance clinics were closed. Dr. Rudolf Dreikurs, a psychiatrist who trained with Adler, came to the USA during the 1940s and carried on Adler's work. Dreikurs' books *Children the Challenge,* written for parents, and *Maintaining Sanity in the Classroom,* written for teachers, illustrates the Adlerian SBFC approach (Dreikurs, 1958; Dreikurs, 1968). A comprehensive review of the development of SBFC from the 1940s to the present can be found in Gerrard (2008, 2013a). At a time, when Freudian therapists were emphasizing psychoanalysis with a patient on a couch in the analyst's office, Adler was promoting the well-being of children, families, and schools through an educational and prevention approach.

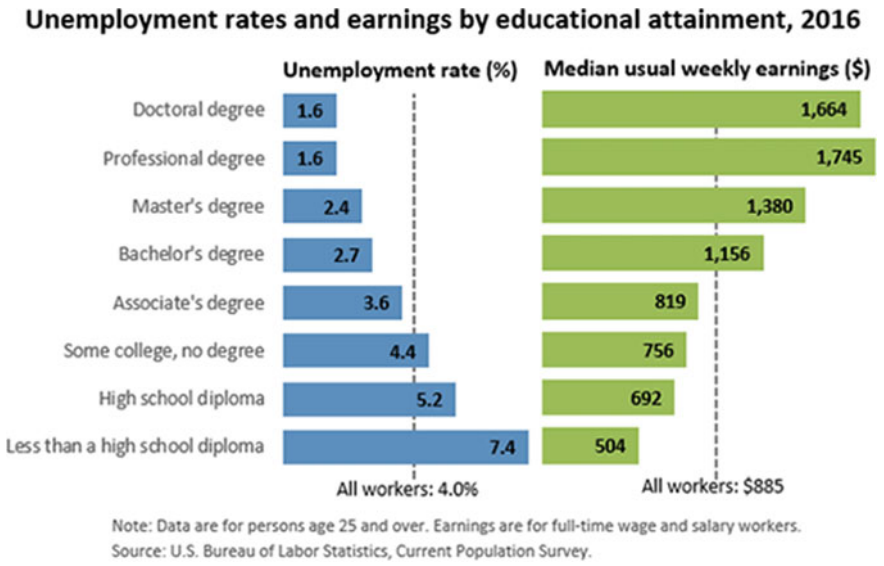

Fig. 23.1 USA unemployment rates and earnings by educational attainment, 2016

For that time, it was a revolutionary approach to mental health and presaged the school mental health and full-service school movements that developed in the 1990s (Dryfoos, 1994; Foster et al., 2005).

The Need for SBFC

Success at school is widely considered critical for the well-being of children. As can be seen in Fig. 23.1, academic success is strongly correlated with unemployment and wages (US Bureau of Labor Statistics, 2016). Both unemployment and low wages are correlated with poor mental and physical health (McKee-Ryan et al., 2005; Pharr et al., 2012). Thus, when children fail academically, they are at risk for future problems associated with unemployment, low wages, and potential health and mental health problems.

The Benefits of Parent Support for Children's Well-Being and Academic Performance

There are several known factors that interfere with school success. Family problems, such as divorce, marital discord, domestic violence, parental mental illness, incarceration, substance abuse, family illness and death, siblings in gangs, neglect, physical

and sexual abuse, are all known to be adverse childhood events (ACEs). All of these can produce negative outcomes in adulthood, including poor physical and mental health, substance abuse, and risky behaviors (e.g., unsafe sex) (Centers for Disease Control & Prevention, 2016).

When families are dysfunctional, for example, when parents are in the process of a divorce, there is often domestic violence, marital conflict, child abuse, and neglect or substance abuse. During marital discord, children often experience a variety of problems. These include behavior problems (Henderson et al., 2003; Jogdand & Naik, 2014; Morris et al., 2002) delinquency (Coll et al., 2004; Loeber & Stouthamer-Loeber, 1986), depression (Cummings, Keller, & Davies, 2005; Elgar et al, 2005), suicidality (DeVille et al, 2020; Zhai et al., 2015) risky peer behavior (Anyanwu et al., 2020; Haghdoost et al., 2014), and substance abuse (Bahr, 2005; Henry et al., 2004).

Not surprisingly, when children experience problems at home, it can have a negative effect on their ability to do well at school. Poor academic performance has been linked to lack of parental support (Lagana, 2004; Lara & Saracostti, 2019; Pons-ford & Lapadat, 2001), divorce (Potter, 2010; Jeynes, 1998); mother absence (Ma, Deng & Zhou, 2018); and parental loss (Abdelnoor & Hollins, 2004; Berg et al., 2014). However, when parental support is strong, this has a positive effect on children's academic performance (Anguiano, 2004; Chen & Gregory, 2009; Castro et al., 2015; Catalano & Catalano, 2014; Cheung & Pomerantz, 2011; Chohan & Khan, 2010; Deslandes & Cloutier, 2002; Eccles & Harold, 1996; Fan & Chen, 2001; Fan & Williams, 2010; Flouri & Buchanan, 2003; Garbacz et al, 2017; Grolnick et al, 2000; Grolnick & Slowiaczek, 1994; Hill et al, 2004; Hill & Tyson, 2009; Jeynes, 2009, 2016; Johnson et al., 2001; Newman et al., 2007; Patall et al., 2008; Ross, 2016; Shumow & Lomax, 2002; Simons-Morton & Crump, 2003; Spera, 2005; Wang et al., 2013; Wang & Eccles, 2012a, 2012b, 2013; Wilder, 2014).

Mental health practitioners who use an SBFC approach help children succeed at school by working with families to reduce the family stress that is negatively impacting the children. SBFC practitioners also collaborate with parents to increase their parental support and mobilize family resources and strengths to help improve children's well-being and academic performance.

The Benefits of School Support on Children's Well-Being and Academic Performance

Unsupportive school environments, such as the presence of bullying (Monks et al., 2005; Skrzypiec et al., 2011, 2012; Smith et al., 2015; Slee et al., 2003; Slee & Skrzypiec, 2016), low school cohesion (Maxwell et al., 2017; Springer et al, 2006), incompetent or harsh teachers (Banfield et al., 2006; Range et al., 2012; Yariv, 2011), can have a negative impact and directly affect children's well-being and academic performance.

Extensive research demonstrates that supportive teachers, effective and caring school administrators and positive school climates benefit children's well-being and promote school involvement and academic success (Aldridge et al., 2016; Chapman et al., 2013; Denman, 1999; Frydenberg et al., 2009; García-Moya et al., 2015; Huang et al., 2013; Jose & Pryor, 2010; Jose et al., 2012; Konishi et al., 2010; Lau & Li, 2011; Maddox & Prinz, 2003; McGraw et al, 2008; McNeely & Falci, 2004; Niehaus et al., 2012; Oberle et al., 2011; Prelow et al., 2007; Resnick et al., 1997; Shute & Slee, 2016; Svavarsdottir & Orlygsdottir, 2006; Thomson et al., 2015; Wang & Degol, 2016). Mental health practitioners who use an SBFC approach help children succeed at school by collaborating with teachers, principals, and other school staff to promote school cohesion and engagement.

The Strengths of SBFC

SBFC has nine strengths: family and school focus; systems orientation; educational focus; parent partnership; multicultural sensitivity; child advocacy; promotion of school transformation; interdisciplinary focus and evidence-based support.

Family and School Focus

The most distinguishing feature of SBFC is its focus on helping children by strengthening family and school relationships. This is in contrast with more traditional mental health approaches that focus solely on school intervention or on family intervention. The SBFC metamodel is a diagram that emphasizes the importance of family and school in prevention and intervention with children (Fig. 23.2).

The extensive research, previously reviewed, indicates that supportive family and school environments significantly impact children's well-being and thus improve their academic performance. Therefore, the SBFC practitioner works with children to help strengthen their resilience in dealing with school and family challenges. They also work with the family to reduce family tensions that negatively impact children and mobilize family resources that empower them. Working with the school also improves school cohesion and engagement, reduces bullying, and strengthens school–family relationships. Other systems, such as the peer group and the community, are also the focus of intervention. But the main emphasis in an SBFC approach is the family and the school. These are the two main institutions that affect the lives of young children. During adolescence, the peer group becomes more important and can be more significant than the family in influencing student behavior. However, early intervention and prevention are widely viewed as more important in preventing children from developing more serious problems in adolescence and adulthood.

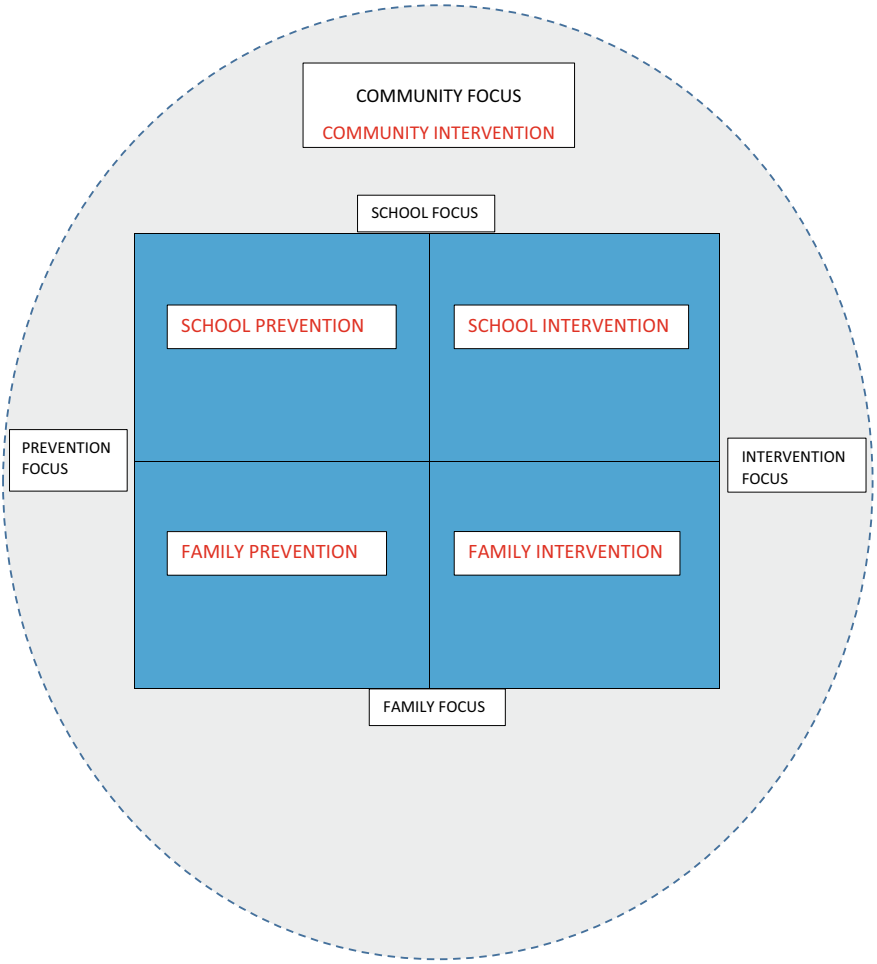

Fig. 23.2 The SBFC metamodel

Systems Orientation

SBFC is a systems approach. The SBFC practitioner is constantly aware, and on the lookout for, how parents, grandparents, siblings, teachers, principals, friends, neighbors, and community organizations such as churches, synagogues, temples, mosques, sporting centers, etc., affect children. Bronfenbrenner's ecological model (Ecological Systems Theory, 2020; Bronfenbrenner, 1979) is a useful model for SBFC practitioners because it directs attention to the multiple systems that can affect a child (see Fig. 23.3).

SBFC practitioners typically work most often with a child's Microsystem, Mesosystem, and Exosystem.

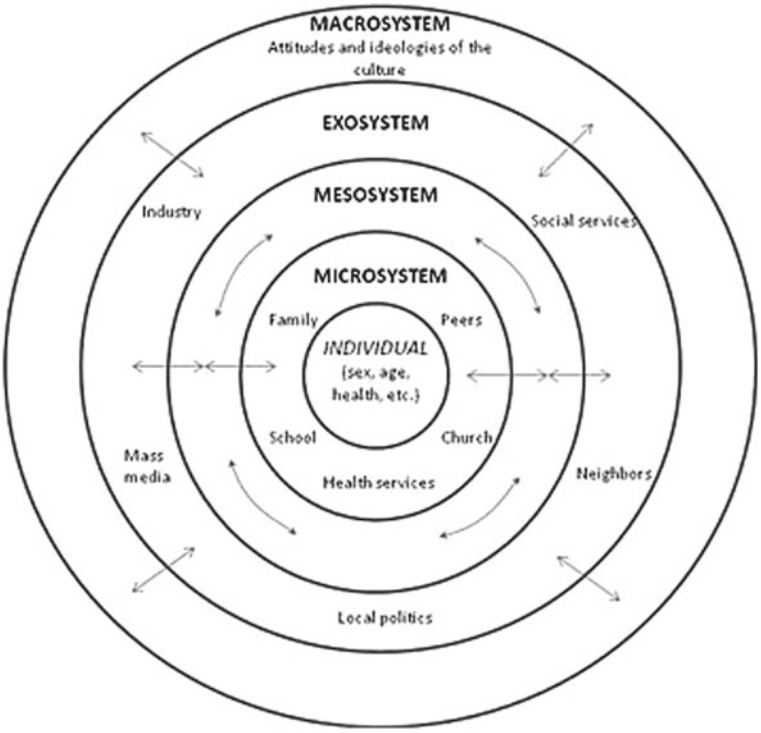

Fig. 23.3 Bronfenbrenner's ecological systems theory

Microsystem: Refers to the institutions and groups that most immediately and directly impact the child's development including: family, school, religious institutions, neighborhood, and peers.

Mesosystem: Consists of interconnections between the microsystems, for example between the family and teachers or between the child's peers and the family.

Exosystem: Involves links between social settings that do not involve the child. For example, a child's experience at home may be influenced by their parent's experiences at work. A parent might receive a promotion that requires more travel, which in turn increases conflict with the other parent resulting in changes in their patterns of interaction with the child. (Wikipedia, July 13, 2020)

The systems theory most widely used by SBFC practitioners is family systems theory (Bowen, 1978). The central premise in family systems theory is that a family is a social system in which the behavior of every person has an influence on the behaviors of every other family member. Behavior of a child which appears "individual" may be the result of interpersonal influence, or "pressure" exerted by other family members. Family therapists frequently use the term "identified patient" to indicate the family member who demonstrates problem behavior or psychopathology (e.g., the child who throws temper tantrums at school and at home), but whose aberrant

behavior is actually caused by dysfunctional behavior in the family (e.g., severe marital conflict in which the child is encouraged to take sides). You cannot treat the identified patient without treating the family.

An important family systems assessment approach is the Circumplex Model (Olson, 2000). In the Circumplex model, families are assessed on two key dimensions: Flexibility and Cohesion. Flexibility refers to the ability of a family to adapt to change. Families that are incapable of changing as situations demand are Rigid (e.g., have authoritarian parenting). Families that are overly reactive to change are Chaotic (e.g., lacking in parental discipline). Families between these opposite poles of Rigid and Chaotic are considered Flexible and are examples of healthy family systems. Cohesion refers to the degree of closeness between family members. Families that are overly close are Enmeshed (e.g., family members are overly dependent on each other, and independent thinking is discouraged). Families that lack closeness are Disengaged (e.g., no warmth between family members). Families that are between these opposite poles of Enmeshed and Disengaged are Connected and are examples of healthy family systems. Olson has developed instruments that can be used to measure Cohesion and Flexibility in order to position a family's location on the Circumplex Map (see Fig. 23.4). It is important to note that the Circumplex Model does not diagnose individual behavior: it assesses relationships.

The Circumplex Model can also be used to diagnose school relationships and relationships between schools and families. In Fig. 23.4, a Chaotically Disengaged

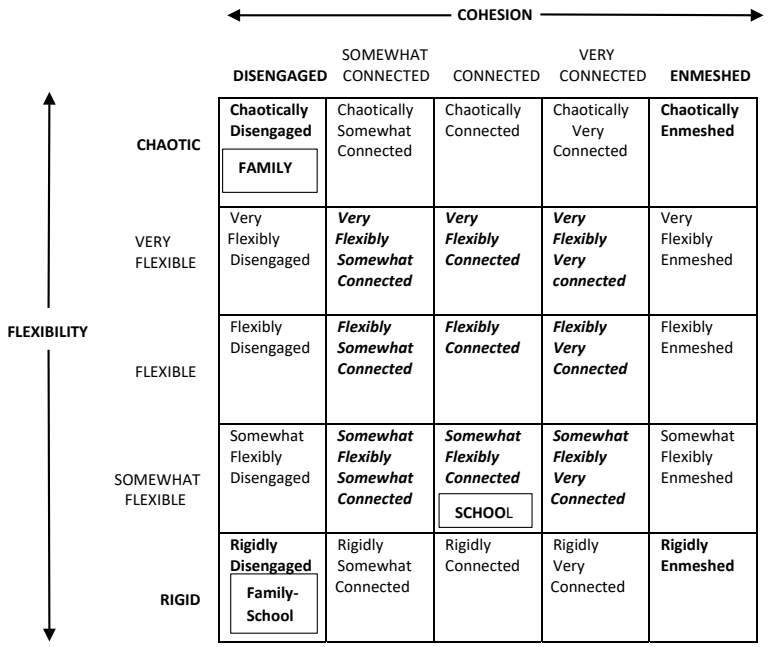

Fig. 23.4 Circumplex model

family is shown in relationship to the school where the child is a student. A Chaotically Disengaged family would typically be one in which there are few family rules enforced. Members act very independently of each other. There is a lack of warmth and closeness between family members, and there is little parental authority exercised. The school as a whole is classified as Somewhat Flexible-Connected. This would be typically a school with very clear leadership by teachers and principal, rules that are enforced (but with some flexibility), and a school where staff and students have positive relationships. A student who might feel unaccepted in a Chaotically-Disengaged family, would likely feel more accepted in a Connected school. This same student might have difficulty conforming to school rules if they come from a Chaotic family where few rules are followed. The Circumplex Model is a systems assessment approach and can also be used to assess family–school relationships. In the example, we are currently considering the family and the school (denoted by the letters F-S) and have a rigidly–disengaged relationship. A typical illustration of this would be where the principal sent a letter to the parents complaining about the student not following rules and hinting that the family needs "therapy." The parents in return did not respond to the letter which they found insulting. No further communication takes place between the school and the family.

As the SBFC practitioner does this type of systems analysis, the practitioner would also be thinking of ways to repair the family–school relationship by facilitating a more connected, collaborative relationship between principal and parents. Furthermore, the SBFC practitioner would be motivated to help the family become more connected and flexible and the school to be less rigid in dealing with the family. That is, the SBFC focus is on modifying relationship systems. Peer group relationships and relationships between dyads (two person groups, such as mother–child, child–teacher, father–principal, principal–teacher) can also be diagrammed on the Circumplex Model (Gerrard, 2015).

Educational Focus

School mental health professionals, such as school social workers, school counselors, and school psychologists, are trained to work directly with students to assist them with school problems. Because the traditional school mental health practitioner is not trained in family systems intervention, when students present with family problems, school personnel will typically refer the family to a community mental health center that offers family therapy. But frequently the family does not accept the referral and resents the implied message that something is wrong with the parents and that "therapy" is needed. Also, many families regard mental health therapy as a sign they are "crazy." Many mental health researchers acknowledge that the social stigma concern can be a barrier to seeking professional help (Bathje & Pryor, 2011; Corrigan, 2004). The emphasis in the SBFC approach is not on "therapy," but on promoting the academic success of children. This explicit educational focus is more appealing to parents who typically are eager to have their child succeed at school. Thus, inviting a

parent to meet with the SBFC practitioner to discuss ways to help a son or daughter do better at school is less threatening than being invited to meet with a mental health professional to discuss family problems. During the session when the SBFC practitioner assists parents to help their child do better at school, ways of lowering family stresses are discussed, but always in an educational context. The framing of the work between the family and the SBFC practitioner as educational avoids the use of language that frames the family as deficient.

Parent Partnership

In an SBFC approach, the relationship between the parents (or guardians) and the SBFC practitioner is framed as a collaborative partnership where the two parties meet to identify ways to help the child succeed at school. This is in contrast to the therapist–client frame of mental health which is hierarchical and implies a deficiency on the part of the client. Treating the parents and family as partners is important because in every family there is typically one or more family members who will be a source of strength and empowerment for a child who is struggling academically. The parent partnership approach is respectful of the parents' roles and defuses parents' feelings of concern about meeting with a mental health professional. In many situations, the difficulty the child is having at school is precipitated by actual events at the school, for example, incompetent teachers, low school cohesion, bullying, etc. To resolve some of these issues, a school intervention would be appropriate.

Multicultural Sensitivity

Most psychotherapy and mental health approaches were developed in Europe and America and, as such, are Eurocentric or Americentric in nature. That is, they emphasize the importance of the individual and stress concepts like assertiveness and independence. However, many clients come from collectivistic cultural backgrounds where values such as interdependence and being family-oriented are considered more important. These Western individualistic approaches to mental health are culturally inappropriate with Asian, African, Middle Eastern, Latinx, First Nations Peoples (e.g., Native American), and other ethnic groups (Gopalkrishnan, 2018; Sue & Sue, 2008).

> Much of the theory and practice of mental health, including psychiatry and mainstream psychology, have emerged from Western cultural traditions and Western understandings of the human condition. Notions of Cartesian dualism of body and mind, positivism, and reductionism have been central to the development of mainstream mental health systems as they are widely implemented today (8, 9). While these relatively monocultural understandings of mental health have provided powerful conceptual tools and frameworks for the alleviation of mental distress in many settings, they have also been very problematic when applied to the

> context of non-Western cultures without consideration of the complexity that working across cultures brings with it (10, 11). Tribe [(1), p. 8] suggests that Western cultural approaches to health tend to be "predicated on a model that focuses on individual intrapsychic experience or individual pathology, while other traditions may be based more on community or familial processes." (Gopalkrishnan, 2018, p. 179)

Although SBFC was developed in the West, it is not a typical Eurocentric or Americentric mental health approach. It is a systems approach. Family, as a resource, is a primary focus. This family-centric emphasis makes SBFC culturally congruent with a wide spectrum of families with different cultural backgrounds.

Child Advocacy

Although SBFC practitioners work to strengthen the well-being of families and school personnel, they are first and foremost advocates for children. Clearly, children are more vulnerable and require greater protection. As the child advocate, the SBFC practitioner must establish an effective relationship with families and schools and frequently act as advocates for both families and schools. However, in the advocacy hierarchy, children are the top priority.

Promotion of School Transformation

Schools, like families and individual clients, can be dysfunctional. Research reviewed above demonstrates some of the ways schools can be dysfunctional: for example, bullying may be common, school engagement and cohesion can be minimal, and teachers are sometimes harsh or incompetent. These problems seriously interfere with a student's well-being and academic performance. Effecting change in the behavior of principals or teachers is challenging for the SBFC practitioner who often is employed by the school and whose immediate supervisor may be the principal. It is therefore imperative that SBFC practitioners develop good working relationships with school personnel and have the courage to "speak truth to power" in a way that does not alienate. The family therapist, Salvador Minuchin, wrote of the central importance of the family therapist being able to "join" with the family as though the therapist were a distant uncle or aunt. This, too, is an important skill for SBFC practitioners in their relationship with school personnel.

Interdisciplinary Focus

Within the mental health professions, SBFC is an interdisciplinary approach. It may be used by any of the mental health disciplines: psychology (school psychology,

family psychology), counseling (school counseling, family counseling), social work and school social work, psychiatry, and family therapy. The term SBFC practitioner, or SBFC professional, is used to denote the interdisciplinary nature of SBFC. What is important about SBFC is not the theoretical orientation (e.g., behavioral or humanistic) or the mental health discipline, but the use of a systems focus with an emphasis on how family and school systems influence children. The SBFC metamodel in Fig. 23.5 illustrates some of the categories of intervention and prevention that an SBFC practitioner with any theoretical or discipline orientation could consider in helping their client, the child.

Let us use one category as an example: Group Counseling under the School Intervention category. Group counseling is a useful intervention when several students

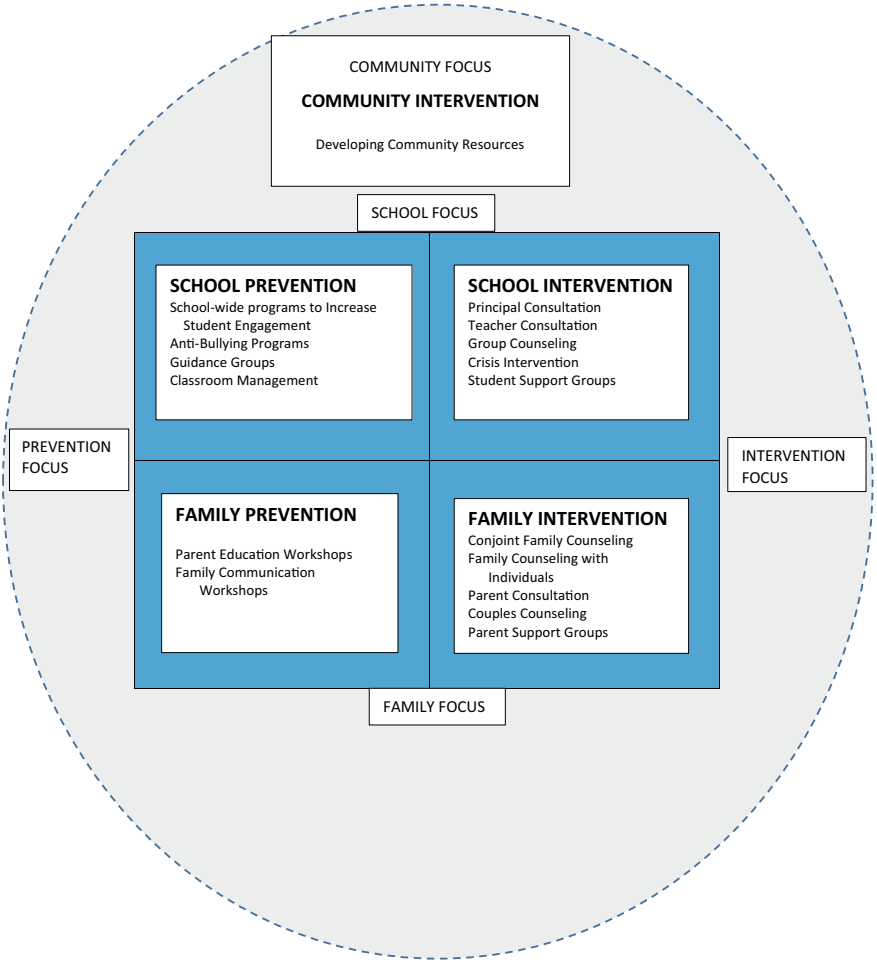

Fig. 23.5 The SBFC metamodel with prevention and intervention categories

are experiencing the same problem (e.g., death of a family member or dealing with bullies). However, the SBFC practitioner can implement a group counseling program from a behavioral or humanistic perspective, or perhaps a combination of the two. If the mental health practitioner is willing to adopt the SBFC perspective—which is granted as a theoretical perspective—the practitioner can use its flexibility within the general theoretical orientation of the mental health discipline in which they were trained. In this sense, the SBFC approach should be viewed as a value-added element to any mental health practitioner's training.

Evidence-Based Support

There is modest evidence-based support for SBFC in eight randomized control group studies comparing school and family intervention with school only or family only intervention (see Box 23.1). In all 8 studies, the combined treatment (the SBFC intervention) was superior. In addition to these RCT studies, there is extensive correlational and qualitative research supporting the SBFC approach (Gerrard, 2008, 2013b).

Box 23.1 Evidence-Based Support for SBFC

Apisitwasana, Perngparn, U., & Cottler, L. (2018). Effectiveness of school- and family-based interventions to prevent gaming addiction among grades 4–5 students in Bangkok, Thailand. *Psychology Research and Behavior Management,* 11, 103–115. https://doi.org/10.2147/PRBM.S145868

Conduct Problems Prevention Research Group. (2007). Fast track randomized controlled trial to prevent externalizing psychiatric disorders: Findings from grades 3 to 9. *Journal of the American Academy of Child and Adolescent Psychiatry,* 46(10), 1250–1262. https://doi.org/10.1097/chi.0b013e31813e5d39

Crozier, M., Rokutani, L., Russett, J., Godwin, E., & Banks G. (2010). A multisite program evaluation of families and schools together (FAST): Continued evidence of a successful multifamily community-based prevention program. *The School Community Journal*, 20 (1), 187–207. ERIC: EJ891838.

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SBFC is a Global Movement

SBFC, although developed in the West, has evolved into a global movement. The Oxford Symposium in School-Based Family Counseling, an international association, meets annually at Oxford University and other international sites. Its mission is to promote SBFC worldwide. To date, members come from approximately 20 countries. The International Journal for School-Based Family Counseling is an SBFC resource containing articles on SBFC as applied to immigrant families in New Zealand (Everts, 2008); school violence in South Africa (Marchetti-Mercer, 2008); assessing Chinese families in Macao (van Schalkwyk, 2010); school refusal in Hong Kong (King, 2012); using reflecting teams in SBFC in the UK (Agudelo, 2017); Black fathers and autistic children in the USA (Hannon, 2017), and other topics presented at the yearly international conference held at Brasenose College, Oxford; Venice International University; the University of Barcelona; and the University of Hong Kong. During the 2020 coronavirus pandemic, a Special Interest Group of the Oxford Symposium in SBFC, called the Disastershock Global Volunteer Team, translated the book *Disastershock: How to Cope with the Emotional Stress of a Major Disaster* (Gerrard et al., 2020) into 25 different languages. This practical stress reduction book, written for parents, teachers, and other professionals working with children, was then distributed by the 101 person global team as a free ebook to countries around the world ("Disastershock," 2020). In winter 2021, members of the Disastershock Educator Collaborative Team developed a book called *Disastershock: How Schools Can Cope with the Emotional Stress of a Major Disaster, a Manual for Principals and Teachers* (Disastershock Educator Collaboration Team, 2021). This ebook is also available free on the website https://www.disastershock.com.

The largest SBFC program is Place2Be, a UK organization that provides integrated school and family counseling in over 300 schools in England, Scotland, and Wales (Adams-Langley & Everts, 2013). The Sifriyat Pijama program in Israel uses a home and school-based approach to promoting reading literacy in a way that promotes school and family cohesion, fosters cultural identity of children, and empowers disadvantaged families (Hareven, 2019). The Center for Child and Family Development in the San Francisco Bay area is an SBFC university–schools partnership that has served over 20,000 children and families in 70 public, private, and Catholic schools over a 35 year period.

The first masters' degree program in SBFC was offered at California State University, Los Angeles, in 1992 (Carter & Perluss, 2008). Certificates in SBFC approaches may be earned at Central Connecticut University and at Loyola University, Chicago (which also offers continuing education training in SBFC through the Family and School Partnership Program).

SBFC Challenges and Solutions

There are three common challenges faced by mental health practitioners and educators who want to develop SBFC programs: the "silo" nature of mental health professional training, difficulties in engaging parent and family involvement, and funding SBFC programs.

Challenge: "Silo" Professional Training

Because most mental health professionals are trained in a narrow "silo" approach to mental health that does not emphasize collaboration between the mental health disciplines, it may be difficult for some mental health professionals to adopt the systems approach required to practice SBFC. This tendency for the mental health disciplines to operate in isolation from each other, even to the point of engaging in "turf wars" with each other, is a major barrier to developing SBFC programs (Carter et al., 2017; Soriano, 2017). There are, however, strategies that can be used to minimize inter-professional competition and maximize collaboration with other mental health professions in a school district where one wishes to implement an SBFC program. These include: making a concerted effort to collaborate with other mental health professionals working in schools; becoming familiar with approaches used by other mental health disciplines by reading their literature; emphasizing that SBFC is an additive approach to the other mental health disciplines, not a replacement for them; using neutral, interdisciplinary language, e.g., terms like SBFC practitioner and SBFC professional; being familiar with the evidence-based support for SBFC (Carter et al., 2017; Powers & Swick, 2017). Mental health practitioners who are trained only in school or family mental health approaches, can develop an SBFC

perspective by taking continuing education in the approaches they are less familiar with. They can also develop an SBFC team by collaborating with a mental health professional who has the training and skills they currently lack. For example, a traditional school mental health professional could collaborate with a traditional family therapy professional, and thereby learn from each other as they link school and family interventions.

Challenge: Engaging Parent and Family Support

Engaging low-income families in SBFC presents challenges. Parents' work schedules may make it difficult or impossible to attend counseling during normal workday hours. As an SBFC solution, the flexibility of the practitioner is important. Stepping away from the normal 9–5 workday with staggered hours of, e.g.,12–8 p.m. and availability to meet with parents on Saturday mornings, is helpful. But this requires administrative support and an appreciation of the parents' dilemma. Asking a low-income parent to miss work to attend a counseling session is simply unreasonable. Although the literature clearly indicates that students' success in school depends, to a great extent, on the degree of parent engagement, many school districts communicate with low-income families in a manner that marginalizes them (Strickland & Lyutykh, 2020). SBFC addresses this issue by communicating with parents with respect, engaging them as equal partners to promote their children's success, and frames the purpose of the parent–SBFC practitioner meeting as "educational" rather than "mental health/therapy."

Challenge: Funding of SBFC Programs

Any mental health program in schools requires funding, and this can be a challenge for developing a new SBFC program in a school district. Mental health practitioners and educators who want to develop an SBFC program can provide evidence-based support for administrators who make program decisions. The research evidence supports a combined school and family mental health intervention as being more effective than a school only or a family only approach in helping children succeed at school (see Evidence-Based Support above). Presenting this information to school principals, and school district superintendents, may facilitate SBFC program funding. The Center for Child & Family Development, an SBFC program in San Francisco, utilizes a cost-effective approach by staffing schools with masters-level trainees in Marital and Family Therapy. These trainees are provided with SBFC in-service training to complement their traditional family therapy training and prepare them to work in school environments. The schools are charged a nominal fee which is a fraction of what it would cost to hire a full-time licensed mental health professional. This university–schools partnership program has provided more than 20,000 children and

families with SBFC services in over 70 San Francisco Bay area public and private schools over a 35 year period (Gerrard, 2013b). The Place2Be SBFC program which is in over 300 schools in the UK receives funding from multiple sources: schools, corporate donors, and grants (Place2Be: Improving Children's Mental Health in Schools, 2020).

Ultimately, the maintenance of an effective SBFC program requires visionary leadership, adequate funding, and political skills to negotiate challenges. Persons wishing to implement a SBFC program will find useful guides in the SBFC texts: *School-Based Family Counseling: An interdisciplinary guide* (Gerrard et al., 2020) and *School-Based Family Counseling: Transforming family–school relationships* (Gerrard & Soriano, 2013). The bibliography at the end of this chapter contains additional resources helpful for developing and maintaining an SBFC program to benefit the well-being of children, families, and schools.

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Chapter 24
Role of Mental Health Professionals in Extending Professional Support to People in Need

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Abstract This chapter will present an outline of a model of service delivery that has been in use by a London "Child and Adolescent Mental Health Service" (CAMHS) to provide services to children, young people, and families whose multiple difficulties make it hard for them to access conventional clinic-based services. The "THRIVE Framework for System Change" ("THRIVE") (Wolpert et al. in THRIVE-framework for system change, 2019) which underpins this service redesign, builds on the resilience of families, and the skills of supporting key workers who have the closest relationships with them. This chapter will outline the model of service delivery and use examples to illustrate its outcomes for the most vulnerable young people, their families, the staff working with them, and the organizations/agencies delivering services to these families.

Keywords Child and adolescent mental health · Safeguarding · Resilience · Vulnerable families · "THRIVE" · "Hard to reach" · Troubled families

Introduction

Over the last 6 years, the UK government has realized the importance of addressing the mental health needs of children and young people given that a high percentage of difficulties begin in childhood and adolescence, recognizing the vulnerability those who have suffered traumatic experiences and have abusive histories (Future in Mind, 2015). In the *Long-Term Plan* (2019) the government pledged to increase expenditure and develop new models of service delivery in its efforts to improve access and reach of children and young people's mental health services.

The need for service modernization was informed by access issues but also the effectiveness of mental health services, many of whom adhered to a medicalized diagnostic approach to determine access and treatment (Department of Health and

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_24

Social Care and Department of Education 2018). Evidence from the UK suggests that only 33% of children and young people will be recovered after the best evidence-based treatments and some children and young people do not benefit at all from the services they are offered (CQC, 2018). The causes and consequences of mental health difficulties are best conceptualized within a biopsychosocial model with a number of factors at any point contributing to a child or young person's vulnerability and resilience. The mental health support needs a common framework to think about the range of mental health-promoting practices—talking therapies, psychoeducation, behavior change, medication, and the wealth of non-drug non-health service interventions that come under the label of social prescribing (Husk et al., 2016). The "THRIVE Framework for system change" ("THRIVE") was developed by a collaboration between the Tavistock and Portman NHS Foundation Trust and the Anna Freud National Centre for Children and Families in 2014 in order to address some of the shortcomings of existing service delivery models. "THRIVE" is an integrated, person-centered, and needs-led approach to delivering mental health services for children, young people, and families. The framework stressed the promotion of children and young people's mental health and well-being. It empowers children, young people, and their families to engage in shared decision making around their mental health care, outlining a number of treatment options. The article describes service innovation in Camden using "THRIVE" which is now widely implemented across the UK and has the potential to inform the development of integrated mental healthcare pathways more widely.

The Camden Population

The borough of Camden is in the center of London, stretching over nearly 22 km^2. It is a diverse borough in terms of class and ethnicity, with business districts and exclusive residential areas existing alongside pockets of deprivation. The latest official estimate of Camden's resident population was 262,000 mid-2019 (Camden Profile, 2020). Approximately 14% of Camden residents have an illness or disability that affects day-to-day activities, a number of them being parents. There is a large social rented sector, with 23% of households renting property from the council and 10% in other social renting schemes. Almost a third (30%) of Camden children live in poverty and almost 40% of all households with dependent children are overcrowded (The Camden Commission, 2017).

In terms of ethnic diversity, statistics from 2011 suggest that 34% of Camden residents were from black or minority ethnic groups, 22% are non-British White residents including Irish and others originating mainly from English-speaking countries. Camden-resident children speak 162 languages and dialects[1] and for 23% of the population, English is not the main language spoken (Camden Profile, 2020).

[1]The most widely spoken languages after English are: Bengali (2920 speakers), Somali (1530), Arabic (1160).

The current under 18-year-old population for Camden is approximately 52,405, and there are 663 children from 373 families who are receiving interventions from "Early Help".[2] In addition, there are currently 291 children on a Child Protection Plan[3] and 656 children on a "Child in Need plan".[4] Those children have a great amount of input from social services, education, and the CAMHS team as they have very complex and high needs, but historically traditional children's services have struggled to consistently and effectively engage with these families.

Redesign of the Child and Adolescent Mental Health Service in the London Borough of Camden

Service innovation in Camden was made possible because of a context of collaborative working between commissioners, providers, the Local Authority (including social services), and the Tavistock and Portman NHS[5] Foundation Trust that delivers the local community and Camden Local Authority CAMHS. These supportive and constructive relationships as well as a shared vision have been an essential context in which to creatively meet the complex needs of children, young adults, and families with histories of trauma and abuse. Many of the families referred to these services have been exposed/subject to adverse childhood experiences (ACEs).

It has been well-documented that ACEs such as abuse, neglect, and dysfunctional home environments are associated with emotional and behavioral disorders, externalizing and internalizing problems relating to peers, physical health problems, and poorer social outcomes across their life course (Bellis et al., 2015; Committee on Child Maltreatment Research, 2014; Felitti et al., 1998). Psychological and behavioral problems are linked to the co-occurrence of different types of abuse (Finkelhor et al., 2005) and can, in some case, be the manifestation of lasting changes in the structure and functioning of the brain (Glaser, 2000), and it is evident that psychological presentations are likely. Article 19 of the United Nations Convention on the Rights of the Child states that children and young people who have been the subject of abuse and neglect have the right to care and support to overcome these difficulties (UN, 1989). However, the most vulnerable and traumatized children, young people,

[2]Early help or early intervention, is support given to a family when a problem first emerges or families do not reach the threshold for intervention by children's services. It can be provided at any stage in a child or young person's life. Early help services can be delivered to parents, children, young people, or whole families and the focus is to improve the outcomes for children and young people.

[3]A child protection plan is drawn up by the local authority, and outlines how a child can be kept safe, the actions needed to make things better for the family, and what support the family will need to carry out these actions.

[4]Children in need are defined as children who need local authority services to achieve or maintain a reasonable standard of health or development, need local authority services to prevent significant or further harm to health or development or are disabled.

[5]National Health Services.

and families are often the hardest to reach and the most difficult to help because of distrust and negative prior experiences of agencies, particularly children's services. Professionals struggle to support children, young people, and their families with complex histories of abuse, neglect, trauma, and violence in a way that meets their and their families' needs.

The "Thrive" Framework

"THRIVE" (Wolpert et al., 2016) offers a reconceptualization of service delivery based on needs as opposed to diagnosis. The framework incorporates the principles of the UK's government's initiative of Increasing Access to Psychological Therapies for children and young people (Children YP-IAPT) (Badham, 2011) (Fig. 24.1). "THRIVE" provides principles to organize multi-agency service interventions into categories focused on needs (Fig. 24.2), as opposed to the medical model tiered approach based on criteria and symptom severity.

"THRIVE" has been a useful framework for CAMHS Clinicians to identify when families can effectively make use of direct mental health interventions, and time-limited evidence-based treatment can be provided at an early stage to maximize good outcomes. Families who have enough resilience to cope are supported, with fast easy access to assessment and the minimum intervention, under the quadrant "*Getting Advice*" which may involve a one-off meeting or access to online resources. Long-term treatment is provided only where it is likely to bring improvement in outcomes. This practice area is called "*Getting Help*" and "*Getting More Help*" (Wolpert et al., 2019).

Children and young people who have not responded to mental health interventions or are not willing or able to engage effectively in interventions are supported in a

Fig. 24.1 Children and young people increasing access to psychological therapies principles

Fig. 24.2 "THRIVE" framework and the needs-based approach informing Camden Services

highly integrated way alongside other agencies. The focus is holistic and seamless. This practice area is called "*Risk Support.*" CAMHS clinicians are working alongside other practitioners and play an important role in case management and helping workers manage risk. This can be more effective than trying to engage directly with children/young people and families who are not "therapy ready" or able to make use of therapy at that time. The "*Risk Support*" approach avoids both inappropriate and repeats referrals to CAMHS for families that will not benefit from direct CAMHS interventions, because the CAMHS staff remains part of the network for these families supporting realistically modest multi-agency goals set in collaboration with families.

The Tavistock and Portman NHS Foundation Trust also train Camden social workers in a model of reflective practice to increase their understanding of family dynamics. This program facilitates partnership working with families because social workers, with CAMHS professional support, can adopt a position of curiosity and understanding instead of blame and judgment. Alongside this, CAMHS clinicians are trained in the "THRIVE" framework and evidence-based models of consultation and indirect work such as the "AMBIT"[6] (Bevington & Fuggle, 2012).

The CAMHS Team: Whole Family Service (WFS)

The Whole Family Service (WFS) provides CAMHS to the Social Work Division and the new Resilience and Prevention Division and is part of the Local Authority CAMHS service for Camden. The name of the service is in keeping with the work methodologies being developed in the Resilience and Prevention Division. WFS is made up of two teams: The Whole Family Team for children over five years

[6] Adaptive Mentalization-Based Integrative Treatment.

(WFT) and the Whole Family Team with Perinatal Specialism (WFT-P) for children under five years old. WFS staff are co-located with the Local Authority Camden Multi-Agency Safeguarding Hub, Child in Need social workers, Early Help Special Educational Needs and Children's Centres as well as "Pupil Referrals Units"[7] and the "Youth Offending Service".[8]

Clinicians spend 60% of their time as link workers to one of the above agencies, providing assessment, consultation, and some direct work, and 40% of their time in the WFS on direct case referrals to the WFS. They can also bring cases from their link agency into WFS if there is a need for multidisciplinary CAMHS input.

WFS is made up of multidisciplinary professionals; the members of the team are experienced professionals from Clinical and Educational Psychology, Systemic Family Therapy, Child, and Adolescent and Adult Psychotherapy and Psychiatry, and Social work. The service also includes trainees linked to training courses across London. On average, WFS has 240 active referrals open (one-third of which are under WFT-P, and two-thirds WFT).

Depending on their skills, training, and interests, clinicians work in the WFS Family Therapy clinics, Non-Violent Resistance (NVR) Parenting groups (Weinblatt & Omer, 2008) and Webster Stratton groups (Webster-Stratton & Rae Lenz, 2006). Clinicians also offer video feedback work (Juffer et al., 2017; Kennedy et al., 2011), individual trauma-focused work such as trauma-focused cognitive–behavior therapy (TF-CBT) (Ramirez de Arellano et al., 2014), eye movement reprocessing desensitization (EMDR) (Shapiro, 2014), and narrative exposure therapy (NET) (Onyut et al., 2005). The WFS focuses on providing evidence-informed interventions with effective outcomes for children, young people, and families who have experienced trauma, maltreatment, attachment, and parenting difficulties (Aarons et al., 2011).

WFS works in a flexible and responsive way, spread across the borough to reach families close to where they live. There is an understanding that many of the families referred to the service can find it hard to access help and build relationships with professionals because of their life experiences, WFS clinicians try to engage those families by providing interventions at home, schools, children centers, parks or any place that the family chooses.

WFS also works closely with interpreters and local ethnic and culturally informed organizations. Clinicians support Camden staff (key workers, social workers, teachers) to develop a collaborative, thoughtful approach with families. The children, young people, and families benefit from a more "joined-up" experience supported by WFS reflective practice groups where curiosity about the families' is developed instead of judgment and blame. This promotes joint working in a non-hierarchical community of practice approach. The "AMBIT" term "Thinking Together" (Bevington & Fuggle, 2012) has replaced the hierarchical terms "Consultation" and "Clinical Supervision." Senior members of the WFS attend "Thinking

[7] Specialist schools for children with Social–Emotional and Mental Health difficulties, with Special Educational Needs who can't attend mainstream schools.

[8] Youth Offending Teams work with young people that get into trouble with the law.

Together" meetings three times a week with social services to discuss complex child protection cases.

The "AMBIT" reflective support model is embedded practice within the WFS itself. The service has "Reflective Practice" meetings twice monthly, where clinicians present cases to discuss/reflect on with colleagues to share best practice and access the breadth of in-service expertise. It is held using a system of "Reflective Teams," normally used in assistant-to-group supervision (Andersen, 1995). The Reflective Team observes the clinician who brings the case (the supervisee) and another clinician will ask questions (the supervisor). The other members observe the supervision session and subsequently reflect on the conversation. The supervisor and supervisor then discuss the team's reflections. This process supports clinicians to generate innovative and multidisciplinary informed solutions to complex cases to enable them to progress with families where there is an impasse, repeated patterns of familial crises/trauma, or high potential for dis-integration within the family's professional network.

In considering the diversity of the community it serves, WFS has taken the initiative to reflect on themes around diversity and equality in their team meetings in line with the protected characteristics named in The Equality Act (2010). This also entails a reflective team approach where two members of the team are taking an observer position during the meeting to consider the "voice of the patient," and themes around equality and diversity both for the families discussed and clinicians discussing them. At the end, the observers will reflect on these themes, before the wider team discusses their reflections.

Case Examples

The cases below demonstrate how the teams support families in the community who have complex trauma histories and overlapping social and emotional vulnerabilities. As such, clinicians are required to work alongside families and professional networks, in the face of multiple dynamic, and static risk factors and significant adversity. The THRIVE framework was applied to conceptualize how families may access different levels of support at different points during treatment in response to the complexity of presenting risk. The following case examples respectively illustrate the work of the WFT-P and WFT and area.

Jayden (WFT-P)

Jayden (36 months) is a White British and Black Caribbean boy who was referred to the WFT-P by his social worker. There were concerns in relation to conduct, self-regulation, and sexualized behavior. Jayden had been subject to a "Child Protection Plan" (CP plan) at birth and the case escalated to Public Law Outline[9] (PLO).

The family are from a low-socioeconomic background and reside in social housing, which is overcrowded. Jayden is the eldest of two, his mother, Jenny, has a diagnosis of depression and anxiety (moderate range) and has a complex trauma history. She was taken into care by social services during her early teens and considered herself isolated and lacking in social support. She had issues with substance misuse and served a 12-month custodial sentence when Jayden was 12 months old, which she later deemed to have been a major barrier to forming a secure attachment with him.

The assessment indicated that the family would benefit from "*Getting Help*," where there would be a period of focused intervention targeted toward the parent's goals. They were offered an evidence-based parent–child intervention (to promote positive parenting) alongside adult psychotherapy for Jenny.

Clinicians regularly discussed this family with the wider team to reflect on the strengths and challenges they presented. During the course of the intervention, Jenny's mental health deteriorated with covert substance misuse and involvement in criminality and Jenny stopped engaging with the service. Clinicians started providing support under the quadrant "*Risk Support*." They supported the professional network and provided information and progress reports to Social Care.

Jayden alongside his younger sibling, Kayla, was placed in the care of his maternal great aunt, Julie, clinicians helped the children with the transition to living with Julie. Jayden was displaying disinhibited, impulsive, and aggressive behavior at both home and school, which generated concerns about his and other children's safety, and resulted in exclusions from his class on an almost daily basis. At home Julie was feeling overwhelmed and at points would shout at Jayden, and then feel guilty.

A clinician worked closely with the Social Worker, school and Julie to develop a formulation in understanding the meaning of Jayden's behavior and to ensure that as far as possible Jayden's experiences in his mother's care, were integrated into the conceptualization and understanding of his current difficulties. Jayden's behavior was reframed within the context of his caregiving experiences (inconsistent, frightening), disrupted attachment relationships, and trauma. Through "*Risk Support*" the network could consider how Jayden had experienced few and inconsistent boundaries and that now he was having to learn about new boundaries by testing them out. This approach facilitated his school shift from a narrative of Jayden being "risky, unpredictable, and aggressive" to that of Jayden being a child that was traumatized by his earlier experiences.

[9]The Public Law Outline (PLO) sets out the duties local authorities have when thinking about taking a case to court to ask for a Care Order to take a child into care or for a Supervision Order to be made. This is often described as initiating public law care proceedings.

This mobilized a more nurturing rather than punitive response both at home and at school. The support plan for Jayden focused on helping him to develop a sense of safety by offering him consistency, emotional containment, and helping him with emotional regulation, alongside offering clear and sensitive boundaries. WFT-P clinicians supported the school to make an application for an "Educational Health Care Plan"[10] (EHCP) for Jayden, to put in additional one-to-one support from a member of staff while Jayden was at school.

The clinicians needed to be flexible by being available for telephone calls between appointments to help the school, Social Worker and Julie, to reflect on various challenging situations with Jayden that were often dysregulating for those supporting him. Julie was given the opportunity to process her feelings around becoming the main caregiver for her niece's children "*Getting more help.*" She was given support to help her talk to Jayden and his sister about difficult topics, such as why they are no longer living with their mother, and why their mother stopped coming to see them.

As the concerns for Jayden began to diminish, Julie was able to connect with the needs of Kayla (aged 24 months) who presented as withdrawn and overly self-reliant. She often got overlooked in the context of her brother's behavior. A video feedback intervention, called "Video Feedback Intervention to Promote Positive Parenting and Sensitive Discipline (VIPP-SD)" was used (Juffer et al., 2017).

Through viewing the video material, Julie observed Kayla's very subtle cues signaling her attachment needs and signs for exploration. She was then able to identify ways that she could sensitively respond to Kayla's needs and to encourage playful interaction between them. Gradually, Kayla began to signal to her great aunt for help and comfort and use her as a "safe base."

During the course of the intervention, it was agreed in court that Kayla and Jayden would remain with Julie in the long term through a Special Guardianship Order.[11] Jayden became much more settled at home and at school. Kayla became more expressive and engaged with Julie. For Jayden and Kayla, where a lot of their earlier experiences had been disrupted, it felt especially important that the WFT-P had offered their intervention as a unified service to prevent further fragmentation.

Amber (WFT)

Amber was born to parents who were White British and African-Caribbean. She was placed in an informal care arrangement with her Maternal Grandmother from age 6 months to 4 years old due to concerns relating to her mother's involvement

[10] An Education, Health and Care (EHCP) plan is for people aged up to 25 who need more support than is available through special educational needs support. EHC plans identify educational, health, and social needs and set out the additional support to meet those needs.

[11] A special guardianship order is an order appointing one or more individuals to be a child's 'special guardian'. It is a private law order made under the Children Act 1989 and is intended for those children who cannot live with their birth parents and who would benefit from a legally secure placement.

in criminal activity. Amber returned to live with her mother, Sharon, and Sharon's partner at the age of 4 years and witnessed frequent episodes of domestic abuse and substance misuse. Amber's half-brother was born when Amber was 6 years old and two years later her step-father left the family home.

At 10 years Amber was finding it difficult to concentrate at school and was displaying some challenging behaviors. She was diagnosed with "Attention Deficit Hyperactivity Disorder" (ADHD). A year later, the transition to secondary school was difficult with a lot of challenging behaviors, resulting in her being permanently excluded and placed in a Pupil Referral Unit (PRU). Amber made a positive connection with a PRU member of staff but refused to engage with mentors or with CAMHS, despite multiple referrals.

By the age of 13, Amber had stopped attending her reviews for ADHD medication and was smoking cannabis and spending her time with older peers. She then went missing from her home and was found 230 km away. She stopped attending school and was engaged in multisubstance use, in particular alcohol, cannabis, and LEAN (a concoction of Codeine, cough syrup, and Sprite). Amber was reportedly involved in fights in her local area, and there were concerns raised about whether she was being sexually exploited. Sharon was concerned about disinhibited sexual behavior and reported that Amber was returning home late, not responding to parental boundaries, and had unexplained physical injuries. She was referred to Social Services and placed on a Child in Need plan.[12]

Amber was referred to the WFT aged 15, after concerns in the multi-agency network about her emotional well-being because she threatened a member of the public with a knife, in what was perceived to be an unprovoked incident. Amber started to work with the Youth Offending Team on a Youth Referral Order,[13] she had built a positive relationship with her Youth Offending Service worker and they were meeting on a weekly basis. However, Sharon was reporting increasing episodes of Amber going missing, and concerns that her behavior seemed bizarre and frightening. Amber was reporting moments of feeling low in mood and at times full of rage. There were also network concerns for the family's safety in their home. The family needed to move (for their safety) but that resulted in increased episodes of deliberate self-harm and dysregulated behavior from Amber.

It was assessed that Sharon would benefit from "*Getting Help*." A clinician from the WFT started to work with Sharon to offer her support using a trauma-informed model. The contact was weekly and enabled her to think about how Amber's behavior triggered her own experiences of trauma which might then be preventing her from de-escalating the situation. Sharon also attended a WFS facilitated NVR parenting group which aims to help parents work in a trauma-informed way to de-escalate their children's violent behavior and to start to safely rebuild the relationship. Weekly

[12] A Child in Need plan is a UK Social Services plan for children who are aged under 18 and need local authority services to achieve or maintain a reasonable standard of health or development.

[13] Where young people aged between 10 and 17 years old who have appeared in court for the first time and have pleaded guilty to the offense meet with all parties to negotiate a contract of reparation (payback) to the victim or community and a program of work to address offending behavior for 3–12 months.

contact was maintained following the ending of the group and work to embed the principles of NVR. Due to the multiple demands on Sharon's time, appointments were offered by phone as well as within the home and clinic.

Under "*Risk Support*" a clinician met with the professional network to help them think about Amber's emotional well-being and mental health needs. The clinician attended a number of different forums and professional panels to ensure that Amber's case was discussed using a trauma-focused lens and that her history of developmental and interpersonal trauma was placed at the center of multi-agency formulations.

After a few months, Amber agreed to direct contact with a WFT clinician and engaged in an assessment. She was able to share the range of complex emotional difficulties which she was experiencing: hypervigilance, flashbacks, and intrusive images of incidents that had occurred recently as well as events leading back to Amber's early life. Amber was given a diagnosis of PTSD, alongside her low mood and emotional regulation difficulties. Amber met with her clinician in a variety of locations including home, school, the local area, and the youth offending service. Nonetheless, Amber found it difficult to attend appointments when her anxiety was high, so engagement with WFT was fragmented and there were multiple missed appointments.

Despite this, she was able to engage in psychoeducation on the impact of trauma, and sessions providing techniques to help her regulate her emotions. Slowly, the therapeutic engagement increased and she undertook Narrative Exposure Therapy (KID-NET) work (Neuner et al., 2008; Ruf & Schauer, 2012) using her lifeline (Onyut et al., 2005; Schauer et al., 2004) to document her positive and challenging experiences. The impact of sharing her life experiences with the clinician appeared to form a significant moment of transition to a less chaotic and more stable state. Gradually Amber re-engaged with education and succeeded in passing her "National Vocational Qualification"[14] level 2 in construction.

Amber's family moved out of London and Amber started driving lessons. Although still misusing substances her engagement in criminal activity decreased. Amber's journey into a positive trajectory is at its beginnings, but with a greater understanding of her experiences and resources to manage overwhelming emotions, Amber developed more emotional regulation and stability in her daily life.

In both cases, the families faced a number of complex psychosocial difficulties and were engaged with multiple professional teams. By working holistically, the WFS was able to offer a joined-up, systemic approach to the multifaceted difficulties these families' faced. In using the "THRIVE" framework, the service was able to meet the families where they were and provide support which was both strategic and accessible to family members.

[14] An NVQ (National Vocational Qualification) is a work-based way of learning—which is carried out at a college, school, or workplace. Each NVQ level involves a range of on-the-job tasks and activities that are designed to test you on your ability to do a job effectively.

Outcomes

In offering a service model based on family need, and multi-agency working which is contextualized by equality and diversity, it was important for the WFS to conduct questionnaires and interviews with service users and multi-agency colleagues; to review and evaluate the service redesign, incorporate service users' voices into service quality improvements, and generate good practice-based evidence. A sample of the feedback received is summarized below.

Outcomes for Service Users

An experience of service evaluation in July 2020 found that families were satisfied with the accommodating and flexible service that was provided. Comments received expressed gratitude about clinician's persistence to make contact, and their flexibility in the length of the sessions and the location where the service users were seen. Feedback included quotes such as: "*We kept in regular contact and I was offered a space to speak outside of our regular appointments",* and [the clinician] … "*was always available and in contact and I haven't been ignored*."

Service users reported feeling involved in decision making about their care and that clinicians provided a non-judgmental approach that was accepting of their particular circumstances. Families described feeling understood, heard, and connected to the clinicians they were working with; "*I really felt understood by [clinician] and some of my experiences have been quite graphic and [clinician] never shied away from some of the things that I've disclosed with her and she made me feel very comfortable.*"

Further feedback highlighted that service users were aware of the effective communication between professionals in their network, stating that a "huge benefit" was that they didn't have to repeat their story to multiple agencies.

Outcomes for Staff

Multi-agency staff commented on how co-located Local Authority and CAMHS staff have become a multi-agency system that feels "*truly integrated*" and "a *community of practitioners*" (as described in a local service user audit).

Social Work staff commented on "Thinking Together" as a genuine opportunity to pause and reflect on anxiety-provoking situations, before then making multi-agency plans.

Feedback from key workers on WFS clinicians included quotes such as "*I really do find all the clinical advice really helpful, especially with feeling confident exploring mental health issues with clients*" they said "*The relationship with clinical staff is so valued; I am a better person and support worker because of them.*"

Organizational Outcomes

WFS is recognized as a source of knowledge, skill, and experience that adds quality to social work. The presence of the WFS increases capacity in the clinic-based CAMHS teams, and this in turn helps reduce waiting times and thus contributing to increasing access to those families who need therapeutic help. Average waiting times for an assessment have been reduced from 3.4 weeks to 2.6. Camden exceeded national access targets for children and young people accessing help, support, and treatment and achieved high levels of satisfaction from service users. The changes were cost neutral but a wider range of CAMHS staff are now more available to a far wider group of Local Authority services, and hence to a far wider constituency of vulnerable families.

Challenges

Co-location in Local Authority settings cements professional relationships and allows trust to develop between professionals and agencies but provides challenges to WFS clinicians due to a lack of dedicated clinical spaces for seeing children, young people, and families. Also, WFS staff are working in different locations and sometimes logistically this can be a great challenge.

Data recording and information sharing remain an area of difficulty. Although there are clear advantages to having all CAMHS staff using the same electronic recording system, Local Authority Agencies have expressed anxiety about not having all the clinical data available on families on the local authority system. Other internal issues are managing cases that are open to more than one team, with both CAMHS teams having to agree who was responsible for the oversight of care plans, safeguarding, risk assessments, and regular safeguarding supervision.

Furthermore, in terms of client outcomes, WFS clinicians can initially be perceived as part of a group of the professionals that families do not trust. Engagement can be difficult and take an extensive amount of time and patience which may not fit with the timelines of other agencies wanting change. On some occasions, clinicians may recommend one kind of support is provided for a child and a family's long-term well-being, while the family courts develop other plans and timelines for the child. Thus, clinicians may find themselves in difficult positions and with limited ability to make changes for the children and young people that they are working with.

Finally, it is important to acknowledge that the complex nature of CAMHS and the service transformation creates limitations to objective evaluation. Any qualitative research would take place *after* the service is already working with the "THRIVE" framework; consequently, the changes rely on recollection from observers comparing the "conventional" and transformed CAMHS model, and a quantitative analysis be non-experimental risks bias.

Conclusions

The "THRIVE" informed redesigned services have resulted in a comprehensive needs-based CAMHS offer to vulnerable families where there are concerns about children and young people's welfare. As exemplified by the case studies and evaluation feedback, WFS staff have influenced the decisions made by the various agencies and providers with a substantial impact on the lives of these families. The restructured CAMHS services allowed for better use of resources, reduced waiting times, and a focus on interventions that are suited to meet different needs in different contexts. The implementation of this approach has had its challenges but has only been possible because of the collaboration between different agencies, commissioners, and providers.

The work of WFS staff illustrates how the expertise of a small number of highly trained CAMHS professionals can reach a larger number of children and young people through other trusted professionals using the "Risk Support" approach. WFS staff have become experts using this to enhance the experience of care of vulnerable children, young people, and families. The co-location of CAMHS staff in Local Authority Agencies and the use of "Risk Support" has facilitated this integrated approach to case management and the mainstreaming of CAMHS thinking through professional networks. Integrated case management means that where children, young people, and families are unable to benefit from treatment, but remain a significant concern/risk, interventions informed by CAMHS are tailored to a family's needs. Many of these children and young people have spent years being re-referred to services including CAMHS without significant improvement. In the new system these cases are managed within a CAMHS informed multi-agency network and more achievable, conservative outcomes are agreed. The network holds collective responsibility and accountability providing a "wrap-around service" through a trusted worker as opposed to just one agency managing risk and trying to shift the responsibility onto another leading to a disjointed experience for the family.

Using "Risk Support" has required a change in mind-set and ways of working and has been helped by the relatively high levels of resources available to CAMHS in Camden. However, using mental health professionals' expertise through frontline workers is a way of working which is relevant to countries where highly trained mental health professionals are in short supply and may need to extend their reach to large populations. In Camden, the implementation of "THRIVE" has been important in allowing the CAMHS services to continue to evolve, meet needs and build resilience of staff and service users. Furthermore, it is contributing to the borough's aim to safeguard the rights of vulnerable and at-risk children and young people to receive care and access the support that meets their mental health needs.

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Chapter 25
The Mental Health of Educators: Gaps, Needs, and Solutions

Emily Hernandez, Adriana Aceves, and Natalie Peikoff

Abstract The need to address the mental health and well-being of educators has never been greater. While there has been a steady increase in mental health awareness and support of students in recent years, current research indicates a profound lack of programs and interventions to support the mental health and wellness of educators on a global scale despite the need. This chapter seeks to shed light on the mental health and well-being of educators and their unique experiences, the barriers that prevent them from treatment, and validated wellness measures. This chapter explores the varying interventions and mental health programs in place for educators, the growing need for mental health-focused support, and exemplary programs that suggest a more comprehensive, universal program designed to support educators and their varying mental health needs.

Keywords Educator · Teacher · Mental health · Stress · Burnout · Fatigue · Educator employee assistance programs · Employee assistance programs for teachers

Introduction

Mental health is but one aspect of overall health, yet it is interconnected with other aspects of health such as physical, social, and spiritual health. Mental health is a component of "well-being" in which the person is aware of their own potential, has healthy coping skills to deal with the normal stresses of life, can work productively and effectively, and feels capable of making a contribution to their community. The positive aspect of mental health is stressed in the World Health Organization's (WHO) definition of health; "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, WHO, n.d.). This understanding of complete physical, mental, and social well-being

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_25

is complex. Mental health includes one's emotional, psychological, and social well-being. The state of our mental health has a direct impact on how we feel, think, and act as we navigate life. It impacts our ability to handle stress, our relationships, and the choices we make.

Mental health is important because it can affect one's physical health and social relationships. The reciprocal relationship between physical, social, and mental health works together to create a sense of overall health or well-being. Much of the work in "mental health" includes aspects that address physical and social life domains as an integral part of achieving good mental health which contributes to overall good "health." Further, experiencing mental disorders can increase the risk for developing physical health problems. According to the National Institute of Health (NIH), mental health is important because it helps with coping with stress, being physically healthy, having good relationships, being productive, contributing meaningfully to community, and creates awareness of realizing one's full potential (MedlinePlus, 2015). Not only is the concept of health multifaceted, it is also interconnected. A two-way relation between physical health and subjective well-being exists; poor physical health impacts a person's sense of well-being, while a high sense of well-being can reduce physical health impairments (Steptoe et al., 2015). Mental health shares this interrelatedness to the other aspects of health, similarly having an impact on overall well-being. Focusing on improving one's mental health will positively contribute to one's overall health and sense of well-being.

Within the workforce specifically, the implementation of comprehensive workplace wellness programs is on the rise to support employee health and productivity. As the concept of well-being is gaining public attention, leaders across all employment sectors are turning to subjective self-reports of well-being by their employees. The data collected is rapidly becoming a focus of intense debate in public policy and economics worldwide; the improvement of personal health and well-being is emerging as a key societal aspiration for all (Steptoe et al., 2015). As the importance of expanding the definition of health and well-being to encompass all components is gradually becoming the new societal norm, many employers are now viewing employee health through this holistic lens, moving toward implementing programs that support employees on all levels. Mental health is important for everyone but particularly critical for employees working in the educational sector.

Educational Sector

The educational sector focuses on providing academic instruction to children in primary and secondary grades. In this field, an educator primarily refers to a teacher or instructor in a school system who works directly with students in a classroom setting. Although, due to the systemic nature of school systems, for the purposes of this chapter, the term "educator" is expanded and may also refer to an employee that works in the school setting directly with students. It should be noted that school systems and the field of education in general look very different across cultures and

continents, and varying experiences and perspectives will be reflected in this chapter to address educator experiences on a global level. While the education sector may look different globally, the educator role is important in the healthy development of children and youth.

Education and the Role of the Educator

Despite cultural differences, the importance of education is a concept in which universal consensus exists. Education is one of the main pillars of sustainable development in a knowledge-based economy. The focus on school as a means for preparing young people for adulthood is one of the most important characteristics of developed countries (The National Commission on Excellence in Education, 1983). Academic performance and high achievement are highly valued across cultures, as such academic success can improve the quality of life for students by expanding their career opportunities as they enter adulthood. With growing interest in academic performance and the global competition for achievement, parents, educators, and concerned citizens around the world are asking questions about how best to prepare children and youth for successful adulthood in this day in age (Huitt, 2011). With many advances in technology that facilitate and enhance instruction as well as changes to educational learning standards, the past 20 years have seen an extraordinary surge in interest in the measurement of education and success, or what researchers in this field refer to as the measurement of educational "outcomes" (Biesta, 2009). As education and the role of the educator quickly evolves, it is important that schools have adequate interventions to support teachers in adapting to their varying responsibilities.

Just as the definition of health and well-being is multifaceted, so is the role of the educator, whose influences transcend the classroom. Educational leaders are constantly looking for ways to generate high achievement in schools and often seek quality teachers to implement and test out the newest instructional approaches. It is through academic institutions that educators around the world, in addition to providing instruction, also represent and initiate children and young people in conventions and social ways of being and doing, in areas such as cultural, professional, political, etc. (Biesta, 2015). The importance of the role of the educator is reinforced by researchers, pointing out that schools are where most will engage in formal, systematic learning experiences in contrast to the informal and sometimes conflicting lessons drawn by the home, community, and larger society (Wikeley et al., 2007) The influence educators have on today's youth is not to be overlooked.

The role of the educator directly impacts students in multiple ways. Educators have an impact on students not only as their instructors but also serve as role models of successful, well-adjusted adults for many who do not have such role models at home. Having close interactions with adults that demonstrate the benefits of pursuing an education and serve as a motivational figure in their lives can be a beneficial experience, so long as the teacher feels successful and satisfied in their profession.

Identifying risk factors for teachers' occupational mental health problems becomes vital not just to the teaching profession but society as a whole (Tang et al., 2013). It is clear that education is widely accepted as the means to societal progress. If educators are expected to prepare students in a manner that positively impacts society, it is imperative that they are provided with support that will enable them to successfully do so. As the facilitators of academic success and achievement, the well-being of educators should take precedence when strategies are being developed to increase academic excellence.

Wellness and well-being should be prioritized as changes to the educational sector transform the role of the educator. Educational leaders often speak about encouraging teachers to continue to grow, learn and be excited about their work. They believe that such excitement about their careers depends on access to both ongoing high-quality learning and career opportunities that enable them to increase their instructional skills as well as share their expertise and provide valuable feedback (Darling-Hammond, 2017). Although this may be an effective way for educators to feel involved in the development of instruction, excitement about their jobs and motivation to continue to grow is impossible if their well-being is sidelined. With the concept of wellness gaining more attention globally, the goal is that this interest reaches the field of education in order to make a positive impact that benefits all stakeholders. As educational reform has resulted in vast changes to instructional standards and techniques to better prepare students for the future, the role of the educator has changed as well. Educators are directly affected by the advances in educational policy and quickly adapt to the changes imposed by educational leaders as well as the expanding demands of the role, but overextending themselves can come at a cost to their mental health and well-being.

Educational Reform

In addition to the increasing work demands of educators worldwide, educators are also faced with adapting to institutional changes at a cost to their overall well-being. Recent changes in educational research and reform in many countries around the world not only have a tremendous impact on educational practices and the role of educators but also on job satisfaction and happiness (Biesta, 2015). For example, in China, Hong Kong in particular, various educational reforms and transformations to policy since the 1990s were found to be closely associated with reports of negative work experiences and mental health issues (Tang et al., 2013). Since then, the work environment of teachers in addition to their well-being has gained increased awareness. Also impacted by educational reform, is Ontario, Canada, where the Education Quality Improvement Act (EQIA) was adopted in 1997 and has since restricted the autonomy of teachers and involved many changes to the Ontario public education system (Koenig et al., 2018). Researchers have recommended that governments should pay more attention to the implementation of new policies related to education and its overall impact on the well-being of educators (Tang et al., 2013).

This recommendation should be applied to any country conducting major changes to their educational systems and policies. Educators are greatly impacted by educational reform policies. Some of the types of changes brought about by educational leaders that directly impact educators include: reallocation of the control of decision making from elected school board officials to government, implementation of new curricula, and mandating the amount of time teachers must spend in direct instruction (Koenig et al., 2018). Educational reform, lack of input by teachers, increasing needs of students, and cultural views of stress and productivity all impact the well-being of teachers, students, and society as a whole resulting in the increasing need to address the mental health of the educator.

The Need for Addressing the Mental Health of the Educator

International studies on work-related stress provide evidence that educator mental health is a global issue that needs to be addressed. It is generally recognized that teaching is a stressful occupation (Travers & Cooper, 1993). Countries that have conducted correlational studies on work-related stressors and mental health have found statistically significant evidence of a negative correlation between the two. Reports based on British national surveys suggest that teachers have a higher incidence of work-related mental illness (Tang et al., 2013). Additionally, in China, teachers have a lower health status than the general population; moreover, the quality of life of female educators is worse than that of male educators, and deteriorates with age (Yang et al., 2009). Regardless of gender or geographical region, the professional responsibilities of today's educators are so great that there is a need to consider and address the socio-emotional risks surrounding the occupation.

Educators carry with them an unparalleled professional load in today's society. Navigating their changing professional responsibilities and showing up each day for their ever-growing classrooms, managing school politics and bureaucracy, working tirelessly to meet core standards and competencies, mediating student conflict, endless paperwork, and bearing witness to increased school violence and suicide rates among students and colleagues. In America, the expectation to carry this work load, which has far succeeded the normal scope of an education professional, has become the norm and the expectation. What has not become commonplace, however, is mental health support systems specifically in place for educators. In addition to unrelenting work stressors, those who work in education face their own personal life stressors that can impact their ability to teach and be at their best each day. Without professional help and support services in place, educators are often left to their own devices and still expected to show up to work each day with a smiling face, ready to serve children and youth, and make a difference. The limited research surrounding educator mental health indicates that the concept of internal or district provided mental health and/or wellness programs is unprecedented, and yet teachers themselves are consistently reported to be at increased risk of common mental health disorders compared to those in other occupations (Harding et al., 2019; Johnson et al.,

2005; Stansfeld et al., 2011). Although the increase of mental health awareness in the field of education is promising, more work is needed in order for student-focused interventions and supports to be available to the educators that serve them as well.

Meaningful progress has been made when it comes to the mental health and well-being of students. Social emotional curriculum, mindfulness and meditation, and accessible mental health services have been implemented in many school systems. However, these types of programs and interventions are seldom in place for those who teach, lead, and educate these very students. The emotional and psychological well-being of those who work in the education sector has been greatly overlooked, and yet the need has never been more prominent. This chapter seeks to shed light on the growing need for comprehensive workplace wellness and mental health support services for educators, school personnel, their families, and the current barriers to receiving such services. This chapter will also highlight existing research, its gaps and limitations, and review exemplary programs and validated wellness measures that address the need for consistent and accessible mental health services for those who work in the field of education.

Latest Evidence

Stress, burnout, compassion fatigue, vicarious trauma: these are all words and phrases that currently represent the common experience of many educational professionals. Teaching is a highly stressful occupation and teachers suffer from more mental health problems than other professions (Kinman et al., 2011). The demands of the current role of the educator are now far beyond the traditional expectations of their job. Educators often speak about rewarding experiences in their years of teaching, sharing tales of connections they made with students, and moments when they truly felt they had made a difference beyond the academic lessons they taught. The meaningful relationships fostered and memories created are some of the most important reasons that educators have for staying in the field, and it seems as though students are increasingly turning to teachers for support beyond academics.

Despite the altruistic nature of the teaching profession, there is a lot of stress that accompanies balancing the academic and emotional well-being of students in addition to the pressure of meeting academic standards set by educational institutions. A body of research indicates that teachers are more vulnerable to work-related stress, psychological distress, and burnout than many other occupational groups (Johnson et al., 2005; Jones et al., 2003; Kyriacou, 2000). Although educational leaders speak about the importance of educators, their claims are problematic because they tend to consider the teacher as a "factor" and believe that, in order to increase the "performance" or "outcomes" of the educational system, it is important to make sure that this "factor" is as effective and efficient as possible (Biesta, 2015). Perceiving the educator as a human being is often overlooked when developing educational policies, thus increasing the educator's risk of occupational mental health outcomes such as burnout, compassion fatigue, and vicarious trauma. Many students rely on

the connections they make with school personnel not only for academic support and guidance but also for socio-emotional support and advocacy. Educators take on a role far beyond that of their traditional position, with responsibilities much greater and more emotionally taxing than ever before.

While personally rewarding, providing ongoing extensive support to students often leads to the educator's own health and well-being being set aside. In turn, the educator's mental health suffers and so does the ability to provide the best support for students. In a recent study on the deteriorating mental health of educators in China, researchers found that teachers' mental health is an essential factor affecting the quality of education (Yang et al., 2019). Teacher mental health is particularly important compared to other professionals, because teachers' mental health is not simply about the teachers themselves, but also about their students and their future successes (Yang et al., 2019). In addition to the mental health of educators having an impact on quality of instruction and in turn students' academic success, research has proven that educator mental health can have an effect on student mental health as well. Results of research on the association between educator and student mental health and well-being suggest that better teacher well-being is associated with better student well-being and with lower student psychological difficulties (Harding et al., 2019). Similarly, lower teacher depressive symptoms were also associated with better student well-being. The findings also suggest that teacher presenteeism and the teacher–student relationship may be mediating factors in these relationships. Additionally, the results show an association between the quality of the teacher–student relationship, teacher presenteeism and teacher absence with student well-being and psychological distress (Harding et al., 2019). It is clear that working in close proximity to someone who is experiencing poor mental health can have a direct effect on a person's psychological health, but the mental well-being of educators can impact more than just students.

Current literature provides evidence that not only is the mental health of the educator important for personal well-being but also for student psychological well-being, workforce stability, and the progress of academic institutions. In a comparative study on the mental health of teachers between Hong Kong and the UK, it was found that teachers' occupational mental health problems currently represent an international priority that is quickly gaining global attention (Tang et al., 2013). In a recent publication by the Substance Abuse and Mental Health Services Administration (SAMHSA) (2020) on School Mental Health "Crisis Leadership Lessons," it is stated that promoting educator mental health and well-being is vital not only for educator health but also for workforce stability and the provision of optimal quality care and safe school systems (p. 14). If it is the expectation that educators be vigilant about tending to the mental health needs and well-being of students, then the mental health needs and well-being of educators must be tended to as well. With the effects of workplace stress being closely analyzed, researchers have identified specific areas of concern that require attention and understanding. Implementing appropriate support for educators with these issues in mind is key in successfully improving the mental health of educators.

Issues/Concerns

There is a compelling case for addressing worker mental health on a global level. The prevalence of mental health issues in employees is increasing around the world, as is its cost to workplaces, economies, workers, and societies as a whole. Of particular importance is the negative impact of mental health issues on educators and school systems in general. When educators experience poor mental health, the outcomes can be devastating for so many—the educators, the families of educators, and the students alike. Those who work in the education sector are no stranger to feelings of stress and burnout due to the nature of the profession. Relevant research shows that a positive relationship between work quality and mental health is now well established, along with the importance of securing workers' legal and ethical rights to psychologically safe work (Corr et al., 2014). But, with growing work demands and expectations, personal life stressors, workplace, and vicarious trauma, the mental and emotional burden of the modern educator is unprecedented and certainly troubling.

Stress

The education sector is reported to be one of the most stressful professions (Safe Work Australia, 2013). Teachers, counselors, administrators, and other school staff are often tasked with taking on many different roles beyond their typical job descriptions, with students commonly seeking their support during times of distress. In contrast to general stress, educator stress is in a category of its own and can be defined as "the experience of unpleasant negative emotions arising from aspects of working as educators, triggered by educators' perception of threat in dealing with the demands imposed on them" (Kyriacou, 2011, p. 161). Educators understand that when students have issues beyond the microcosm of school, it becomes very difficult to concentrate and thus affects their learning. In order to create an environment where students are able to feel safe and supported, educators often go out of their way to provide such assistance to students. Although this seems like best practice for all educators, the occupational stress that comes with it is often overlooked. Teachers' overall health is increasingly becoming a worldwide concern due to the high incidence of occupational stress experienced by teachers and education staff (Mérida-López et al., 2017). In the Punjab province of Pakistan, findings from a study regarding work-related stress among teacher-educators revealed that all 128 participants of the study were under work-related stress to some extent (Tahseen, 2015). Furthermore, Tang et al. (2013) found that the emotional demands involved in work with young people often contribute to teachers' high rates of mental health problems; this idea is also corroborated by their findings of a negative correlation between mental health and perceived stress. The field of education is one that is often described as rewarding, but also demanding and stressful.

The occupational stress experienced by educators is exacerbated by limited resources that affect all stakeholders. Occupational stress and mental health-related difficulties experienced by teachers have been found to influence the growing teacher attrition and high turnover rates within school settings (Mérida-López et al., 2017). To add to the already extensive list of workplace stressors, the position of educators is further complicated for many by the lack of available resources required for them to adequately do their job. Educator reports from Pakistan reveal that their major job stressors included the absence of medical facilities at the campus; nonavailability of prescribed books, computer, and internet facilities; students' poor academic background; absence of adequate office facilities; excessive official paperwork; lack of opportunities for professional development; lack of proficiency in English; little time to relax during the day; and overcrowded classes (Tahseen, 2015). Many educators are then left with the additional task of compensating for the lack of resources by voluntarily investing their own money, making adjustments to lessons to make use of whatever instructional supplies are available, or providing students with supplementary instruction, all of which take up what little is left of the educator's time and energy, thus contributing to increasing levels of stress, burnout, and compassion fatigue.

There appears to be a pattern in which educators support students until stress, burnout, or vicarious trauma leaves them unable to support students any longer, leaving many students who benefit from such connections to their own devices. Educators who continue to work despite its toll on personal well-being affect not only the students but also the school system in general. Experiencing these emotional states and additional stressors may increase vulnerability to developing major mental health problems, thereby leading to sickness-related absence and extensive costs in the educational sector (Mérida-López et al., 2017). This pattern is further complicated when the boundaries of work and home are blended.

The role of the educator does not stop when the last school bell rings. Many educators are required to bring work home that includes grading and preparation for assignments and classes. Also, time invested for preparing stimulating classroom environments is usually completed after work hours as most educators fail to find the time during the school day for these activities. This means that the work day of an educator is extended. This extension of work-related activities blends in with the personal and family life of the educator that can also add to stress levels and impact the educator's personal/social life. What many fail to recognize is that in addition to the stressors placed on educators by the demands of their position, educators have to deal with their own share of personal life stressors outside of their careers.

Personal and Environmental Life Stressors

Personal Life Stressors

Educators are not immune to their own personal life stressors; many experience family conflict, stage of life issues, financial problems, substance abuse, trauma, and mental health issues. These personal life stressors impact the availability or "presenteeism" of the person very similar to students who may be unavailable for learning in the classroom due to significant personal/family issues happening in the home. Researchers that study the domains of work and family have found that there is a considerable amount of conflict that "spills over." Identified is work–family conflict in where issues in the workplace spill over into the home environment and family–work conflict in where issues in the home/family spillover into the work environment (Thomas et al., 2003). The result indicates an impact in either the personal home or school environment. In their study in Australia on work and family stress of teachers, Thomas et al. (2003) found that teachers reported strong indicators of both work and family stress, but that work stress impacting the home was significantly greater than the rating for home stress impact on work, suggesting that time spent at work and on work-related tasks may impact the quality and quantity of family time. The greatest family stress indicated that responsibility for child rearing was the greatest stressor for female primary teachers, followed by household chores, financial pressures, extended family problems, own health, lack of emotional support, and partner tension (Thomas et al., 2003). It appears that educators become particularly adept at coping and learning to "juggle work and family pressures" (Thomas et al., 2003, p. 83). This may be related to the resilience level of the teacher and protective factors involved. Howard and Johnson (2004) suggests that protective factors can make a real difference in teachers' lives and are often relatively simple to learn, organize, and support.

However, these coping mechanisms and "juggling acts" can break down over the long term and as stress factors change or intensify and contribute to chronic stress, burnout, and compassion fatigue in the educator. In addition to dealing with personal and family stressors, environmental stressors can also impact the educator.

Environmental Life Stressors

Environmental stressors are an additional factor that educators in many communities are exposed to that can affect the educator. Community and environmental issues have a direct impact on the classroom as they directly impact students and the culture and climate of the class. Issues related to poverty, community or political violence, and/or social or civil unrest spill over into the classroom and affect learning and the educator. While these issues exist outside of the classroom environment, they must be addressed by the educator as they affect the lives of students and will impact the

way that learning and teaching happens. For example, in South African learning environments, educators experience a high incidence of trauma due to violence, death and abuse in the community (Marsay & Higson-Smith, 2005). The study in South Africa highlights the need to evaluate the stressors of the work environment and how those differ based on geographic location. Some educators experience crime and violence in their communities, others experience poverty and disadvantage, and some educators rarely or may never experience environmental stressors at all. In an American study in 2013, teachers were interviewed about their experiences teaching in predominantly low-income, violent areas near Washington D.C. Reportedly, not only are teachers personally affected by the local community violence but also by their students who are victims or bear witness to crimes and violence. These teachers reported feeling ill-prepared in supporting students who have experienced community violence. They also reported feeling fear for their own personal safety as well as symptoms of somatic stress, both of which impact their mental health and teaching abilities, affecting educators and students alike (Maring & Koblinsky, 2013). Evaluating the environmental stressors that educators are exposed to as well as their effects is crucial when developing programs to support the well-being of educators. Without a clear understanding of educator experiences both in and out of the classroom, not only will employee wellness programs not be successful, but also quality of instruction will suffer as well.

Occupational stress and strain can have a variety of effects characterized by adverse psychological and physical effects on the person. Continuous experiences of workplace, environmental, and personal life stressors can create a buildup of tension in the educator, increasing the likelihood that they experience burnout and/or compassion fatigue. Burnout and compassion fatigue are two examples of how occupational stress can manifest over time if not taken care of.

Burnout

Burnout is a common condition that happens as a response to chronic stress in jobs where individuals work with people (Maslach et al., 1996). It is the psychological term that describes a general exhaustion and lack of interest or motivation regarding one's work.

Although burnout can occur in any profession, it is most commonly reported in the helping professions such as mental health providers, teachers, doctors, nurses, lawyers, and the like. Burnout is described as a tripartite syndrome having three dimensions: (a) emotional exhaustion; (b) depersonalization, defined as a negative attitude toward clients [students], a personal detachment, or loss of ideals; and (c) reduced personal accomplishment and commitment to the profession (Maslach, 1993). The manifestation of burnout is found to happen as a result of chronic environmental-related stressors and/or triggers and the interaction with specific personality characteristics that may either inhibit or manifest in the condition of "burnout" (Kokkinos, 2007). When left unaddressed, burnout can cause a physical

and emotional collapse of which there is no specific treatment. The best treatment for burnout is prevention and mitigation of the stress conditions which contribute to it.

Burnout is common in the profession of education. Teaching is considered to be a stressful occupation and the result of chronic exposure to these high level stress environments can manifest in burnout. In recent years, the field of education has evolved from a curriculum-based approach to a "whole child" instructional approach, making the education profession one with a high rate of burnout. Many educators feel the burden of multiple competing priorities and struggle with finding the time to meet all the needs of students in the classroom. Specifically, research has found that there are certain issues in teachers' jobs that cause them more concern, stress and eventually burnout. The two main sources of job stress that systematically predicted dimensions of burnout are related to discipline (managing student misbehavior) and time constraints (Kokkinos, 2007). Other areas found to contribute significantly were role ambiguity and appraisal of teachers by their students (Kokkinos, 2007). Recent research on burnout includes a more integrative approach including both environmental and individual factors that contribute to burnout as opposed to only work-related stressors (Kokkinos, 2007).

With the increasing amount of stressful responsibility held by educators nationwide, the prevalence of educator burnout is no surprise but is hardly ever addressed. Educators who experience burnout are likely to experience a loss of enjoyment, a sense of pessimism, increased absenteeism, and difficulty maintaining boundaries (Saakvitne et al., 2000); yet they are still expected to present with a positive attitude each day despite their own daily burnout, which can be detrimental to their overall well-being and teaching abilities (Lavy & Eshet, 2018). Burnout not only affects the educator who is emotionally exhausted but all of their students as well. For example, educator burnout impacts student academic outcomes, with a direct correlation to lower motivation and effective learning as well as higher stress levels (Zhang & Sapp, 2008). Students feel the burnout of their teachers, and their own academic outcomes are at risk because of it. When educators continue to work and provide emotional support despite undergoing burnout, they are more prone to experiencing compassion fatigue.

Compassion Fatigue

As much as educators want to be supportive of their students, some experiences shared may be too overwhelming and out of their scope and training. For many students, educators are the sole person they entrust with their personal issues and trauma placing a significant burden on teachers that can be emotionally taxing. This can even be true for professionally trained school counselors and support personnel due to the overwhelming need and increasingly high caseload of students they serve in school settings. Processing and talking through students' difficult experiences may come at a cost to the educators own mental well-being. Educators are often

confronted with the difficult task of working with students who have experienced trauma, which requires deep reserves of emotional strength and as a consequence leaves them vulnerable to experience compassion fatigue (Marsay & Higson-Smith, 2005).

Compassion fatigue is a concept that refers to the emotional and physical exhaustion that can affect helping professionals and caregivers over a period of time, as a result of experiencing a traumatic case, or an accumulation of traumatic experiences (Hydon et al., 2015). Compassion fatigue may be especially prevalent for educators working in impoverished and under-resourced communities, where students have a higher likelihood of experiencing family violence, ramifications of poverty, and other adverse experiences. Compassion fatigue includes a general decline in compassion, or emotional desensitization, because of the person's occupation. In essence, over time the person experiences a somewhat of an emotional blunting and one's ability to care and feel is eroded down through the overuse of compassion skills and energy. The American Institute of Stress (2020) discusses the commonalities of burnout and compassion fatigue to include: emotional exhaustion, reduced sense of personal accomplishment or meaning in work, mental exhaustion, decreased interactions with others (isolation), depersonalization (symptoms disconnected from real causes), and physical exhaustion.

The prevalence of compassion fatigue among educators is one that requires attention and concern. Almost 50% of educators in South Africa experience extremely high levels of compassion fatigue (Marsay & Higson-Smith, 2005). The importance of having a support system in times of need is emphasized if they are to continue to provide such extensive emotional support to their students. The absence of emotional support in combination with workplace stressors can have serious and lasting effects on educators if their compassion fatigue and burnout are not addressed, thus increasing their likelihood of undergoing their own trauma and/or suicidal ideation. The following comments made by educators exemplify the nature of the experience of compassion fatigue and also reflect a recurring theme on the effects of compassion fatigue and trauma on educators teaching under such conditions (Marsay & Higson-Smith, 2005, p. 6):

- "It takes my whole being out of me."
- "I do not sleep at night. I lose motivation to be creative—survival mode sets in and severe depression."
- "It has a lot of negative effects. It has made me to consider myself as a failure and I have kind of held myself responsible for poor behavior and performance."
- "I feel helpless and lose meaning in teaching and those who are not interested in learning."
- "I feel helpless and do not know where to refer."
- "It's hectic, stressful because you don't deal with only one person but different people with different stories."
- "It leaves me traumatized."

The terms "burnout" and "compassion fatigue" are often discussed together or have been seen to be used interchangeably. While they can coexist, there are important

differences to understand. Compassion fatigue has a more rapid onset while burnout emerges slowly over time. The main difference between burnout and compassion fatigue is its origin. While burnout originates from occupational/institutional stress and being overworked with limited resources, compassion fatigue originates from working with individuals who have experienced trauma. Compassion fatigue can be seen more as a form of "emotional burnout." Prolonged exposure of compassion fatigue if left unaddressed can lead to trauma.

Trauma

Trauma is difficult to delineate, as it is a subjective experience; the same event may be perceived very differently by two different people. Nonetheless, it is an important construct to define and measure given its prevalence and influence on daily functioning. The Diagnostic and Statistical Manual for Mental Disorders-5 (DSM-5) classifies trauma as that in which an individual is exposed to "actual or threatened death, serious injury or sexual violence" (American Psychiatric Association, 2013, p. 271). Based on a combined sample of 68,894 respondents, the World Health Organization (WHO) reports that 70% of the general population across 24 countries have experienced traumatic exposure consistent with the DSM-5 definition of trauma (Benjet et al., 2016). Furthermore, Kessler et al. (2017) estimated an average of 3.4 trauma exposures per individual. Exposure to environmental stressors, e.g., crime, violence, drugs, poverty, and natural disasters, increases the likelihood for trauma to occur.

Although the majority of people will experience at least one traumatic experience in their life, some people are disproportionately vulnerable to an increased incidence of such. Research designed to explore rates of direct and indirect exposure to violence events by educators in El Salvador found that the top five direct experiences of violence, as reported by approximately a quarter to half of the participants, included seeing a dead body, being physically assaulted, experiencing war-related violence, seeing someone holding a weapon, and being involved in a life-threatening accident (Rojas-Flores et al., 2015). In addition to interpersonal violence, around a third of educators in El Salvador reported experiencing traumatic events related to earthquakes and other natural disasters (Rojas-Flores et al., 2015). Further, researchers emphasize the impact of environmental stressors when 33% of educators in South African Learning environments expressed that personal trauma had a negative effect on their work (Marsay & Higson-Smith, 2005). When examining the data, the cause for concern is that one-third of South African educators reported not working effectively in the classroom due to their own personal traumatic experiences. Awareness by educational leaders of the environmental stressors as well as the increased risk of experiencing a traumatic event may be useful when evaluating which supports educators are in need of the most.

Experiences of violence in schools is another concern for educators. In addition to encounters with traumatic environmental stressors that directly impact educators' well-being and ability to teach, workplace violence in schools such as student misbehavior, perceived violence at school and verbal victimization, are positively correlated to teacher reports of anxious, depressive, and somatic symptoms (Galand et al., 2007). The *Indicators of School Crime and Safety Report: 2014* by Robers et al. (2015) detailed that in the 2011–2012 academic year, approximately, 9% of educators in the USA had experienced threats by students, and more than 5% of educators had been physically attacked. A prevalence of violence against educators also exists in other nations, including, but not limited to, Canada (Wilson et al., 2011), Taiwan (Chen & Astor, 2008), and Turkey (Cemaloglu, 2007). Workplace violence increases the potential for serious consequences to the educational system; as a result of victimization, educator absenteeism may increase or their ability to teach may be negatively impacted, which could result in classroom disengagement, impact continuity of lessons, and significantly reduce the quality of education (Wilson et al., 2011). Galand et al. (2007) emphasize the importance of having support programs in place for educators in their findings that the effect of school support on educator well-being is stronger than the direct effect of school violence. Educator wellness programs should include interventions that help educators process their personal traumatic experiences. Giving educators the opportunity to address their trauma may increase their emotional availability when it comes to helping their own students. However, student trauma also can directly affect the educator.

Vicarious Trauma

When students experience significant hardship and trauma in their lives, the impact often goes beyond just the student; their personal trauma has a detrimental effect on the lives of their teachers as well. The term "vicarious trauma," also commonly referred to as "secondary traumatic stress," is defined as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995, p. 7). For educators, wanting to help often comes at a debilitating cost and this means sharing in the suffering of their students. Trauma knows no boundaries, and most educators—regardless of geographical region—may come across a student whose trauma is likely to impact their own socio-emotional well-being. In South Africa, studies reported 61% of educators stating that dealing with trauma in the classroom had a negative effect on their personal lives (Marsay & Higson-Smith, 2005). A few common themes were identified in the research, such as educators experiencing feeling tired and drained, interference with their sleep and work, negative emotions (anxiety, anger, and depression), reduced confidence in their ability to teach, and a sense of helplessness and hopelessness. The responses by educators in South Africa demonstrate that dealing with trauma in the classroom can have serious physical and psychological

effects. Many of the symptoms reported by educators closely resemble post-traumatic stress disorder, but despite the similarities, the symptomatology mentioned is to be attributed to vicarious trauma.

Vicarious trauma can result in physiological symptoms that resemble post-traumatic stress reactions, which may manifest themselves either in the form of intrusive symptoms, such as flashbacks, nightmares, and obsessive thoughts, or in the form of constrictive symptoms, such as numbing and dissociation (Beaton & Murphy, 1995). Vicarious trauma may also result in disruptions to important beliefs, called cognitive schemas that individuals hold about themselves, other people, and the world (McCann & Pearlman, 1990). Below is an example of how educators' secondary traumatic stress can be reflected in their daily interactions with students in the classroom (Hydon et al., 2015):

> Margaret is a fourth-grade teacher in a low-income neighborhood. She is a new teacher who has been working at her school for 2 years and genuinely enjoys teaching her students. However, she has begun feeling more and more concerned with the level of violence her students have been talking about that happens in their neighborhood, and she begins feeling unsafe while on campus. She is constantly worrying about her students' safety. One of her students has shared with her that he is haunted by night mares, and proceeds to describe to her the minute-to-minute details about the shooting that he witnessed on his way home from school 3 days ago, leaving 2 bystanders dead just several blocks away from campus. He writes about it and draws graphic pictures that he shares with her. He is fearful in class, and he has been difficult to keep on task during lessons. Margaret has been working extra hard trying to figure out how to help him, to no avail. After work, Margaret is unable to focus on her personal life and is constantly thinking about the shooting, noticing at times that she is jumpy and having difficulty reading for pleasure. She frequently finds herself getting angry and agitated. One day in her math class, this young boy asks her for help on an equation that she has already explained in class, but he still can't understand how to solve it.
>
> Ordinarily Margaret would spend a little extra time with him to explain the difficult concepts. But today is different, today she responds with, "Look, I've already told you how to do it. You're just going to have to figure it out on your own!". (p.323)

This example delineates that absorbing students' personal traumas and life experiences directly impact the educator and further negatively impact the effectiveness of their teaching, quality of the student–teacher relationships, and ultimately student learning. When examined qualitatively, it is interesting to note how the educators' commentary upholds what has been documented about the effects of trauma being multifaceted, affecting body, mind, emotions, and spirit (Marsay & Higson-Smith, 2005). The aforementioned symptoms are concerning due to being commonly associated with anxiety, depression, and/or post-traumatic stress disorder; which can potentially lead to suicidal ideation, attempts, or completion.

Suicide Risk

As previously indicated, teaching is one of the professions with the highest stress levels and teachers are prone to the development of stress, burnout, compassion

fatigue, vicarious trauma, and other psychological disorders such as anxiety and depression. Depression is defined as a severe affective or mood disorder and is also considered to be the fourth leading cause of social disability in the world, making this a major concern involving the risk for suicide (Vignola & Tucci, 2014). Teacher mental health is a concern worldwide due to the high incidence of stress in the profession (Mérida-López et al., 2017). According to international evidence, teachers from different economic and cultural backgrounds have symptoms related to stress and depression; with one study of Nigerian teachers reporting that the prevalence of stress among teachers was over 72% (Asa & Lasebikan, 2016). While teachers generally report being satisfied with their work, they continue to report high levels of stress about their activities (Skaalvik & Skaalvik, 2015). This level of satisfaction with the profession can be diminished over time with exposure to chronic stressful conditions, the onset of burnout and psychological symptoms.

The high levels of stress reported in the profession are a concerning factor for the development of more severe psychological disorders, such as depression. Research indicates that teachers are found to be at a higher than average risk for depression and the experiencing of psychological distress symptoms (Schonfeld & Chang, 2017). Teachers are also more exposed to violence than members of other occupational groups, and exposure to violence is a risk factor for mental health-related problems (Schonfeld & Chang, 2017). Stress may be related to the presence of symptoms of depression in that the higher the stress load a teacher has, the more susceptible they are to showing signs of depression (Rodrigues et al., 2020). Teachers in special education are at an even higher risk of burnout and depression (Saddler, 2014). Untreated depression is one of the main factors in suicide. Symptoms related to depression may place the educator at an elevated risk of suicide.

Given this information, it is important to consider the potential for suicide risk in teachers. Knowing the warning signs of suicide is the number one mitigator for intervening with youth which may pose a risk for suicide. Educators play a critical role in prevention and intervening with depressed and/or suicidal youth. Although, most school systems fall short in shifting the lens to providing this same level of prevention and support for educators. While some studies show that teachers are at an average to low average risk of suicide (Schonfeld et al., 2017), there is still a need to consider the suicide risk of educators given the high levels of stress and depression reported in the profession particularly as the landscape of teaching is transforming and the levels of stress reported by teachers is increasing. In 2020, an educator-focused employee assistance program in the USA noticed an increasing trend in requests for crisis counseling and self-reports of suicidality among teachers (Los Angeles County Office of Education, n.d.). The program that serves over 51,000 school employees in over 45+ school districts found that during an 18-month period, 183 educators reportedly experienced suicidal ideation and required crisis counseling and assessment for suicide risk. While statistically this is less than 1% of educators in covered school districts, this is still 183 educators working in schools directly with children in classrooms that sought out mental health support because they were experiencing suicidal thoughts and/or ideation (Los Angeles County Office of Education, n.d.). Think about the ramifications of this playing out in the classroom, the overall

effects on the classroom environment, culture, connection, and learning. As previously described, the overall mental health of educators is directly linked to student learning. In order for classrooms to be well, teaching to be effective, students to be well, it is important that teachers also be well.

Prevention of suicide and attempted suicide by teachers is a critical responsibility of school administrators and school systems. This means that systems and structures must be in place to provide training and resources to school administrators regarding educator mental health. Treating the "whole school" similar to working with the "whole child" is necessary for a thriving school system. An understanding that educators are an integral component of the "health" of the school system and directly linked to student learning is necessary. There is a need for attention to educator mental health and programs to be provided with a focus on prevention and therapeutic actions and support when needed that enable the teacher to have access to the support they need (Rodrigues et al., 2020). One study found high levels of stress, depression, and anxiety symptoms in teachers and organized an informational lecture on mental health for all teachers. While an intervention was provided to increase knowledge of symptoms, there was still a gap in accessing services by teachers. This gap in accessing services could possibly be due to issues related to confidentiality at the workplace and the common stigma related to accessing mental health services (Gonçalves et al., 2015). This is a perfect example of one of the many barriers experienced by educators in accessing support systems for their own mental health and wellness.

For this reason, it is important the educational institutions have a support plan and services in place that are easy to access and most importantly completely confidential for the employee. Due to limited resources, many schools rely on existing support staff professionals at the school or educational institution to provide support. This not only depletes the internal resources of the school taking time and resources away from staff that are employed to work to serve children, but it also places an additional burden on support professionals increasing their risk for burnout and compassion fatigue, in addition to being unethical due to confidentiality and dual relationships with employees. Further, in the case of a crisis with an employee, many school administrators lack the knowledge, training and experience, and guidance to intervene with a suicidal employee. This results in either a lack of interventions and support for the educator, or an overly aggressive and/or inappropriate response that is usually observed by colleagues and students that can negatively damage and shame the educator further. Evidence shows educators are experiencing high levels of stress and depression and that these constructs are major factors in suicide risk. More research is needed in order to fully understand the gravity of teacher suicide risk and school response. Unfortunately, this is a major gap in many educational institutions, and the scholarly literature is scarce with the majority of work focusing on student suicide and its impact on teachers. There are many systemic and structural gaps in place that pose significant barriers to educators accessing mental health and supportive services despite the increasing needs of the profession.

Barriers to Educator Mental Health

When educators seek out mental health services to deal with the aforementioned issues, they are often faced with barriers that hinder their ability to improve their socio-emotional well-being. Many of these issues stem from bureaucratic barriers, such as insurance policies that do not cover mental health services—or at best, offer limited, sporadic sessions that do little in terms of making significant progress toward treatment goals. Counseling services can be difficult to obtain even if they are covered under insurance, and for educators already experiencing burnout, navigating complicated systems to begin receiving services becomes another daunting task. Other barriers to mental health treatment include: lack of access, limited opportunities for conjoint family therapy, lack of benefits for educators who do not qualify for coverage, and overall limited research on the specific mental health needs of educators.

Lack of Access

The lack of access to mental health supports prevents many educators from receiving the help they need thus creating a barrier to achieving overall good health and well-being. Adequate mental health coverage should be included in educators' health benefits packages, especially due to the fact that occupational risks for educators are more likely to affect mental rather than physical well-being. Further, mental health benefits provided through general health insurance packages should not have extensive waiting lists to access services, nor should it be difficult to request or be authorized for such services. Human resource departments should supplement their employee benefits with employee assistance programs to serve this gap. Benefits payable to teachers in Pakistan are recommended for those who are forced to discontinue teaching because of physical or mental disability (Tahseen, 2015). This type of support can make educators feel more inclined to seek mental health services before experiencing serious detrimental effects to their well-being. In addition to individual services, the level of functioning in the family system is another component that affects the overall well-being of educators.

Access to family therapy is an additional barrier facing educators. Educators often find it difficult enough to access individual therapy, that the concept of being able to participate in conjoint family therapy seems practically impossible. The marital and family units are seen as the most important determinants of whether the person feels emotionally supported and matured (Jevne & Zingle, 1990), yet very few if any insurance companies cover the cost of conjoint family therapy. Nevertheless, educators are expected to show up to their jobs and go about their work day placing their personal issues on hold. As previously discussed, the spillover between work and home life directly impacts performance and learning. Workers need health insurance that provides short- and long-term mental health coverage, including conjoint family therapy (Rosenbloom et al., 1995). With access to regular therapy sessions, as well as

the ability to participate in family therapy, educators would be in a better position to teach and support students. Educators cannot be expected to provide the best services to students when their mental health is in a vulnerable state and accessing immediate counseling services is nearly impossible.

Insurance Benefits

Insurance coverage serves as a major barrier to accessing quality, comprehensive mental health services for many educators. Although many employers do provide health benefits for their full-time educators, these packages do not always include mental health benefits. Additionally, many employees employed in school systems are not full-time employees. Part-time employees frequently do not have coverage for health benefits, much less any benefit that would cover mental health services. These employees are greatly affected by lack of access to medical benefits and if not covered by a marital partner, or parent, they may not be covered at all. A study on the impact of mental health insurance laws on state suicide rates in the USA found that when states enact laws requiring insurance coverage to include mental health benefits at parity with physical health benefits, the suicide rates decrease significantly by 5% (Lang, 2013). The recommendation is that education systems worldwide provide their educators access, through their employer's insurance, to mental health providers who specialize in trauma, burnout, and compassion fatigue as it relates to the field of education, given the occupational risks associated with emotional well-being. This access to mental health services should be extended to their family members as well, providing opportunities for family therapy. Having easy access to these providers is another important component in addressing this issue as well, since the burden and responsibility of seeking mental health services is often placed on the employee; hotlines, same-day appointments, flexible scheduling, and sessions on a regular basis should be available. Bell et al. (2003) suggest that some responses, such as altering workloads or providing insurance with extensive mental health benefits, may be costly to the organization; however, neglecting such an investment may also be costly to the agency in terms of staff turnover and low morale. For those school systems in which funding may be an issue, a practical and cost-effective way of providing such services would be through collaboration in research with other educational and health-related groups (Ryan & Jevne, 1993). Despite the increased global interest in mental health and well-being, there is clearly a need for more comprehensive, accessible employee assistance programs (EAPs) and specific services for employees in the education sector.

Existing Educator Support Models and Programs

Employee Assistance Programs (EAP)

In the USA, EAPs first began in the 1930s as internal support programs for employees, specifically implemented for workers in need of alcohol rehabilitation to help restore work function in manufacturing industries. Today, EAPs are widely available to a vast majority of employees in the public and private sector and have a broader range of service delivery models, most recently even focusing on workplace health and well-being (Attridge, 2019). EAPs provide workplace counseling and consultation services that focus on the prevention and/or remediation of personal problems experienced by employees, or members of their families. They are funded by employers and utilized by human resource departments as an additional employee benefit. EAPs are the mainstream services organizations use to provide support to employees for immediate short-term personal or occupational stress-related issues (Kirk & Brown, 2003).

Like the USA, Canada also offers EAPs (referred to as Employee and Family Assistance Program—EFAP) for many employees in the public and private sectors, recognizing the important role of mental health on employee productivity and business outcomes. In other parts of the world, EAPs are less common. In a 2016 survey to determine the number of EAPs in the world, 839 different programs were identified. While 70% of these EAPs were based in the USA, the survey indicated a growing popularity and interest in employee assistance programs and services worldwide (Attridge, 2019). In many countries, EAPs may be less utilized by employers based on prioritization of employee benefits and health packages. Although, there is a growing trend for providing these types of services by employers as the topic of mental health continues to emerge as a vital component for employee health and the stigma is reduced.

In assessing mental health initiatives by employers on a global level, the World Health Organization (2005) suggests the importance of mental health varies greatly among countries, regions, and social groups, and that workplaces too have unique cultures and values of their own. For this reason, universal mental health programs or initiatives are unlikely. There are, however, a number of organizations across the world who are committed to supporting their employees' mental health. In a monograph written about mental health and employment, the World Health Organization (2000) discussed good practice in employer-sponsored global mental health programs and included the USA, Canada, Australia, Spain, Finland, Italy and the UK as world leaders. In developing countries and more rural areas, an employer's concern about employee mental health in general is less likely, let alone the implementation of programs or initiatives. In order for programs to be successful or even put into place at all, they must be culturally relevant and culturally sensitive (WHO, 2000).

Despite the increasing trends and interest in the mental and emotional well-being of employees, research and data are minimal when it comes to successful employer-sponsored mental health programs across the world. Much of this may be related to the confidential nature of utilization of services since participation in services is considered to be protected health information. In the USA; however, research proves that EAP-based mental health and workplace wellness services are effective in reducing symptoms of depression, workplace stress, and other mental health-related issues when utilized. Research also indicates that mental health EAPs are extremely underutilized, primarily because of poor communication to employees about what is available to them and their families but also because of the perpetual stigma in seeking out such services (Dunning, 2014). In the education sector specifically, research on the use and success of EAPs is essentially nonexistent.

Education-Focused Employee Assistance Programs

Despite limited research, EAP programs that focus specifically on working with educators are important. At this time, employee assistance programs specifically focused on educators are limited for teachers in the USA. Most educational institutions will collapse this type of employee benefit into existing health benefits packages. The difficulty with this route is that employees do not receive the immediate support needed when in distress. For example, an employee may have to follow the protocol for requesting mental health services which can take up to one to three months before services ever begin through most insurances. Many avoid going through this process or begin the process and end up not following through as time continues. Some may feel concerned about the information being on their medical record through their insurance. Most employees contact an EAP when in the midst of some type of personal, family, or occupational crisis. The employee needs access to immediate support not support three months later. EAPs have the ability to provide immediate support to employees telephonically, can intervene in crisis situations with the employee, and provide immediate access to services and resources. EAPs provide the immediate intermediary support when an employee needs it due to short-term personal and life issues that arise. If more long-term support is needed, resources and referrals are provided to transition the employee to those services. EAPs also have the ability to work systemically within an institution to foster workplace wellness and health which provides a layer of prevention within the system. Researchers posed the question: if we place individuals in situations that could be hazardous to their health, are we ethically responsible to address their special personal/professional needs to ensure a healthy career? If an ethical obligation does exist, an organizational structure, such as an employee assistance program with an empowerment focus, needs to be incorporated into each school district employee benefit package. Further, if educators are expected to assist students in dealing with trauma and crisis, services must be in place to make sure the educator is both prepared to be of service and also in a healthy mental space of their own. The goal of any employee assistance program

becomes a response to these recognized teacher needs within an empowerment and developmental perspective (Ryan & Jevne, 1993). An EAP specifically focused on educators understands the needs of the educational sector employees and is better able to assist in navigating the frequent political and bureaucratic educational system and is better able to support the educator because they understand the system and challenges.

It is imperative that employee assistance programs shift from a bureaucratic approach to one with a focus on humanitarianism. The proposed employee assistance program by Ryan and Jevne (1993) is presented as a credible response to the present wellness needs of the [educator]. They suggest that teachers would benefit from an information package on the various aspects of teacher wellness (Ryan & Jevne, 1993). Accessibility to services is to be considered throughout the development of EAPs that are focused on educators. The development of evening and weekend sessions as well as the organization of support groups to support the varying needs of teachers is highly recommended. In addition, the proposal expands the services of the traditional employee assistance programs for [educators]…[emphasizes] early assessment and intervention (Ryan & Jevne, 1993). Preventative approaches and attention to educator mental health can prove to be cost-effective to the educational sector, likely to reduce teacher turnover rates as well as absenteeism. Early assessment and intervention are likely to lower the prevalence and risk of teacher burnout and trauma, thus providing educators with the tools necessary to successfully support their students. Effective EAPs can also provide immediate support and intervention during a crisis or disaster, mitigating the long-term effects of such exposure. Most importantly, the prevalence of suicidal ideation, attempts, and completion among educators are likely to lower with mental health supports in place that are endorsed by educational leaders and accessible to all.

Mental Health/Counseling Hotlines

Mental health, or counseling, hotlines are a standard aspect of public health approaches to psychological crisis intervention. Clinical aims of mental health hotlines include reducing callers' crisis states, psychological distress, and suicidal ideation. Mental health hotlines are designed to provide immediate support services to people who may be experiencing mental health problems, facing stressors, feeling socially isolated, and/or have suffered abuse or trauma (Pirkis et al., 2016). Helplines vary in their approach. Some are directive, offering strategies and advice, and others are nondirective, providing someone who listens but does not suggest interventions (Pirkis et al., 2016). Despite gaining awareness in the recent years, the concept of mental health hotlines dates as far back as 40 years. The terms, hotlines, helplines, and crisis lines, are frequently used interchangeably.

The utilization of hotlines as an access point for outreach to individuals in crisis is seen worldwide. Since the development of the first crisis line by the Children's Hospital of Los Angeles in 1968, thousands of mental health hotlines have been

established around the world (Ingram et al., 2008). Presently, 175 countries have helplines, crisis lines, and or suicide hotlines available to their citizens (Therapy-Route, 2020). In 1992, the national helpline SANEline was established in the United Kingdom (UK) by the mental health charity SANE. The helpline is an after-hours telephone helpline for individuals experiencing mental illness, their families and carers, and for professionals and voluntary organizations interested in all aspects of mental health (Fakhoury et al., 2001; SANE, n.d.). A great feature of SANEline is that it focuses on providing services during hours when most people in the workforce are available. Availability of mental health services during extended hours can greatly benefit educators who often work during the hours of operation of many mental health agencies. SANEline provides one-on-one support, information on therapy groups, current laws pertaining to mental health, as well as intervention and treatment (Fakhoury et al., 2001). In China, a hotline by the name of Lifeline Shanghai was established in 2004; it is a free service that provides psychological services to callers aimed at restoring mental and emotional stability by facilitating social readjustment and teaching effective coping skills (Lifeline, n.d.). In order to meet the growing need of mental health services, Lifeline Shanghai rebranded themselves as simply "Lifeline," providing services to people all across China (That's Shanghai, 2019). In Australia, the largest telephone helpline that provides access to crisis support, suicide prevention and mental health services is also called Lifeline. Lifeline (Australia) is a nonprofit organization with a telephone line that offers 24-h crisis support (Pirkis et al., 2016). The USA currently has a suicide prevention hotline also by the name of Lifeline, comprised of 163 call centers around the country, as well as a website with a live chat function. Efforts to streamline contact with mental health hotlines through the implementation of a three-digit number in the USA are currently in motion, in order to facilitate access to life-saving resources (Dwyer, 2019). In California, the Employee Assistance Service for Education (EASE) program offers a 24-h counseling hotline specifically for educators and family members (Los Angeles County Office of Education, n.d.).

As far as the effectiveness of mental health hotlines, studies have found significant decreases in callers' crisis states and hopelessness during the course of telephone sessions, with continuing decreases in symptoms in the weeks following the calls (Kalafat et al., 2007). Positive experiences over the phone as well as being provided referrals can be the first step toward individuals seeking in-person therapy services. Approximately, one-third of callers who receive referrals to mental health agencies follow up with the referral and seek services (Kalafat et al., 2007). An additional benefit to the use of hotlines is that callers to helplines typically remain anonymous. The anonymity of mental health hotlines makes callers more willing to seek services without fear of judgment. Although limited information and research on the effectiveness of mental health hotlines has been conducted, the good news is that there is a vast availability of resources and phone numbers for consumers around the world. As people increasingly access these hotlines, enough data will be accumulated to produce larger-scale studies on its effectiveness. Although hotlines may be an accessible option for educators, these services are open to everyone; crisis counselors may not have a full understanding of the experiences of the educator, and may only be

able to offer temporary solutions or a space for educators to vent their emotions. The use of hotlines paired with workplace health programs may be a good combination to achieve educator mental health and well-being.

Workplace Health Programs

Occupational stress and strain induce worsening physical and mental conditions for teachers, while coping resources could promote their health. Having adequate coping resources, especially social support, in workplaces may be an important factor for improving teachers' quality of life. Moreover, psychological interventions should be set up for teachers, and psychological counseling should be provided to relieve stress and enhance quality of life (Yang et al., 2009). The following educator wellness programs have been found to successfully increase levels of health and well-being in their respective schools/districts.

Washoe County School District (Nevada) Wellness Program

The Washoe County School District in Nevada developed a wellness program for its employees as a method of reducing absenteeism among teachers as well as the cost of health care. The program offered multiple options for activities to participate in, all promoting overall health and well-being. Participants had the opportunity to enroll online as well as in person (at any of the district schools and/or facilities) to a variety of wellness programs promoting dental hygiene, hydration awareness, road safety, healthier alternatives to sedentary leisure activities, physical activity, adequate amounts of sleep, and responsible energy intake/nutrition. Available to the district's 6246 employees covered by WCSD's insurance, the effectiveness of this initiative was observed over the course of two years. Although no statistically significant reductions in healthcare costs were observed, significant differences were discovered in absenteeism among teachers. Participants of the Washoe County School District Wellness program were found to miss an average of three fewer days than nonparticipants of the program. From a fiscal perspective, this equals the cost of saving $15.60 (USD) for every dollar invested in the program (Lever et al., 2017). Despite encompassing multiple facets of wellness and the success of this program in reducing absenteeism in teachers, it should be noted that mental health was not explicitly addressed nor included in any of the activities made available. It can be surmised that the addition of activities that promote the development of resilience and mental well-being could increase the success of the program.

Mindfulness-Based Interventions for Teachers

The practice of mindfulness has gained global popularity in recent years. This technique has been found to be particularly successful in building resilience among employees who work in occupations that pose risks to mental health and well-being. Harker et al. (2016) believe cultivating and sustaining resilience can buffer the impact of occupational stressors on human service professionals. Results of their study on work-related mental health problems among human service professionals in Australia showed statistically significant evidence that higher levels of resilience were a predictor of lower levels of psychological distress, burnout, and secondary traumatic stress. Additionally, they found that one of the psychological factors associated with the development of resilience among employees is mindfulness, and that higher levels of mindfulness were predictors of lower levels of psychological distress and burnout (Harker et al., 2016). In some American school districts, promising workplace mental health programs do exist, which are generally focused on mindfulness-based interventions and self-help. There is limited research on the effectiveness of mindfulness-based interventions, but the research that does exist indicates that it has a positive impact on educators. Results from a 2015 study suggested that educators who participated in MBSR reported significant gains in self-regulation, self-compassion, and mindfulness-related skills (observation, nonjudgment, and nonreactive) (Frank et al., 2015). The authors note that these findings provide promising evidence of the effectiveness of MBSR as a strategy to promote educators' personal and professional well-being, and improve coping with day-to-day and more serious stressors (Frank et al., 2015; Grossman et al., 2004; Hofmann et al., 2010).

Cultivating Awareness and Resilience in Education (CARE)

Cultivating Awareness and Resilience in Education (CARE) is a program designed with the goal of reducing stress and improving the performance of educators. The premise of the program was to provide instruction in three practices directly related to stress reduction—emotion skills instruction, mindfulness practices, and compassion practices—and measure its effectiveness in meeting the established goals. Emotion skills instruction (ESI) promoted the regulation of emotions in the classroom via experiential activities, e.g., role-plays and reflective practices (Jennings et al., 2013). These activities were conducted to increase teachers' understanding, recognition, and awareness of the various emotional states they experience in the classroom as well as their emotional patterns and the schemas associated with them. The skills acquired through ESI can help increase teachers' attentiveness to student needs, classroom climate, and their own emotional states when student behavior becomes challenging. CARE provides mindfulness instruction through awareness practices that focus on breathing techniques and their application throughout the workday (Jennings et al., 2013). Mindfulness can help increase focus in daily activities such as presenting a lesson, standing, and walking. Through an acquired focus on the present moment, teachers can expect improved interactions with students, parents, and their

colleagues. Compassion practices were implemented to promote increased empathy among teachers. This technique involves loving-kindness guided meditations, in which well-being, happiness, and peace are offered to the self as well as to others. By sending positive intentions to themselves and others, compassion reflections can help educators feel more connected and empathic toward students and their needs. CARE was piloted with 53 teachers from urban and suburban school settings, who participated in CARE's three 20-min phone coaching sessions as well as five full-day sessions over the course of eight weeks. A control group was included for statistical comparison as well. The results of the trial reported improvements in not only stress reduction and educator efficacy but also in burnout, mindfulness, and overall well-being (Jennings et al., 2013). Because CARE is a relatively new initiative, there is still a need for additional research to further investigate its effect on the classroom environment and student learning outcomes.

Community Approach to Learning Mindfully (CALM)

CALM is a brief daily school-based intervention to promote educator social emotional competencies, stress management, and well-being. Harris et al. (2015) evaluated the feasibility and efficacy of the Community Approach to Learning Mindfully (CALM) program for educators with 64 educator participants. Intervention sessions included gentle yoga and mindfulness practices and were offered four days per week for 16 weeks. Pre- and posttest measurements included self-report surveys of social emotional functioning and well-being, blood pressure readings, and diurnal assays of cortisol (Harris et al., 2015). According to Harris et al. (2015), compared to the control condition, CALM had significant benefits for educators' mindfulness, positive affect, classroom management, distress tolerance, physical symptoms, blood pressure, and cortisol awakening response.

Employee Assistance Services for Education (EASE)

One example of a comprehensive EAP model program focused on educators in the USA is the Employee Assistance Services for Education (EASE) program in California (Los Angeles County Office of Education, n.d.). The program was established in 1979 and is provided by the Local Educational Agency (LEA) as a confidential support service for school districts to provide these specialized benefits to their employees at an extremely low cost per employee. Most school districts struggle with budgetary constraints, and this is a cost-effective way to offer excellent support services to educators. The EASE program provides a 24-h mental health line for educators and family members, mental health counseling for educators and family members, resources and referrals, consultation with administrators, crisis counseling, mobile crisis response for school site crises or disasters, conflict mediation, and psychoeducational workshops and training for educators. Most importantly, all services provided are confidential and the employee can feel comfortable accessing

services without their employer being notified. The service is highly utilized by school districts, higher education institutions/community colleges and educators as an option for immediate crisis and mental health support (Los Angeles County Office of Education, n.d.).

Although few workplace health programs focused on education currently exist, the results of pilot programs are promising. Data shows that although such programs may not directly reduce healthcare costs for institutions, financial benefits can be seen in reduced absenteeism, and increased physical health. Future programs should consider the implementation programs that address all the components of wellness, as some appear to be more focused on physical health while others place a greater emphasis on mental health. Although both types of programs have been proven effective, workplace health programs with a holistic design can be expected to be substantially more successful than their more compartmentalized counterparts. Validated wellness measures can help researchers and program developers acquire statistically accurate information on the educator population, their needs, and the effectiveness of existing wellness programs.

Validated Wellness Measures

Funding for programs, especially in the field of education, is not easy to come by. The availability of funds is often dependent on the measurable results of proposed programs. Educational leaders look at various forms of data, such as rates of attendance, academic success of students, parent surveys, etc. when deciding if money should be allocated to a program. For the purpose of evaluating wellness programs for educators, validated measures are important in determining employee needs, setting baselines of well-being, tracking improvements, and making necessary adjustments to programs. Such measures typically come in the form of self-reports, through either questionnaires or rating scales. Validated wellness measures provide solid evidence for the efficacy as well as the benefits of developing, incorporating, or continuing to fund existing programs.

Interpersonal Mindfulness in Teaching Questionnaire

The Interpersonal Mindfulness in Teaching Questionnaire is a particularly useful tool for program evaluation, as it is the only measure in the literature specifically designed to evaluate wellness in teachers (Frank et al., 2015). The questionnaire was designed in order to have a psychometric method of measuring the mindfulness of educators. Teachers are asked to respond to the 20-item measure by describing how true each item is for them on a 1 (never true) to 5 (always true) Likert scale. The items were designed to reflect aspects of mindfulness (intrapersonal and interpersonal) that were believed to be the most prominent in the context of teaching, such as

teacher focus during instruction/daily school activities as well as responsibility and sensitivity during interactions with students (Frank et al., 2015). Responses are then evaluated to measure levels of intrapersonal mindfulness and interpersonal mindfulness. Frank et al. (2015) report that the Interpersonal Mindfulness in Teaching Questionnaire has been validated through confirmatory factor analysis and has good test–retest reliability. When creating an educator wellness program that incorporates mindfulness practices, this questionnaire can help determine the pre-intervention levels of intrapersonal and extrapersonal mindfulness in teachers as well as whether any differences existed after implementing said intervention.

Teachers' Sense of Efficacy Scale

Educational systems interested in incorporating an educator wellness program can also utilize the Teachers' Sense of Efficacy Scale as an effective method of identifying educator needs. This scale can be utilized to quantify how competent educators feel when confronted with challenges in the classroom. The types of challenges experienced in the classroom are separated into three dimensions: instructional strategies, classroom management, and student engagement. Teachers are asked to gauge "how much they can do" given certain situations in each of the dimensions on a scale of 1 (nothing) to 9 (a great deal) (Tschannen-Moran & Hoy, 2001). Measuring educator efficacy is important because their perceived levels of success can impact how they relate to students in the classroom and the effort they invest in teaching. This scale also gives leaders an idea of how much power educators feel they have in various aspects of the educational system outside of the classroom, such as determining class sizes, community involvement, collaborating with administration, etc. This information can be beneficial in bridging gaps in communication between teachers and administration. The dialogue that this scale results in can be used as the stepping stone toward empowering educators and involving them in decision-making processes.

Professional Quality of Life Scale (ProQOL)

Although it is not specifically designed for educators, the Professional Quality of Life Scale (ProQOL) is a validated employee wellness measure. It is useful, nonetheless, due to it being particularly appropriate for employees in the helping professions. The ProQOL focuses on compassion satisfaction (the positive emotional effect of helping others) and compassion fatigue (burnout and secondary traumatic stress) (Hundall Stamm, 2009). This scale is particularly interesting because it addresses the spectrum of experiences of those in helping professions such as education. Measuring the levels of compassion satisfaction among employees in helping professions is just as important as measuring negative effects because it gives those developing wellness

programs a goal that strives toward happiness and well-being, rather than simply reducing or eliminating levels of stress, compassion fatigue, etc.

Worksite Health Scorecard (HSC)

The Centers for Disease Control and Prevention offer a Worksite Health Scorecard (HSC) that allows employers to assess their evidence-based health promotion interventions (Roemer et al., 2013). At no cost to employers, this is a useful tool that can be used to identify the areas of need in terms of wellness programs available to employees. The HSC covers 12 domains, including: nutrition, weight management, physical activity, organizational supports, tobacco control, emergency response to heart attack and stroke, stress management, signs and symptoms of heart attack and stroke, depression, high blood pressure, high cholesterol, and diabetes. Despite this measure not being designed for the field of education, the HSC was created in an effort to improve workplace culture and promote employee wellness, which aligns with the literature on educator mental health and the vision for future employee wellness programs.

While other measurements have been proven to be useful in educator wellness program development, the need for more measurement tools designed for the field of education is evident. Measurement tools specifically designed to evaluate the occupational risks of educators as well as the effectiveness of wellness interventions would facilitate program implementation and evaluation. The information acquired through specific educator wellness scales can help produce programs that are tailored to the needs of a specific school, district, region, or culture.

Cultural Impact on Health and Wellness

Many education professionals across the globe are united in their feelings and experiences as educators. However, when it comes to addressing their mental health and well-being, the approach varies tremendously. Because of the unique cultures and values in different countries, states, geographic regions, and employers, educator mental health is treated and prioritized inconsistently. Addressing the impact of culture on educator mental health is crucial to understanding barriers and systemic issues facing educators. Unfortunately, current research is limited in addressing the cultural impacts on mental health and wellness but also the devastating effects of negative mental health on educators in general.

Studies on wellness in the education sector conducted in various countries appear to be in consensus regarding the effects of occupational stress and the lack of resources available to educators. Although the literature points to all educators experiencing a certain degree of work-related stress, it is important to note the culturally

significant differences in responses to such experiences. The most common distinction between Western countries and others is the levels of individualism versus collectivism respectively. The characteristics of each culture appear to affect workers' occupational health in different ways (Tang et al., 2013). For example, Hong Kong teachers are more likely to perceive higher stress levels because of their social image in society, pointing out that teachers "over commitment" may be perceived as having a good virtue of loyalty in the collectivist culture (Tang et al., 2013). When educators are continually being praised for their seemingly unrelenting dedication, their likelihood of expressing feelings of burnout, compassion fatigue, or trauma/secondary traumatic stress diminishes. In contrast, educators from individualist countries appear to feel undervalued and not supported by their educational leaders. Although educators worldwide may share similar sentiments about occupational stressors, their approach to such experiences varies; educators from collectivist cultures in which teachers are highly regarded tend to feel shame at expressing any levels of stress, whereas educators from individualist cultures may express their hardships and seek help but may often unable to access any resources. The differences demonstrated among the samples between the UK and Hong Kong call for the consideration of cultural differences in designing interventions that are appropriate for the needs of each country's educational system (Tang et al., 2013). Knowledge of educator health and wellness relies on the limited research available. In order to identify each system's particular needs, extensive research focused on educator wellness is needed.

Gaps/Limitations in Research

When the topic of school-based mental health is addressed in school settings, it usually pertains to the mental health of students. The results of professional research on the topic proved the same. While teachers' emotions and emotional regulation are core components of their workday, their importance and impact have not been fully acknowledged in recent research (Sutton & Wheatley, 2003). Research surrounding the mental health and well-being of educators is scarce, as is any research on the effectiveness of established educator mental health programs. Current literature around workplace mental health initiatives focuses on employees in traditional business settings, and seldom includes educators and those who work in school settings. To better understand the current state of research on teacher wellness, Lever et al. (2017) conducted a search on research platform PsycINFO using the words "wellness" and "teacher." The search found 64 peer-reviewed results published between 1984 and 2015.

Although there has been a notable increase in recent publications, particularly in the last five years, the school staff wellness topic is still a fairly new area within mental health literature. The existing research fails to address the benefits of educator-focused mental health programs or simply whether they exist for educators at all. At this time, there is a lack of research available that addresses the specific barriers keeping educators from obtaining mental health services. What is known, however,

is that there is a clear lack of access to these services and an increasing need for them among educators worldwide.

Conclusion

The decline in the mental health and well-being of employees is increasing around the world, as is its cost to workplaces, economies, workers, and societies in general. In the educational sector, meaningful progress has been made when it comes to ensuring the mental health and well-being of students, but a considerable gap exists on ensuring support for educators which has a direct impact on students. The implementation of interventions for students such as social emotional curriculum, mindfulness and meditation, and accessible mental health services have been seen in school systems worldwide. Awareness of mental health and its impact on overall well-being is important for everyone but particularly critical for employees working in the field of education. International studies on work-related stress provide evidence that educator mental health is a global issue that requires immediate attention. Current literature provides evidence that not only is the mental health of the educator important for personal well-being but also for student psychological well-being, workforce stability, and the progress of academic institutions.

Educators all over the world are experiencing the impact of educational reform, having to adjust to changes in the reallocation of control of decision making to government officials, implementation of new curricula, mandated amounts of time providing direct instruction, and the ever pressing individual needs of students. Furthermore, the present role of the educator is now far beyond the traditional expectations of the job, as more and more students turn to their teachers for socio-emotional support. Absorbing students' personal traumas and life experiences directly impact the educator and further negatively impact the effectiveness of their teaching, quality of the student–teacher relationships, and ultimately students' academic success. Occupational, personal, and environmental stressors only contribute to the decline of educator mental health and well-being. The prevalence of educator burnout, compassion fatigue, and trauma is no surprise, due to the increasing amount of stressful responsibility held by educators, yet it is hardly ever addressed by educational leaders or institutions. Given this knowledge on the risk factors of the profession, it is also important to consider the potential for suicide risk in teachers and have systems in place for prevention and mitigation of such risk. The presence of these symptoms among educators is one that requires attention and concern. Additional problems exist when educators do attempt to seek out mental health services to deal with the aforementioned issues, often facing barriers that limit their ability to improve their socio-emotional well-being. Difficulty accessing services due to bureaucratic barriers such as limited access or coverage through employment benefits often deter educators from pursuing much needed mental health support.

Existing educator support models and programs such as effective employee assistance programs (EAPs) focused on education can be a useful intervention during a

crisis or disaster, relieving the long-term effects of exposure to stressors in the workplace. In addition to EAPs, the use of hotlines in combination with workplace health programs may also be an effective method to achieve educator mental health and well-being. The aforementioned educator wellness programs have been found to successfully increase levels of health and well-being in their respective schools/districts and can serve as a guide for the development of other programs in the future. Furthermore, validated wellness measures provide solid evidence for the efficacy as well as the benefits of developing, incorporating, or continuing to fund existing programs.

It is crucial to address the role of culture on educator mental health in order to understand the different barriers and systemic issues that educators experience. Unfortunately, current research surrounding the mental health and well-being of educators is scarce and fails to address the cultural differences on educator mental health and wellness. Future research must first address the increasing need for mental health services and support for educators. Specifically, research should address the overall mental health and well-being of educators, looking closely at how daily functioning is impacted by work and life stressors. Additional research should focus on the implementation of low or no cost mental health services readily available to educators, and how such programs may have a positive effect on those who utilize them. Addressing these topics in professional research will further indicate that teacher mental health is a major concern that deserves attention, scrutiny, and funding.

Recommendations

The following recommendations are provided for future educators, educational leaders, and local educational agencies in hopes that it can highlight the importance of mental health services for educators as well as guide future development and implementation of programs aimed at increasing the mental health and well-being of educators worldwide.

Educators

Educator Preparation

The field of education is one of the most emotionally rewarding occupations that exists. Soon-to-be educators are often excited to begin teaching and look forward to the amazing experiences they will have in the classroom with students. There is, however, concern that prospective teachers trying to understand teaching, the profession, and the pedagogy might be disheartened by stressful experiences of their own teachers, resulting in the fading of interest in pursuing career opportunities as teachers (Tahseen, 2015). Educators should be alerted to their own vulnerability to the effects of secondary traumatic stress and assisted with knowledge of holistic

strategies which can be identified and implemented (Marsay & Higson-Smith, 2005). Learning, developing, and practicing basic self-care routines will help mitigate the increasing levels of stress likely to be experienced. The development of effective coping skills and a regular self-care routine is critical for teachers. The occupational risks of teaching and how to effectively deal with burnout, compassion fatigue, and vicarious trauma/secondary traumatic stress should be brought to awareness of prospective educators during their school training. The addition of a course that addresses such matters in teacher credentialing programs is critical to assist educators in being prepared for entering the educational workforce (Koenig et al., 2018). Findings from research conducted regarding the efficacy of a proposed wellness course could not only benefit future educators; the implementation of a course like this may also potentially help bring more awareness of teacher wellness to educational policymakers in order to provide additional support for increased government funding to educational programs toward educator mental health.

Teachers as Well-Being Leaders

Approaches focused on prevention and mental health support of educators with a focus on the aforementioned aids in building a climate of trust between educators and their employers as well as a sense of understanding of their experiences both in and out of the school setting. An organizational approach, addressing sources of stress in the psychosocial work environment and not solely individual coping, could have significant positive effects (Tang et al., 2013). Findings by Mérida-López et al. (2017) provide guidance in developing further useful intervention programs, not only for purposes of alleviating role conflict and role ambiguity in educational organizations, but also to facilitate the development of personal resources such as emotional regulation ability (ERA) in preventing and treating the mental health problems experienced by educational staff. Establishing a site liaison that focuses on school employee well-being and providing support, connection, and resources would be helpful at school sites. This role would focus on the inclusion of prevention, training, and implementation practices that support an organizational climate that focuses on positive and healthy well-being. When teachers feel supported, the results will be evident not only in their well-being but also in that of their students and of the educational institution as a whole.

Educational Leaders

Prioritizing Employee Wellness

Evidence that a positive correlation exists between work quality and mental health has been established. Ongoing research on health and well-being—along with the

exploration of employee rights to psychologically safe work environments—demonstrates that employers worldwide are on the right path toward promoting employee wellness. The concept of wellness, however, albeit receiving attention in the corporate sector, has not been explored through a systematic lens with employees in the field of education. Thus, the time has come for educational leaders to demonstrate concern about employee wellness (Sackney et al., 2000). Fortunately, it appears as though researchers are headed in the right direction. Leaders play a crucial role in determining the intellectual and emotional wellness of their employees (Sackney et al., 2000). This of course depends on how well leaders understand the experiences of the educator. Once the impact of trauma on the learners, educators, and the learning environment is recognized by educational leaders, then the shift in the role of the educator as caregiver will be acknowledged (Marsay & Higson-Smith, 2005). If educational reform is to happen, policies and support structures should be implemented to assist all concerned and the impacts to educators by such changes should be taken into consideration. Educators are likely to prosper if they are provided with sustained personal and professional support by their school leaders (Marsay & Higson-Smith, 2005). Educational leaders need to establish good employee relationships, ensure that the employee feels valued, and provide for employee input in the system decision-making processes (Sackney et al., 2000). Not only should educational leaders be responsible for providing the proper support to promote the wellness of their educators, but additionally, school administrators must take steps to look after the safety of teachers. These steps include ensuring accuracy in the reporting of crimes and threats against teachers, even if the reporting is an embarrassment to administrators and school districts; otherwise, there is no credible basis for implementing measures to reduce teacher victimization (Schonfeld et al., 2017). The importance attached to wellness should be evident in each school system's vision and purpose because unless leaders view wellness as being important, little will be accomplished in this regard (Sackney et al., 2000). When educator wellness is prioritized, educational institutions will notice the difference. Lastly, educational leaders should lead by example, thus prioritizing their own physical and emotional wellness and engaging in active self-care practices and routines. When in doubt, educational leaders should provide and make resources available for outside support for employees.

Educational Institutions/Local Educational Agencies (LEA)

Prioritizing Educator Mental Health and Funding

Growing research supports the economics of encouraging staff wellness and offers justification for the investment in wellness programs. The workplace wellness literature, when combined with the growing research literature in school staff wellness, supports the idea that school employee wellness programs can promote improved physical, social, and emotional well-being in school staff while having a positive impact on student success and school climate, particularly as it relates to improved

teacher attendance and, thus, improved academic continuity for students (Lever et al., 2017). The need for educator mental health is evident and only increasing. Educational institutions hold the responsibility to prioritize employee health and wellness and provide proper allocation of funding for such support services for the overall wellness of the organization. LEAs should consider cost-effective funding options of providing support and such services to school district organizations that provide an example of the prioritization of educator mental health and wellness.

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Part VII
Psychological Capital

Chapter 26
Resilience: Concepts, Approaches, Indicators, and Interventions for Sustainability of Positive Mental Health

M. Manjula and Apoorva Srivastava

Abstract Resilience is broadly conceptualized as an individual's positive adaptation to adversity which includes not only functioning well under adversity and overcoming difficulties but also becoming stronger after that. Resilience has been theorized under three broad approaches, (1) as an outcome, (2) as a trait, and (3) as a developmental process. Accordingly, the first set of research looks at outcomes after an adverse event (presence or absence of symptoms/distress and/or functioning, the second approach considers factors contributing to vulnerability and resilience, whereas the third approach looks at the process of developing and enhancing resilience. Blending of all these approaches is seen while formulating interventions for enhancing resilience. Mental health, happiness/positive emotions, and well-being/life satisfaction are considered as indicators of resilience. Mediating role of resilience in mental health and well-being has been established in the literature. Defining resilience for the purpose of research, assessment, and formulation of intervention continues to be plagued with lack of clarity. However, the resilience-based interventions largely aim at prevention of mental health problems and promotion of well-being. Resilience-based interventions are carried out in individual and group formats with face-to-face, and online modes. In addition, resilience interventions are used across age groups, settings and formats. These intervention programs are found to be helpful in increasing resilience, well-being, positive emotions and coping across a number of groups such as students, working professionals, health service staff, individuals with medical and mental health conditions and those who work in emergency situations. Though resilience has been examined extensively, there is not enough clarity with respect to conceptualization, assessment, models of intervention and outcomes specific to resilience. Long-term studies for mental health outcomes are sparse. The chapter attempts to critically evaluate resilience with respect to the above-mentioned domains.

Keywords Resilience · Positive emotions · Well-being · Interventions · Mental health

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_26

Introduction

Rock bottom became the solid foundation in which I rebuilt my life.
—J.K. Rowling

As the quote by Rowling suggests, one of the interesting phenomena of life is the capacity of individuals to face adversities or difficulties and come out stronger. This positive adaptation to hardships includes not only functioning well under adversity and overcoming challenges but also becoming stronger after that, broadly known as resilience. The word resilience is derived from the Latin verb *resilire*, meaning "to leap back". The American Psychological Association (2014) defines resilience as "the process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress". It is described as positively adapting to adversities and maintain mental health (Wald et al., 2006). Resilience can involve traits, outcomes, and recovery-related processes. Yehuda et al. (2006) conceptualize resilience as involving a continuous, conscious reintegration of self so that there is forward movement in the positive direction, and there is no returning. Learning from the adverse experiences faced by a person facilitates this process.

Owing to its complex nature, there are multiple attempts to define it from different perspectives hence the existence of different definitions across different contexts such as societies, families, individuals, and organizations. (Southwick et al., 2014). This topic has garnered increasing interest of researchers over time. In the past years, it has spread over multiple disciplines as one of the significant topics of study including but not limited to psychology, psychiatry, sociology, genetics, epigenetics, endocrinology, and cognitive neuroscience (Herrman et al., 2011; Hu et al., 2015). Despite such interest in the field, a consensus about the definition has not been reached yet.

The research on resilience in psychology was pioneered by researchers studying children who developed well despite facing chronic adversities like poverty, maltreatment, etc., (Diminich & Bonnano, 2015; Garmezy, 1972; Masten, 2001). Since then, the scope has broadened, and the term has come to be understood in different ways. In the current conceptualization, borrowing the definition given by Connor and Davidson (2003) resilience is considered as "a multidimensional and dynamic characteristic that keeps changing with context, time, and age, within the individual as well as across gender and cultural origin". Following this, it can be said that individuals can have different levels of resilience in variouis domains and phases of their lives and that contributing factors of resilience may change depending on the context (Kim-Cohen & Turkewitz, 2012). For example, some parental behavior like nurturance and protection may foster resilience during infancy; however, the same degree of it may interfere with identity formation and fostering independence during adolescence or young adulthood (Southwick et al., 2014). Levels of resilience may also vary according to age as mentioned above, with a decrease seen over 70 years of age (Rothermund & Brandtstädter, 2003). Due to its presence in varying degrees

in different domains of life, rather than an all or none phenomenon, resilience can be said to exist on a continuum (Pietrzak & Southwick, 2011).

Depending on the context, many types of resilience are identified, for instance, "minimal-impact resilience"; "emergent resilience" to name a few (Bonanno & Diminich, 2013). For example, resilience would be different for someone who has survived a natural disaster from a refugee or suffering from chronic schizophrenia (Southwick et al., 2014). Thus, response to a stressor takes place in the context of other variables like social support, culture, religion, community, society, available resources, and interaction with other individuals. The capability of these contexts to support the individual depends on their resilience and adaptability (Southwick et al., 2014). Overall from these factors, it can be surmised that modifications in resilience may occur throughout one's lifetime, at both individual and sociocultural levels (Davydov et al., 2010). Additionally, resilience trajectory might have brief periods of disequilibrium after a highly adverse event followed by healthy adaptive functioning. These brief responses might neither be resilient nor pathological (Bonanno, 2012; Bonanno et al., 2011).

Approaches to Understanding Resilience

Presently, there are three methods to understand resilience—trait, process, and outcome (Hu et al., 2015).

Outcome Approach This approach conceptualizes resilience as an outcome after an experience of a stressful event before the individual presents for treatment or any intervention. Meaning that the individual is able to adapt and function without developing any symptoms/dysfunction (Happer et al, 2017). According to Pelton et al. (2014), children who do not show any psychopathology despite being exposed to severe adversities or trauma are resilient. Along similar lines, Cicchetti et al. (2007) also identify high levels of functioning and low levels of psychopathology as defining characteristics of resilience from their study of maltreated children. Resilience acts as a buffer against the development of any psychological problems (Van der Walt et al., 2014) and "immunity" to individuals against negative effects of adversities (Garmezy et al., 1984). It is conceived to operate along with the trauma and intercedes before the development of symptoms, so resilient individuals will have minimal or no symptoms. This seems to correspond with the protective factor model, thereby reducing the probability of negative outcomes.

Some of the limitations of this approach because it defines resilience as the absence of symptoms (Peltonen et al., 2014) and/or presence of adaptive functioning (DuMont et al., 2007), there is no specific measure of the construct in researches following this approach and the mechanisms of resilience also get overlooked. Being conceptualized in this manner fails to account for the cultural considerations of adaptation, which is out of sync with Ungar's (2008) theory. Wherein it is understood that cultural context is a dominant factor in understanding resilience. Considering the difficulties

in measuring resilience defined as an outcome and correlating it with a lack of symptoms, future research is needed to address these issues (Happer et al., 2017).

Trait Approach or Trait Resilience According to this perspective, resilience is defined as a personality trait that an individual is born with, which can shield him/her against the impact of adversity or stressful events (Connor & Davidson, 2003; Ong et al., 2006). It is also defined as a generalized, characterological quality that is not specific to situations but applies across situations (Block & Kremen, 1996). Thus, it is stable, innate (Happer et al., 2017), and a by-product of adaptive temperament (Wachs, 2006).

An essential and active element of trait resilience is positive emotions. Positive emotions help reduce the risk of negative emotions and facilitate thriving (Tugade et al., 2004). Also, they are part of effective coping, providing a buffer against various kinds of future adversities (Davydov et al., 2010). The impact of trait resilience has been seen to be constant across a wide range of ages (6–60 years) when compared to external protective factors, as was determined by Hu et al., (2015) in their meta-analytic study. It was also found to be a stable predictor of mental health.

Connor–Davidson Resilience Scale (Connor & Davidson, 2003) or resilience scale by Wagnild and Young (1993) is example of measures used in research when resilience is conceptualized as a trait. As with resilience defined as an outcome, the trait approach does not account for cultural and environmental influences on individual resilience (Ungar, 2008). The uniqueness of the approach lies in the innate nature of trait resilience.

Dynamic- or Process-Oriented Approach This approach conceptualizes resilience as a dynamic process that involves active adaptation to and rapid recovery from major adversities (Fergus & Zimmerman, 2005; Luthar et al., 2000). Rutter (2006) conceptualized it as an interactive concept wherein there is relative resistance to the risks posed by the environment as well as conquering adversity/stress. Masten (2015), taking a systems perspective, defines it as "capacity of a dynamic system to adapt successfully to disturbances that threaten the function, survival, or development of the system". Invulnerability to psychopathology is not a defining characteristic of resilience here, rather the ability to regain equilibrium is more important (Wagnild & Young, 1993). Thus, adaptability, meaning the ability to be flexible which facilitates recovery and bounce back from adversities and not to break when faced with adversities, is fundamental (Lundman et al., 2010; Walsh, 2006). These would lead to growth when faced with adversity (Southwick et al, 2014). Resilience has earned support from multiple research studies when conceptualized as an aptitude for coping (Stratta et al., 2015). Thus, the process of adjusting/adapting is given importance in this approach. This approach highlights the importance of mediating factors that facilitate positive outcomes in the process of adapting to adversity (Van Breda, 2018). Scales like Resilience Scale for Adolescents (Hjemdal et al., 2006) and Behavioral Assessment System for Children, 2nd Edition (Reynolds & Kamphaus, 2004), are used to measure resilience as a dynamic process.

Norman Garmezy (1974), a pioneer of resilience research hypothesized resilience as a process and not as a fixed attribute. According to this understanding, it is possible that each individual may show resilience across a number of situations/contexts with positive outcomes; however, the same attributes may not be protective for all risks. Moreover, from this point of view, resilience is not an active attribute but has to be understood based on the context. Hence, resilience cannot be measured separate from the context (as a characterological trait) (Rutter, 2012). Resilience is inferred based on challenges and positive adaptation. Challenges are risks, stressors, or any adversity which threatens the well-being of a person or system. Good developmental functioning or competence in an individual or system is an indicator of positive adaptation (Masten & Cicchetti, 2016). Competence can be enhanced through training and support ultimately increasing resilience. The idea that resilience can increase as a dynamic process makes this approach relevant to developing interventions and treatments (Padesky & Mooney, 2012).

A study by Happer et al. (2017) compared the three approaches of resilience mentioned above in youth receiving trauma-specific cognitive–behavioral therapy. The highest support was seen for resilience as a process, which helped to reduce post-traumatic stress and depressive symptoms and an increase in resilience. As an outcome, resilience garnered partial support, and the trait model had minimal or least support of the three. The findings have implications for the development of treatment for not only symptoms of trauma but also in other contexts and symptoms and fostering resilience.

Determinants of Resilience

Determinants of resilience are multifactorial and multifaceted. An attempt has been made to cluster them largely into groups of personality factors, biology, and sociocultural factors.

Personality Factors Researchers have found a correlation between some personality characteristics or traits and resilience over the years. Personality traits like openness, extraversion, and agreeableness (Oshio et al., 2018) help a person be warm, forgiving toward others, and have wide areas of interest (John & Srivastava, 1999). A positive self-concept with high self-esteem and self-efficacy (Liu et al., 2014; Mak et al., 2011), leading to an internal locus of control; good intellectual functioning, cognitive flexibility (reflected in effective cognitive appraisals, emotion resolution skills), resourcefulness, adaptability, sense of coherence, hardiness, optimism, and hope, are found to be related to resilience (Agaibi & Wilson, 2005; Herrman et al., 2011; Joseph & Linley, 2006; Tedeschi & Calhoun, 2004).

With regards to demographic characteristics like age, sex, gender, race, and ethnicity, social relationships, and population characteristics, Herrman et al (2011) reported that there is variable association depending on the method of study and

definition of resilience. These personality traits and features collectively determine how individuals develop and demonstrate resilience when faced with trauma/stress and adversity.

Biological Factors When conceptualized as a trait, biological underpinnings and genes are important determinants of resilience (Yehuda et al., 2006, 2013). During development, brain structure, function, and neurobiological systems are affected by harsh early environments (Cicchetti & Curtis, 2006), which may lead to changes in brain size, neural networks, receptor sensitivity, and synthesis and reuptake of neurotransmitters (Curtis et al., 2003). The brain changes during the developing years influence the vulnerability to future psychopathology by affecting the ability for moderating negative emotions and consequently impact an individual's resilience capacity (Cicchetti & Curtis, 2006).

In a study on maltreated and non-maltreated children (aged 6–12 years), examining the interaction of EEG patterns, resilience, maltreatment status, and gender, it was found that there was a significant difference in the EEG symmetry across central cortical regions between resilient and non-resilient children, with resilient children having greater left hemisphere activity (Curtis & Cicchetti, 2007). Cicchetti et al. (2007) conducted a multilevel study of adrenal steroid hormones [cortisol and dehydroepiandrosterone (DHEA)] in maltreated and non-maltreated children. It was seen that in non-maltreated children, higher resilience was associated with lower morning cortisol, whereas, in physically abused children, higher resilience was related to high morning cortisol levels. Negative relation was found between morning and afternoon DHEA and resilient functioning. Personality variables seemed indicative of resilience. Taken together, personality, cortisol, and DHEA seemed to independently contribute to resilience (Cicchetti et al., 2007).

A longitudinal study of 7500 adult twins demonstrated the role of genes in how individuals respond to stressful life events. Moderate genetic heritability was found for resilience and was equally influenced by genes and the environment (Amstadter et al., 2014). Epigenetics refers to modifications to the gene expression without change in the DNA sequence. Finding support from animal studies (McGowan et al., 2011), human studies have started identifying how stress response regulation is impacted by epigenetic changes (Wu et al., 2013). For example, gene expression and epigenetic changes are associated with PTSD, and they can predict increased risk for and resilience to the disorder (Uddin et al., 2011). The genetic endowments and their expression seem to play a role in how resilient an individual will be.

Sociocultural (Environmental) Factors There is a growing shift toward studying the multilevel dynamic processes of resilience which are embedded in the context of a person's life and the cultural context in which he lives. Belief systems, lifestyle, and coping with adversities, practices, and pooled cultural knowledge are provided by the sociocultural systems of an individual. These factors collectively allow them to adapt positively under normal conditions and resiliently in unfavorable ones (Harkness & Super, 2012).

Wright and Masten (2015, p. 9, Table 1.2) have delineated processes fostering resilience in individuals and families from a multisystemic (bio-psycho-sociocultural systems) perspective which include the following:

- *Within the Individual*: The genetic predispositions, various self-regulatory systems (physiological, emotional, cognitive, and behavioral) lead to immune function, adequate stress system responses, problem-solving abilities, motivation system, cognitive abilities, temperament, and personality. These within individual processes overlap the ones discussed in the previous sections.
- *Within the Family*: Close and secure attachments with family, cohesiveness, structure, and support, effective parenting in sync with the cultural background, beliefs, and financial stability of the family contribute to resilience.
- *Within the Community*: Safe physical environment, good and affordable housing and education systems, community activities, effective public health services, emergency and legal services and access to them, adequate employment opportunities, recreational facilities, religious and spiritual communities, and positive value-laden friendships all foster resilience.
- *Within the Culture and Society*: The sociocultural components include belief systems giving life meaning and purpose, policies related to the protection of children, economy, and health. Accessibility to resources of material nature, law, human rights, peaceful living, and national security and protection from discrimination and violence are all part of the sociocultural component (Wright & Masten, 2015).

Culture was not a major part of resilience research initially, as the focus was more on individual traits, however, that has changed in recent times. Large-scale research, "the International Resilience Project (IRP)", conducted on 1500 youth from 14 communities and five continents, showed a significant amount of variation in the manner of coping even when the youth faced similar adversities. The findings showed that resilience was not limited to cultural and contextual aspects but to the global aspects as well. Some aspects of resilience were common across all youth but were expressed according to the environment they were living in while some were culturally defined. Aspects of resilience were linked thematically across settings/domains and were not limited to individual, relational, community, and cultural aspects. For example in a study, questions related to aspects of self-efficacy at individual levels were linked by participants with their perception of self-efficacy in interpersonal domains and relationships and community (Ungar, 2008).

Further, seven clusters of protective factors have been identified by Ungar and colleagues, which lead to successful coping in the youth in contexts of poverty, parental mental illness and/or death, economic migration, war, and stigma associated with disability.

1. Good relationships with caregivers, extended family, prosocial peers, mentors, and teachers.
2. Identity—having clear aspirations, beliefs, values, spiritual and religious identification; belief about one's competency and respect for one's skills. All these foster self-reflection and boost self-esteem.
3. Social justice—being treated fairly in the community and finding a meaningful role.
4. Material resources—access to adequate food, shelter, and clothing and availability of financial, educational, employment, and medical assistance.
5. Sense of cohesion and belonging—having a sense of being a part of a community and finding life meaningful.
6. Cultural adherence—identifying and adhering to a set of beliefs, norms, and one's cultural practices and beliefs.

Participants' identification with these factors differed as per the context and in degree as well. The meaningfulness of different protective factors is affected by the degree of exposure to adversity (Abramson et al., 2010).

In their research in Afghanistan Panter-Brick and colleagues found that while the country was undergoing conflict for years, family unity, morals, values, and efforts played important protective roles. The belief of Afghan families in the future mattered to them more than the past when considering their well-being in the present moments (Eggerman & Panter-Brick, 2010; Panter-Brick et al., 2011). This indicates that the importance of cultural beliefs that helps in meaning-making plays is extremely important for individuals struggling with unfavorable circumstances. The sense of hope helped them to make sense of life despite all the chaos, stress, and brutality happening around them (Panter-Brick & Eggerman, 2012).

As per Panter-Brick, further focus should be on "structural resilience", that includes building strong structures in society that provides resources and allow people the opportunity for basic facilities such as means to earn for living, housing, and access to education and health care, that leads to realization of their potential (Ager et al., 2013). As is evident, sociocultural factors have a huge role in fostering resilience by affecting exposure to risk factors (Lawrence et al., 2006) and positive protective factors. Hence, research interest in these variables is rapidly gaining impetus (Masten & Cicchetti, 2016).

Interaction of Systems

Interest in resilience research has been moving toward dynamic and interactive systems. Genetic studies offer new insights into gene-environment interaction in resilience. A multidiscipline and multiple system review by Davydov et al. (2010), included studies from behavioral science, neuroscience, and individual, group, and cultural factors. They proposed that these multilevel forces interact in a complex

manner. The layers that interact include a person's genes (biological factors), psychological factors, gene-environment interactions (family, community), the influence of social and cultural contexts, and the interplay of experiences with these factors (Herrman et al., 2011).

The perception of the severity of daily stressors is affected by the family environment, age, and gender of the individual; however, more research is required to establish the interactions of these factors (Charles & Almeida, 2007). However, supporting the idea of gender modulating genetic effects, a meta-analysis related to brain-derived neurotrophic factor (BDNF) Val66Met polymorphism and depression found it significantly associated with men but not women. It had significant protective effects against depression in the former and not the latter (Verhagen et al., 2010). More research is required to establish the relationship between gender, genetics, and resilience.

The general principles of resilience have their place in research. However, it is equally important to realize the variance of determinants from one person to another depending on the personality, kinds of challenges, resources available for the person, the socio-environmental contexts, etc. Resilience is also found to be related to the ability and flexibility in using different coping strategies and incorporating corrective feedback in adjusting the said strategies. Age and maturity have an important role in the variance seen in the determinants of resilience (Southwick et al., 2014).

Vulnerability and Protective Factors

The focus of researchers has been on identifying vulnerability and protective factors and the mechanisms or processes through which they work to result in positive or negative outcomes. Luthar and Cicchetti (2000) describe *vulnerability factors* as those that amplify the ill effects of adverse conditions on child outcomes. These could be parental separation, poverty, negative school climate, etc. Whereas, *protective factors* are those that change impact of risk factors such that negative effects are averted and positive effects are facilitated. As elaborated in the earlier section, protective factors may include individual and environmental factors. Often it is the interaction of these factors that determines the effect of adversity.

Individual, family, and community form multiple levels of influence and lead to different vulnerability and protective factors (Cicchetti & Lynch, 1993; Luthar & Zigler, 1991; Werner & Smith, 1992). Living in a violent neighborhood would be an example of a vulnerability factor at the community level, while having caring adults or peers in school would be protective factors. At the family level, different parenting styles like inconsistent or harsh parenting and emotionally responsive parenting styles would be examples at the family level of the vulnerability and protective factors, respectively. Parental psychopathology can cause vulnerability because of disturbances in parenting behaviors, socialization of emotion regulation, and interpersonal conflicts (Downey & Coyne, 1990; Luthar & Suchman, 2000; Rogosch et al., 1995).

In such situations, social support from extended family and peers can have a protective influence against stress by increasing self-esteem through strengthening a sense of security and perceptions of control in children (Barrera & Prelow, 2000; Wyman et al., 2000).

At the individual level, poor impulse control, low intelligence, and difficult temperament could exacerbate vulnerability to stressors, while a high sense of self-efficacy, easy-going temperament, emotion regulation skills, and internal locus of control can be protective. The nomenclature of a construct depends on its central effect as to whether it is classified as a vulnerability or protective factor or both (Luthar & Cicchetti, 2000).

Indicators of Resilience

Mental health, positive emotions, and life satisfaction are considered as indicators of resilience.

Mental Health

Research has established a significant relationship between resilience and mental health (Hu et al., 2015; Lee et al., 2012). It has been evidenced that more resilient individuals have better mental health, which seems to be the adaptational consequence of resilience (Hu et al., 2015). Resilient individuals have lesser emotional and behavioral problems and depression as seen in the study by Ziaian et al. (2012). This happens because of the buffering effect and protective role of resilience against adversity, thereby minimizing its impact (Gheshlagh et al., 2017; Hu et al., 2015). Resilience is reported to moderate the impact of stress on symptoms of anxiety and depressive symptoms (Gloria & Steinhardt, 2016; Pinquart, 2009; Wingo et al., 2010).

A meta-analysis involving 60 studies by Hu et al. (2015) concluded that lower trait resilience was correlated by lower mental health outcomes such as depression and anxiety while higher trait resilience was correlated with positive mental health. When conceptualized as a trait, resilience remains constant. Hence, research taking this perspective has identified resilience as a stable predictor of mental health, predicting both positive and negative outcomes of mental health such as life satisfaction, positive affect, and depression, and anxiety.

It is seen that individual characteristics such as optimism and internal locus of control help the individuals to be resilient when faced with negative life events and lead to better and improved mental and physical health (Burns & Anstey, 2010; Vaishnavi et al., 2007). Researchers suggest that improving specific protective factors related to resilience may result in reduction of mental health problems in children and adolescents (Luther & Cicchetti, 2000). High levels of protective factors are

associated with lower levels of mental health issues like stress, anxiety, depression, obsessive–compulsive disorder (Dray et al., 2017). Protective factors, as mentioned elsewhere in the text, range from personal to cultural, for example, positive temperament, good social skills or competence, high levels of religiosity, prosocial behavior (Bond et al., 2005), good social support, and family cohesion (Hjemdal et al., 2007, 2011). Most interventions aim to enhance the skills of the person to increase resilience and mental health.

Positive Emotions

Positive emotions that are considered a part of mental health are indicators of resilience and are also said to be a part of trait resilience. As per Frederickson (2001), "positive emotions fuel resilience". This happens as a consequence of broader thinking, outlook, and perspective, leading to enhanced coping. Positive emotions, beliefs, and meaning lead to better and effective use of coping strategies as these act as resources for the same. The contribution of hope and positive meaning in resilience is also supported by the work of Panter and colleagues (Panter-Brick & Eggerman, 2012).

Greater frequencies of positive emotions or experiencing positive emotions daily have been seen to widen the repertoire of available coping strategies and lead to better choices improving stress management (Burns et al., 2008; Cohn et al., 2009; Tugade & Fredrickson, 2004). This, in turn increases resilience an enduring personal resource involving skills such as emotion regulation, problem-solving, and perspective-taking (Cohn et al., 2009). Positive emotions differentiate between resilient and non-resilient individuals by helping the latter face adversities in a better way, leading to growth and better mental health by managing unfavorable situations effectively (Ong et al., 2006; Tugade & Fredrickson, 2004).

Rutten et al. (2013) propose that the direct associations found between resilience and positive emotions may indicate a reciprocal relationship whereby they have the potential to increase each other. In their study Cohn et al. (2009) found that life satisfaction correlates with positive emotions, but depends on resilience as well. So, individuals live satisfying lives because they feel good and have resources to live well. Thus, resilience and positive emotions contribute to physical, mental, and emotional well-being and enable people to live better lives.

Well-Being

Well-being or wellness defined by WHO as "presence of positive mental health" (Friedli & WHO, 2009)] is also equated as "happiness" by some (Linley et al., 2009). Like resilience, the definition of well-being also defies universal consensus and is conceptualized in multiple ways. Schultze-Lutter et al. (2016) list five domains of

well-being: psychological, cognitive, physical, social, and economic domains, thus concluding that it is a multifaceted phenomenon. It is related to resilience in that when resources to meet challenges are adequate, well-being persists; however, if the opposite is the case, disequilibrium manifests. General well-being can predict resilience and mental health (Gao et al., 2017). Resilience is that part of mental health and coping essential for bouncing back from adversity. Therefore, positive health involves the ability to withstand adversities adaptively, having good social–emotional skills and problem-solving abilities. These lead to a sense of competence and autonomy, which allow realizing one's potential, achieving goals, facing life stressors successfully, being a productive member of society, thus resulting in the sense of well-being (Srivastava, 2011).

Resilience, mental health, positive emotions, and well-being are all interrelated concepts, some of them without worldwide consensus over definition. Future research is required to explore their associations and to develop interventions to enhance these in vulnerable populations.

Assessing Resilience

Since there are several of ways of defining resilience, different measures assess resilience differently. To look at the efficacy of interventions, it becomes imperative to assess resilience, be it as a trait, process, or outcome. Most of the assessment measures of resilience were developed for specific intervention studies, so they are restricted in their conceptualization of resilience. The assessment tools described in this section are limited to self-administered scales addressing individual resilience; scales related to community, social, and family variables are not covered.

The Child and Youth Resilience Measure (CYRM) was developed by Ungar et al. (2008) as part of their study to be used in 11 countries (11 languages) for youth at risk (ages 12–23). It is a self-report questionnaire and is culturally and contextually relevant, measuring resilience across four domains (individual, relational, community, and culture).

Resilience Scale for Adolescents (READ) is used to assess personal competence, social competence, structured style, family cohesion, and social resources to understand stress adaptation in adolescents aged 13–15 years. It is a five-point Likert scale having 28 items (Hjemdal et al., 2006).

Baruth Protective Factors Inventory (BPFI) is used for the 19–74 year age group. It is a five-point Likert scale of 16 items assessing four factors: adaptable personality, supportive environment, fewer stressors, and compensating experiences (Baruth & Caroll, 2002).

The Brief Resilience Scale is a self-report measure used for the mean age range of 19–62 years. It was developed as an outcome measure to assess the ability to recover from stress (Smith et al., 2008).

The Connor–Davidson Resilience Scale (CD-RISC) by Connor and Davidson (2003) is a self-report measure used for adults. It has different lengths of 2, 10, and 25 items. The components assessed are personal competence, trust/tolerance/strengthening effects of stress, acceptance of change, secure relationships, control, and spiritual influences. This scale has been used with the PTSD community and other researchers extensively. In a review by Windle et al. (2011), this was one of the most used scales in the evaluating of resilience.

The **Resilience Scale for Adults** (RSA) (Friborg et al., 2003) is again a self-report scale for adults. It measures personal competence, social competence, family coherence, social support, and the personal structure, which are intrapersonal and interpersonal factors that help with adapt to adverse life experiences. The tool finds usage in assessing protective factors that prevent maladjustment and psychological disorders.

The **Resilience Scale** (RS) measures personal competence and acceptance of self and life. It consists of 25 items rated on a seven-point Likert scale (Wagnild & Young, 1990). The scale has been validated for a wide age range and across different ethnicities.

The **Brief Resilient Coping Scale** (BRCS) is a four-item scale rated on a five-point Likert scale used with adults. The aim is to identify the ability to cope with stress and measures only adaptive coping (Sinclair & Wallston, 2004).

In a systematic review by Windle et al. (2011) on scales to assess resilience, the best psychometric ratings were given to the Connor–Davidson Resilience Scale, the Resilience Scale for Adults, and the Brief Resilience Scale. The choice of instrument, however, depends on the nature of adversity being faced, age of participants, and the level of focus of the instruments.

Resilience Interventions

Resilience, conceptualized as a multidimensional dynamic process, proposes that it may have a trajectory in which there may not be any mental health disturbances, or there are temporary dysfunctions and successful recovery during or after adversities (Kalisch et al., 2015). The interventions to promote resilience are conceptualized on the premise that certain psychosocial factors contributing to resilience are modifiable. Some of the resilience factors that are identified as modifiable and which demonstrated strong evidence (level 1 evidence—systematic reviews and meta-analyses) are self-esteem, self-efficacy, active coping (problem-solving, planning), religiosity or spirituality or religious coping, social support, cognitive flexibility (reappraisal, acceptance of negative situations and emotions), sense of coherence, optimism, positive emotions, hardiness, and purpose in life. There was a moderate evidence (only systematic reviews or single meta-analysis) for the locus of control, hope, humor, and weak evidence (no systematic reviews or meta-analysis) for altruism (Kunzler et al., 2020).

Resilience interventions are conducted across different points in time in relation to the exposure to stressor, which includes before exposure, during and after the exposure to stressor. Interventions carried out before include training programs conducted in preparation for an imminent stressor, for example, military deployment, police induction, assignment of particular operations, etc. This is done to increase preparedness and to prevent mental health problems. Interventions during the stressor include training programs conducted at workplaces. After interventions typically include those conducted after a disaster, emergency situation, etc.

Community-level resilience interventions aim to enhance community resilience. They are supposed to prepare the community to cope with collective traumas like natural disasters, terrorist attacks, and health emergencies that disrupt many systems at once. These approaches recognize that individuals in the community are connected and dependent on one another with respect to response, adaptation, coping, and preparedness in the face of adversities. Interventions strengthening the supports available before the disaster are said to protect mental health in the aftermath of the disaster. Some of the components that are found to be helpful are providing resources for safer neighborhoods, affordable housing, access to health care, instilling hope and sense of dignity, and effective schools (Abramson et al., 2015; Hall & Zautra, 2010). Universal interventions are provided children are at higher risk, for example, military communities, children from broken families, poverty, etc. (Boberine & Hornback, 2014). Though it is a much sought after intervention by both government and non-government organizations, there is no commonly agreed upon definition of the same across the studies conducted addressing the community resilience. A review study found nine common core elements among the definitions of community interventions,they are: local knowledge (about vulnerabilities, information related to disaster, first aid, belief about ability to withstand hardships, etc.), networks and relationships within the community (ties, shared values, trust, etc.), health (available health services, delivery of health services after disaster—physical and mental health), governance and leadership (infrastructure and services, public involvement) communication within the community (communication networks—mode, content, clarity, and appropriateness) resources available (tangible and intangible), economic investment (programs to aid economic growth), preparedness (at individual, family, and government level), and mental outlook (tolerance toward uncertainty, hope, and willingness to adapt) (Patel et al., 2017).

Resilience Interventions: Format, Components, and Outcomes

Most of the studies examining resilience interventions are conducted in a group format, while some are conducted in training format as well as in individual settings. The delivery formats include largely face-to-face in most of the studies, and the other modalities included online or mobile-based training programs or a combination of

different formats. However, online training is a recent trend, and very few studies have examined this format. The number of sessions ranged from.

The resilience training/interventions are based on different therapeutic assumptions and models. The operationalization of the therapy/components varies across studies (Leppin et al., 2014). The guidelines for considering a particular intervention as resilience intervention/training are unclear. Generally, the methods used in resilience intervention/training include psycho-education component (stress, adversity, resilience, coping, cognitive restructuring, etc.), discussions, role plays, practical exercises, and homework assignments. Generally, the frequently used psychotherapeutic approaches include the following:

Cognitive–Behavior Therapy (CBT) The basic assumption of CBT is that cognitive appraisal of the stressor leads to a stress reaction. Hence, modifying the appraisal into more adaptive patterns and teaching adaptive coping strategies will result in adaptive responses to stress and cognitive flexibility (Kalisch et al., 2015). The behavioral strategies such as relaxation and diaphragmatic breathing is used to improve coping and reduce physical symptoms of stress.

Acceptance and Commitment Therapy (ACT) ACT proposes that stress is experienced due to inflexible patterns of handling stressful situations and non-acceptance of emotions. ACT-based interventions teach acceptance and mindfulness skills, commitment, and value-based actions which help in a better adjustment to stressful situations (Hayes et al., 2006).

Mindfulness-Based Therapy Mindfulness comprises non-judgmental awareness of the present moment (including physical sensation, thoughts, and feelings), acceptance of the experiences from "here and now" perspective, and inculcation of *being mode*. Mindfulness-based resilience interventions help the individual to increase cognitive flexibility, accept negative emotions and thus adapt to stressors more efficiently (Grossman et al., 2004).

Problem-Solving Therapy It is based on a problem-solving model of stress and adaptation. Resilience intervention based on this model teaches positive problem orientation and problem-solving skills, thus facilitating active coping and psychological adaptation to stress (Nezu et al., 2013).

Stress Inoculation Therapy (SIT) is based on the theory by Meichenbaum (2007) which proposes that exposing individuals to milder levels of stress would strengthen their coping with stress and foster resilience. This approach is used to increase the preparedness to handle natural disasters, cyclones, etc., in the prone communities (Morrissey & Reser, 2003).

Integrative Approaches These interventions combine components of all the above-said theoretical approaches. For example, Universal Preventive Resilience Intervention Globally implemented to improve and promote mental Health for Teenagers

(UPRIGHT) applied in schools of European countries has four components: mindfulness, coping, efficacy, and social and emotional learning (Horizon, 2020).

New models of interventions have been tried out recently. One of them is a prevention protocol based on the Ryff's well-being model named Cultivating Our Resilience (CORE) program a self-administered online program aimed at promoting resilience and coping skills in University students. It is a 6-week program with six main components: autonomy, self-acceptance, mastery of the environment, purpose of life, positive relationships, and personal growth (Herrero et al., 2019).

A meta-analytical review on the nature of interventions carried out to enhance resilience shows that three categories of interventions were most frequently used (1) cognitive–behavior therapy-based interventions (2) mindfulness-based interventions (3) mixed intervention–combination of cognitive–behavioral and mindfulness interventions. A moderate positive effectiveness was reported for all the three interventions on individual resilience (Joyce et al., 2018).

All these approaches work; however, the mode of action of these interventions has not been examined (Leppin et al., 2014), and in addition, the comparative efficacy of these interventions also has not been examined. However, irrespective of the theoretical background, face-to-face interventions carried out individually are more effective than online and group-based interventions (Vanhove et al., 2015). The resilience training programs are examined across healthcare professionals, college students, children, cancer survivors, youth workers, immigrants, rescue workers, military officers, and general office workers (bank employees, university employees, customer service professionals, managers, physicians, etc.). The common aim of these programs is to enhance resilience/resilience resources. The effects of the resilience interventions may also vary across the target groups which depends on the stressor load. Target groups with a greater risk of experiencing stress and with higher load of stress benefit more from the resilience interventions (Vanhove et al., 2015).

With respect to outcomes examined, most interventions are focused on enhancing resilience through increasing personal skills; however it is also important to focus on enhancing an individual's interaction with others in order to attract and utilize social support. A review of the interventions aiming at increasing the social and behavioral skills to strengthen the social networks was carried out with subjects preparing for surgery, those with cancer and substance abuse disorders. It was found that more than 80% of the studies reported benefits such as reduced psychological distress and decreased substance abuse (Davidson & McEwan, 2012; Hogan et al., 2002). The bidirectional nature of resilience has been highlighted in couple-based intervention (cognitive–behavioral conjoint therapy) carried out in individuals with PTSD (Monson & Fredman, 2012). There is preliminary evidence that bidirectional therapy results in an improvement in both individual as well as dyadic resilience. However, the

literature is limited in this area. It is suggested that interventions including different levels like a romantic partner, family unit, and community may be more inclusive and effective.

Resilience Interventions in Adults

Interventions to promote resilience in adults are relatively less compared to children and adolescents. One such study examining the preliminary evidence of a group-based resilience training was conducted in a workplace setting ($n = 16$). The program was named Resilience and Activity for every DaY (READY). The outcomes considered for the study included positive emotions, cognitive flexibility, social support, life meaning, and active coping. The intervention was based on acceptance and commitment therapy and cognitive–behavior therapy strategies carried out over 13 weeks (weekly once). The authors reported significant improvement at post-assessment on variables such as mastery, positive emotions, personal growth, mindfulness, acceptance, stress, self-acceptance, valued living, autonomy and cholesterol levels (Burton et al., 2010). A review study on non-clinical samples of adults (professionals) showed that overall the resilience programs were beneficial though programs were from different theoretical bases, lengths, formats, and modes (Macedo et al., 2014). Another important review examined resilience intervention in the workplace and its impact on mental health, subjective well-being, psychosocial outcomes, performance outcomes, and biological outcomes. They found improvement in all the domains though there were methodological limitations in most of the studies (Robertson et al., 2015).

Healthcare professionals (HCFs) especially those involved directly in providing care such as doctors, nurses, psychologists, social workers, and hospital staff are at increased risk to experience stress. Interventions promoting resilience are implemented and assessed for their effectiveness in this group (Kunzler et al., 2020). Most of the studies included group interventions for resilience training and delivered face-to-face. The average number of sessions was 12. The theoretical foundations on which these interventions were based included mindfulness and cognitive–behavior therapies. Most of these were compared with waitlist control groups. Resilience interventions resulted in improvement in resilience, reduction in levels of depression, and perception of stress. However, no differences were reported with respect to anxiety, well-being, or quality of life. The effect sizes were moderate for resilience and stress reduction and were small for the rest of the variables indicating a very-low certainty evidence for HCFs. Long-term studies with improved study designs may throw more light on the effectiveness of these interventions.

Resilience Interventions in Children

The resilience interventions in children and youth are carried out at three levels: (1) at the individual level—foster competencies and promote mental health (2) at the family level—interventions address positive parenting, bond with parents, parent–child communication, and family management and (3) at the community level—connecting with community resources, building social capital, learning to provide service and to organize community youth activities (LeMoine & Labelle, 2014).

Most resilience interventions in children and adolescents are designed to prevent mental health problems or promote mental health, build social and emotional competencies, foster care, and build self-esteem and self-efficacy. Mental health in these studies was defined to include depression, anxiety disorders, social and emotional well-being, eating disorders, substance abuse, conduct disorders, and suicide. A review study on preventive and promotive resilience interventions showed that interventions generally included CBT-based interventions [Penn resilience program (PRP), FRIENDS programs], parenting skills interventions, brief psycho-education intervention, school-based interventions, family-based interventions, mindfulness, and arts therapy. Many of these interventions included both children and their parents. These interventions were effective in enhancing resilience and reducing risk of mental health problems (Reavley et al., 2015). A review study also categorizes the interventions as those that enhance resilience, prevent depression, anxiety, and suicide; those that prevent eating disorders; prevent behavior problems, and those that prevent substance abuse. A systematic review involving 5–18 years, with a follow-up up to one year, showed that resilience-focused interventions were effective in reducing depressive symptoms, internalizing and externalizing problems and psychological distress. The short-term outcomes included reduction of depressive and anxiety symptoms, whereas long-term outcome included internalizing problems (Dray et al., 2017). For the students in university (above 18 years), mindfulness-based intervention (mindfulness skills) in addition to mental health support was found to be effective in reducing the psychological distress levels (Galante et al., 2018). However, more studies are required for establishing the comparative effectiveness of the same.

The most common setting of the resilience interventions was school, and the other setting included mental healthcare agencies and detention centers. Some of the early interventions found to be effective in children are grouped according to the age group. The effective interventions for early childhood are largely designed for caregivers (Leve et al., 2012).

- Attachment and biobehavioral catch-up (ABC)—aimed at promoting attachment security and healthy regulation of stress response of the child by teaching the caregivers the skills of being responsive to the child's emotions and nurturing.
- Multidimensional treatment foster care for preschoolers (MTFC-P)—trains foster caregivers to provide positive adult support to the child while being consistent in the limit setting.

- Bucharest early intervention project (BEIP)—provides ongoing support for foster caregivers to manage challenging behaviors, develop attachment relationships, and facilitate language development.

Some of the interventions aimed at middle childhood and adolescence are as follows:

- Incredible years (IY)—includes co-parenting between foster and biological caregivers in order to understand the child better and enhance open communication and negotiate inter-parental conflict.
- Keeping foster parents trained and supported (KEEP)—supported foster parents in applying behavioral management strategies.
- Fostering individualized assistance programs (FIAP)—focuses on planning the services around the individual needs of the child to reduce behavioral and emotional problems and improve placement.

A few programs specifically focus on addressing the mental health problems such as FRIENDS intervention. This program uses CBT principles to teach social and emotional learning and to enhance protective factors in youth in school settings. It is found to be effective in reducing anxiety, depression, anger, post-traumatic stress and dissociation and enhancing self-esteem. Similarly, leadership, education achievement and development (LEAD) intervention is aimed at reducing the risk of minority youth involved in the juvenile justice system. The program involves activities to enhance self-awareness, communication skills, self-control, and self-esteem (Shelton et al., 2009).

Resilience interventions conducted with at risk youth are generally multipronged which simultaneously addresses students, parents, and teachers. These interventions can be divided into three categories (1) training on intrapersonal skills as a source of resilience—used with primary and middle school children, aimed at reducing at risk behaviors such as substance use, sexual behaviors, behavioral problems, and mental health problems. Some of these programs are Seattle social development program, Iowa strengthening families program, child development project, and life skills program. (2) Family and secure attachments as a source of resilience—the focus here is on building stable relationships within the family, enhancing authoritative parenting and building strong attachments. A few examples of these programs are adolescent transition program, family matters, and guiding good choices. Most of these interventions resulted in reduced alcohol use. (3) Community as a source of resilience—these interventions aimed at facilitating connectedness and building social capital at school, neighborhood, and with important adults. The interventions included building resilience through social capital (high support neighborhoods, greater participation in community activities, and engaging youth in community service), building resilience through service learning and organized community youth activities (extracurricular activities) (Davies et al., 2011).

Resilience-based interventions are generally implemented across various groups of vulnerable children. Review studies indicate that these interventions promote

psychosocial factors such as self-efficacy, self-esteem, and positive coping and mitigate mental health problems such as depression and anxiety among children and youth in low-and middle-income countries (Barry et al., 2013). A six-week resilience intervention with components to address protective factors, positive reinforcement, and psychological education was found to increase social resources (self-esteem and personal assets), cultural adaptation, self-efficacy (coping with homesickness, mixing with others), and making positive meaning of adversity in the migrant school children in China (Tam et al., 2020).

The compensatory framework of resilience encompasses individual protective factors such as self-esteem, competencies such as positive coping and environmental resources (social support) which mitigate the negative influence of the adversities (Dray et al., 2014). The interventions based on this model focus on building strengths and facilitating individual protective factors along with environmental resources in the context of the environmental adversities (Hart & Sasso, 2011).

Resilience Interventions and Sustainability of Positive Mental Health

Research has established the relationship between resilience and mental health. While resilience is negatively associated with mental illness (anxiety, depression, suicidality, stress, etc.), it is positively associated with positive mental health (e.g., life satisfaction, subjective well-being, hope, and positive emotions) (Nrugham et al., 2010; Satici, 2016; Shapero et al., 2019; Tomyn & Weinberg, 2016). However, many studies focus on the associations and predictive relation of resilience to mental illness and wellness. Intervention studies mostly have documented effects of resilience interventions on reducing symptoms of mental illness and increasing well-being and positive emotions (Dray et al., 2017; Waugh & Koster, 2015). Longitudinal outcome studies to document the sustainability of the effects of resilience interventions are very sparse. One such study conducted in young adolescents (5th and 6th graders) examined effects of a universal stress management program and followed up for more than a year. The results indicated that the effects were maintained for stress awareness (Kraag et al., 2009). Another study evaluating emotional well-being programs for disadvantaged school children reported that at one-year follow-up the improvement in self-awareness, self-regulation, motivation, and social skills was maintained. However, there was no significant change in emotional and behavioral problems (Clarke et al., 2014). The researchers highlight the lack of follow-up in most studies for a host of variables including mental health outcomes. The effect sizes in most of these studies were small to moderate. Long-term mental health outcomes of resilience interventions in adults are very far and few (Forbes & Fikretoglu, 2018; Kunzler et al., 2020). One study reported reduction in anxiety scores at six-month follow-up after a stress management study (Timmerman et al., 1998), and another study reported improvements in mindfulness and self-compassion at

four-month follow-up, following a mindfulness training program (Pidgeon et al., 2014).

Conclusion

Resilience is a universal, multifaceted phenomenon, presently without a consensus on its definitions. There is a continuing research interest in this field, where each approach of research has focused on different aspects of resilience. The concept has broadened in scope and has come to include resilience as a trait, outcome, and a dynamic process. Research support is found for these multiple ways of understanding resilience; however, the most robust support is for resilience as a dynamic process. Resilience is dependent on time, developmental influences, context, and culture. Thus, it is a result of constant interactions between the individual and the environment, and hence, what is resilience enhancing in a phase of life may become interfering in another phase. Resilience is present on a continuum in an individual, being resilient in some domains of life and not in others. For ease of understanding, the determinants of resilience are grouped into personality, biological and sociocultural factors. However, the interaction of these variables is complex and influential at multiple levels, creating an interplay of vulnerability and protective factors.

Researchers have observed a relationship between resilience as a protective factor for better mental health outcomes, establishing mental health as one of the indicators of resilience. Resilience is seen to moderate effects of stress on mental health. Positive emotions enhance the coping repertoire of individuals. Also, positive emotions and resilience have been seen to reciprocally enhance each other, leading to better mental health outcomes. Well-being is conceptualized as having positive mental health and happiness; can mediate a moderate relationship between resilience and mental health. Overall, mental health, positive emotions, and well-being are taken as indicators of resilience, given their relationship with the construct. Owing to the importance of resilience in mental health and general well-being, specific resilience enhancing interventions have been formulated worldwide. To assess the efficacy of these interventions, it becomes important to be able to measure the construct of resilience. Since most of the assessment measures of resilience were developed for specific intervention studies, they are restricted in their conceptualization of resilience. The ones mentioned in the text are individual level, self-administered scales. Given the complexity of the phenomenon, assessing it efficiently and accurately is a challenge, and the existing tools also are limited to capture the complexity. Often the measures fail to discriminate between the trait and outcomes aspects of resilience. These relationships and the dynamic process of resilience guide the interventions developed to bolster resilience throughout the world.

Some of the problems identified in assessing the of efficacy of resilience-based interventions are (1) definition of resilience as a trait or blend of resilience factors (2) using tools that are not suitable to assess resilience (3) inappropriate research designs. The researchers suggest an outcome-oriented definition and appropriate

research designs in order to establish the utility and effectiveness of resilience-based interventions (Chmitorz et al., 2018).

It is also crucial to keep the severity of the adversity in mind. Authors differentiate between two kinds of resilience, viz. "emergent resilience"—refers to resilience following a chronic adverse event and "minimal-impact resilience"—which is resilience following acute adverse events (Bonanno et al., 2015). In order to understand the phenomenon as a dynamic process, the studies should use designs, wherein the resilience training is provided before the stressor (before posting into a stressful situation—military, emergency ward, disaster management, etc.); provided during the stress and after facing the stressor (Chmitorz et al., 2018; Kalisch et al., 2015). If resilience is understood as an outcome, mental health becomes an important outcome despite stress, and thus, assessment for stress and mental health becomes crucial (Salguero et al., 2011).

In addition, most of the studies considered changes in the scores on resilience scales to detect improvement, and none of them examined the effect of the intervention on the impact of adverse events. In the sense that there are no prospective studies examining the utility of these programs on the future adverse events (Joyce et al., 2018) implicating the need for longitudinal prospective studies. Overall, resilience remains one of the most researched concepts with diverse conceptualizations and approaches that underscore the complexity of the construct, still leaving room for more focused research. In the context of the regular adversities faced at individual and societal levels across the world, resilience interventions garner utmost importance.

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Chapter 27
Resilience and Well-Being Among the Survivors of Natural Disasters and Conflicts

Subhasis Bhadra and Allen R. Dyer

Abstract Disaster response requires a focus on resiliency and well-being rather than just absence of disease. While medical attention is necessary in the immediate aftermath of disaster, well-being involves attention to the psycho-social and spiritual determinants of health. The scientific study of disasters from Boston's Cocoanut Grove nightclub fire to the Bhopal Chemical spill have identified features and approaches that have been refined to prove useful in subsequent disasters. The authors illustrate best practices of mental health and psycho-social support drawing on lessons learned and applied from a number of disasters including the Gujarat Riots of 2002, the Indian Ocean Tsunami (2004), the Iraq War (2003 onward), the Great Sichuan Earthquake (2008), the Haiti Earthquake (2010), the Japan Triple Disasters (2011), the Syrian refugee crisis (2015 onward), and the 2017 hurricanes in the Caribbean. This chapter draws a contour of the survivors of different disasters from the historical perspective touching upon the different interventions done for strengthening resiliency among the diverse group of survivors through community intervention strategies for enhancing their well-being. Focus on survival after disaster is essential, but the complex negative life events produce traumatic stress and emotional turmoil that challenge coping abilities. Thus, resilience building activities are essential to build the capacity of the survivors to bounce-back with enhanced capabilities, better functionalities, higher level of adjustment and satisfaction, and the confidence to deal with future eventualities. Thus resiliency building activities are essential components of psychosocial support programs with a focus of enhancing well-being.

Keywords Resilience · Well-being · Survivors · Natural disaster · Conflict

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_27

Introduction

Disasters in different forms, intensity, and frequency have shaken and shattered the life of the survivors in various parts of the globe. Disaster is threatening and impacts are grave often continue over decades and generations. The damages to human life, environmental ecology caused by the disasters are the major concerns that impact the well-being of the people. Historical researches have shown a number of evidence that human lives from the ancient age have been affected by disasters and many civilizations were completely destroyed. The climate change and subsequent events, like flood, water upsurge, drought, earthquake, spread of disease, in combination with social factors, were the reason for the collapse of many great civilizations. Human life was severely affected, and struggle for reconstruction over decades and centuries further paved the way for new settlements and civilization. The disaster is mainly understood by its impact on human life than anything else. Human life and well-being are closely connected. Further, the essential components for maintaining well-being, namely social justice, equality, equity, human rights, welfare, social security, freedom, all became further prominent features of human life and civilization. Thus, disaster and development are both part of human life that destroy and design the growth for progress in the path of well-being. Neither disaster, nor development is independent of human action. In other words every disaster is a result of human action, as well as every development is equally being driven by humans. It is theoretically established that there is no disaster without human hands (Steinberg, 2000). The impact on human life is a consideration to call a situation a disaster. Earthquakes do not kill people, neither floods nor cyclones. The poor construction of buildings, living near sea, in flood plain, or being on the path of cyclones cause deaths, injuries, and destruction. Similarly, an earthquake in a barren land or flood in uninhabited desert is not a concern for humans, neither called as an event of disaster. Therefore, disaster is understood as social events that severely impact the life and well-being of the survivor in short and long-term. It is not only the event of disaster, rather the subsequent support for revival, opportunities for regaining confidence and maintaining normalcy become important. In the post-disaster period, lack of support makes the situation even more difficult for the survivors that linger on their suffering, thereby returning to normalcy become even more challenging. In the face of disaster revival depends on many associated psychosocial factors, in addition to the physical support, political situation and engagement of the survivors, civil authorities, humanitarian workers, and organizations in the process of recovery. In this phase of survival and recovery, resiliency becomes an important psychological factor that plays an essential role in activating the energy of individuals, groups, and communities to work together in close cooperation to deal with all odds. Resiliency facilitates positive coping and abilities to deal with odds in the face of disaster. Therefore, resiliency is empowering and it is about the capacity to transform oneself in a positive way after a difficult event" (Annan et al., 2003) and in other words resiliency is enhanced abilities to cope with difficult situations. Thus, resiliency and well-being are closely related to each other and one influences the other. Disaster interventions are to improve well-being

through reconstruction, and rebuilding the psychosocial resources, keeping in view the intensity and impact of the disaster immediately and in the long term. This chapter highlighted understanding different types of disasters and the historical perspective in the development of psychosocial support as an important intervention and the implication of the same in different disasters intervention across the globe. This chapter has drawn the specific learning and recommendation for future implication to strengthen resiliency and well-being among the survivors of disasters.

Understanding Disaster

Disaster is multi-dimensional, impacts the wide sphere of life of the survivors, that grossly deteriorates their well-being, imposes hurdles to regain normalcy, thereby often growth and developments are hindered. Disaster is a major challenge toward attaining and maintaining a sustainable environment. Disaster destroys the psychosocial ecology and the environmental equation that impose serious threat on sustainable development. The WHO definition of disaster pointed out that "disaster is a severe disruption of ecological and psycho social balance which greatly exceeds the coping capacity of the affected community" (WHO, 1992). Disaster is understood from different angles, like the damage, extent, consequence, cause of a disaster, as a social event, and so on. Disaster is characterized as centrality that breaks down every day functioning, gross disturbance in normalcy and insufficiency of the system to deliver services. Severity of disaster and aftermath are closely associated with political stability, level of development and repression exercised by an authoritarian regime (Lopez-Ibor, 2005). Quarantelli's (1998) postmodern perspective considered disaster from the perspective of the survivors and increase in the apprehension of lack of social justice and equality. For humanitarian response to facilitate relief, rehabilitation, and rebuilding the basic two type disasters are human-made disaster and natural disaster (Parasuraman & Unnikrishnan, 2000). Human-made disasters are consequences of human error or human intention, whereas natural disasters are inclemency of nature (Lopez-Ibor, 2005). In natural disasters, the survivors receive more empathy and support, most of the time it is predictable and gives some time for the people and authorities to act on preparedness. Except for earthquakes, most of the natural disasters, like cyclone, tsunami, flood, drought, etc., are better predictable with the use of advanced technology. In human-made disasters while human intention to cause harm is involved, like the situation of war, terrorist attack, bomb blast, communal rift, the situation becomes highly volatile and survivors feel very helpless. Usually such events are quite predictable considering the vulnerability factors within the socio-political situations, yet preventing them become quite challenging, as the causes of such conflict are quite deep rooted within the socio-cultural, economic, and political situation of the community, region or state. The accidents are too human-made disasters due to human error. The classic examples are Bhopal Gas Leakage of 1984 in India and Gulf war oil Spill disasters 1991. There are many such disasters that severely impacted the life of the survivors.

"Disaster Management in India" (GOI-UNDP, 2012), published by the Ministry of Home Affairs, New Delhi has classified the disasters in eight different types to ensure effective management protocol considering the nature and origin of forces causing the event of disaster.

1. **Climatic Condition and Water-Related Issues Causing Disaster**: The abrupt climatic conditions often impacted the water bodies, flow or scarcity that caused disasters. Tsunamis, Floods, Overflowing River and Drainage System, Thunder, Lightning, Cyclones, Hurricanes and Tornadoes, Heat and Cold Waves, Cloud Blasts, Avalanches, Hailstorms, Coastal Zone Erosion, and Droughts.
2. **Inappropriate Geological Condition Causing Disaster**: Earthquakes, Landslides, Minor fires, Dam blasts.
3. **Disaster Caused by Accidents**: Incidents of Fire in Urban/Village Area, Collapse of Building/ Bridge/Other Infrastructure, Forest Fires, Oil Spills, Serial Bomb Blasts, Disasters in Festivals, Electrical Disasters, Air/Road/Rail Accidents, Boat Capsizes.
4. **Industrial Disasters and Accidents**: Industrial accidents impacting a large number of individuals, threatened safety and security.
5. **Chemical Disasters**: Chemical Poisoning, Leakage of Chemicals, and similar conditions, impact the life of individuals, imposing threat on the environmental ecology, flora, and fauna.
6. **Disaster Related to Biological Incidences**: In this kind of disaster the biological agent becomes an important cause of the disaster, like food poisoning, cattle epidemics, pest attacks, epidemics, and use of biological weapons.
7. **Radiological and Nuclear Disasters**: This disaster may be due to warfare or accident. Some examples are leakage of disposed of radioactive substances into the environment, nuclear accidents/ disasters, use of clear bombs in war.

According to this categorization, E, F, and G together are called CBRN (Chemical, Biological, Radiological and Nuclear) disasters, which are imposing severe threat on the well-being of the human life and environmental condition and becoming the major worry for civilization in the twenty-first century. Chemical disasters are intentional or unintentional release of hazardous substances in the environment that cause harm to human life and nature. Human error, technology failure, accidents, and terrorist attacks may cause a chemical disaster. "Biological disasters are scenarios involving disease, disability or death on a large scale among humans, animals and plants due to toxins or disease caused by live organisms or their products" (NDMA-GOI, 2008). Biological disaster may appear in the form of epidemics or pandemics or it may be man-made by the intentional or accidental spread of disease causing agents in the atmosphere leading to severe harm. Biological Warfare (BW) or incidents of Bioterrorism (BT) are emerging as a bigger threat to civilization. The pandemic COVID-19 is a biological disaster that has grappled the normal life of people all over the globe. The Sarin gas attack on the Tokyo subway, in 1995 of the chemical bombing in Iraq, Syria from 2007 onwards and use of chemical explosives in terrorist bombing across the globe is increasing and showing the threat to human life.

While this nuclear technology or radioactive substance was invented, was considered as a great advancement to support the development of civilization. But, gradually over at least 30 years these technologies become part of warfare and pose a major threat for humanity. During World War II the nuclear bombing on Hiroshima and Nagasaki showed the devastating power and still the war memorials in Japan remind me of the horror. Further, access of such technologies in the hands of terrorist groups, or the attitude of the rogue nations is increasing the threat of CBRN disasters. Nuclear disaster with radioactive substances leaves a very long trail of suffering that can even cripple the biological balance of an organism and deformities continue for generations. Radioactive substance and exposure to radiation impose various threats to any living organism. Chernobyl nuclear disaster, in Ukraine, Russia in 1986, and leakage of radioactive substance from Fukushima Daiichi Nuclear Power Plant in 2011, in Japan following the Tsunami showed the danger due to nuclear disasters on its consequences on the well-being and threat toward sustainability of the environment.

The overlapping of disasters which are continuing over years cause more survival challenges for the people. Such a situation is called a complex emergency. During emergencies the main challenge for humanitarian workers is to deliver the support in a difficult political and security environment. In complex emergencies the livelihood of people are absolutely destroyed and there are severe threats on the life of common people due to warfare, civil disturbances that lead to large scale displacement and movement of people for securing safety and basic survival. The term complex emergency encompasses severe violence, large-scale conflict, and civil war that are often intended towards ethnic cleansing and genocide. The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) defines a complex emergency as a "humanitarian crisis where there is a breakdown of authority resulting from internal or external conflict and which requires an international response" (Keen, 2008, p. 237). Complex emergencies are human made and characterized by widespread damage to socio-economic structure and often the problems continue for long with political instability. There is an increase in complex emergencies over the last three decades and it poses a threat not only to a national, but also to other neighboring nations and to the region. The complex emergencies are constantly giving rise to the number of refugee and internally displaced people. According to the report (IDMC, 2020), there are 8.5 million people in 50 countries displaced due to conflict and violence (IDMC, 2020). Majority of such events happened in the low and middle-income countries where the life and well-being of the people are considerably low. Syria, Democratic Republic of Congo, Ethiopia, Burkina Faso, and Afghanistan accounted for highest displacement due to complex emergencies. Many other countries of sub-Saharan Africa without any unstable government are experiencing continuous civil unrest and huge humanitarian crises.

In the twenty-first century the intensity and frequency of disasters are continually increasing due to climate change, global warming, and political unrest. The climate change and related disasters are causing displacement of a number of people worldwide and the number of climate refugees is increasing too, as the survivors are losing their home, belongings, and livelihoods. Climate or environmental refugee the term

was coined by Essam El-Hinnawi, in 1985 in one of the UNEP (United Nations Environment Programme) publications (UNEP, 2017). Climate refugees are those people who are forced to leave their traditional habitat, housing, and livelihood because of marked environmental deterioration, disturbances that severely jeopardize their existence and seriously affect their quality of life and well-being. The people may have to leave temporarily or permanently, considering the environment situation and future course of support that they receive for rehabilitation in their traditional habitat. Though, the term climate refugee is not yet recognized by UNHCR. Increasing unplanned human consumption and uncontrolled human aggression worldwide are the important reasons for increasing the number of disasters that are daunting to the well-being and sustainability.

Working with the survivors of different disasters largely depend on the nature of the disasters, the impact, supporting environment, access to the affected areas by the national and international organizations, concern of security and safety of the humanitarian workers, and also the socio-political engagement and environment of the civic authorities of the nation. Ideally, the process of working with the survivors is empowering at the core that results in enhancing resiliency and restoring well-being keeping social justice and human rights at the focus. Though the realities of the disaster interventions program differ in different countries in varied contexts, working with survivors is an international commitment, equally important for attaining the sustainable development goals (SDGs).

Understanding Resilience in Disaster

The resiliency building is an empowering process. Barker (2003) defined empowerment as "the process of helping individuals, families, groups, and communities to increase their personal, interpersonal, socio-economic, and political strength and to develop influence towards improving their circumstances" (p. 142). Disaster is severely threatening toward the existence of the individual and community. Therefore, enhancing resilience is crucial for empowering the survivors to develop adequate coping abilities to deal with odds due to disaster and also strengthening capacity to deal with future problems and eventualities. The individual dimension of resiliency examines two important perspectives; exposure to the adverse situation like disaster and ability to adapt; and further quality of adoption to the adversities positively (Masten, 2001). In an adverse situation of disaster, the survivor would be able to deal with the same based on his/her capacity and resources (both physical and psychosocial) available. "The ability to spring back from and successfully adapt to adversity is resiliency" (Henderson, 2012). "Resiliency is the capacity to transform oneself in a positive way after a difficult event" (Annan, et al., 2003) and in other words resiliency is increased or enhanced ability to cope with difficult situations. A resilient individual is expected to have higher order of functionality to attain well-being in the long-run. Higher-order functionality helps to create a pathway of development in life.

After a disaster the resiliency building activities are expected to enhance the functionality and corresponding well-being for development and ultimately the person becomes resourceful for the community too, for working for the development of the surviving community. Therefore, resilient individuals can influence the community development, reconstruction, rehabilitation and hasten the process of recovery. Masten (2011) defined resiliency from a dynamic systems theory perspective, "the capacity of a dynamic system to withstand or recover from significant challenges that threaten its stability, viability, or development." In this context the community perspective of resilience in disaster recovery becomes equally important.

A resilient community is able to cope with disturbances or changes and maintain adaptive behavior. Community resiliency is about developing the abilities to deal with and respond, mitigate, prevent effectively any threat that may be natural or human made. For understanding community perspective of resilience, level of adoption at community and population wellness should be measured. This explains "high and non-disparate levels of mental and behavioural health, role functioning, and quality of life in constituent (i.e. disaster affected area) populations" (Norris et al.2008; Potangaroa et al., 2015). A resilient community can recover faster and has less vulnerability. They will have capacity to act quickly and respond to disasters. Resiliency is a positive trajectory of functioning, a network among the members, cooperative relationships among the multiple stakeholders, including civic authorities, community-based organizations, youth groups, education department, health workers, child care, family care workers, and other existing systems. Resiliency may not always be a natural outcome, and it is different from fending for survivals. Immediately after a disaster the survivors try to help each other and cope with the situation, is a basic survival instinct during the phase of "honeymoon." In contrast resiliency allows people to respond positively and in a planned manner that is an outcome of disaster preparedness, or mitigation efforts. Resiliency helps in the process of rehabilitation after a traumatic event, and the resilient individual displays higher abilities to adapt to the situation. After the experience of loss there are two types of outcome, through a resilient reintegration process explained by Richardson (Richardson, 2002). An individual can accept the loss and gain a bio-psycho-social-spiritual homeostasis, or may dysfunctionally reintegrate, that result into maladaptive behavior and negative coping. For resilient reintegration two important contributing factors are, internal resources (like, positive coping style, higher self-esteem, motivation, decision-making abilities) and external resources (like, availability of resources, support systems, community networks). Thus, well-planned disaster rehabilitation programs essentially focus on survivors' resilient reintegration, for facilitating normalcy, and even work towards "build-back-better" principles in the long-term.

Resilient communities maintain better well-being and also have sustainable pattern of functioning, which is an outcome of the conscious effort of working on five interlocked sub-systems, namely economy of the community, response of civil society organizations, critical infrastructure support, supply chain management, and governance/institutional sub-system (Argonne National Laboratory, 2012). Economic condition is most important to facilitate recovery and develop better resilient communities. Disasters cause more damage to the poor, and the low-income

countries are largely impacted by the natural disaster and long-term civil unrest. Availability of financial resources, strength of the economic institutions, household level resources, job security, livelihood resources, equitable income are all crucial for building a resilient community. Poverty, inequality, suppression, and hunger as pre-existing vulnerabilities always increase the risk of higher impact and long-term sufferings for the survivors. Strengthening the financial resources, increasing the financial capacity of the household, ensuring minimum income security are essential to develop resiliency of individuals and community. Existence of active civil society organizations is an important social capital for the community. It may be women's self-help groups, youth groups, farmers' cooperative, faith-based organizations that bring the people at the grassroots level together and encourage a cooperative, cohesive culture that becomes a very important resource to deal with disasters. Social capital refers to the connections among individuals and the norms of social reciprocity and trustworthiness that facilitate civic engagement, social solidarity, and cooperation for mutual benefits (Putnam, 2000). A community with higher social capital is always better resilient and has abilities to deal with disasters effectively. Critical infrastructure is about availability of public infrastructure, like hospitals, cyclone shelters, school building, roads, community hall, water supply system, electricity supply, sanitation facilities, etc. at the community level. Similarly, at the household level, having strong building, facilities of water, sanitation at home is crucial to withstand any eventualities. The community level infrastructures are crucial for ensuring safety, security at the time of disasters, and also ensure quick response and supply of relief materials that are essential for handling the disaster situations. The household level infrastructures are equally important for ensuring resiliency of each family to face the adversities. After any disaster, destruction of such a system becomes a major challenge for the survivors and civic authorities. Therefore, having strong governance is equally important to rebuild such systems quickly. This includes the capacity, functions, preparedness, and promptness in delivering the support, by the institutional mechanisms of administration, legislation, judicial institutions, and political framework. While the made of serving is very strong within these institutions and governance is strong with an extensive reach out to the ground, the support services become easier to deliver. Participatory, democratic, transparent, and accountable governance is a basic prerequisite for a resilient community. Supply chain is a combination of different nodes and links or sub-systems that are functional in the disaster affected areas and outside in a state or geographical region. Adequate supply chain helps in transporting support and services as part of disaster preparedness or response. It is needed to facilitate immediate requirements for survivals, like food, clothing, water, medical support, medicines, toiletries, and other things as required. This depends on the political scenario of the nation and region that facilitates access to the affected areas and provides required supplies at the time of crisis. A supply chain is a crucial demand for developing a resiliency of a community. Resiliency at individual level brings higher order subjective well-being and at community level facilitates higher quality in community living.

Concept of Well-Being and Psychosocial Support in Recovery

Well-being and health are closely associated with one another. Within the WHO definition of health "mental, physical and social well-being" (WHO, 1948) is highlighted and further the concept of well-being is elaborated by the WHO Regional Office for Europe (WHO, 2013). Well-being comprises both subjective and objective elements. The life experience of an individual in comparison with the existing social norms and values contributes to well-being. The subjective point of view of well-being explains the level of satisfaction, happiness, and being comfortable within the given circumstances. The subjective well-being may vary over the time according to the situation, thus an objective view of well-being is further explained through various indicators, like, demographic variables (like, age, gender, education, occupation, etc.), health status (like, presence of disease, perception of own health, satisfaction, etc.), social context (like, communication with family/peer-group/community, social environment, school environment, etc.), health-risk behavior (like, consumption/addiction of psychoactive substance, physical aggression, sexual behavior, etc.), and other variables which have impact on well-being according to the culture and context. Thus, well-being describes a "condition of an individual or group, with reference to social, economic, psychological, or medical attention" (Sfeatcu et al., 2014). High level of well-being contributes to positive experience and the vice-versa. Disasters and conflicts severely affect the well-being of the survivors. The well-being contributes toward attending the quality-of-life, which is a combination of living environment, physical, and mental health, education, recreation, social relationships, and communication. Thus, quality of life refers to the overall well-being of individuals from a society. In the context of disasters, the quality of life grossly deteriorates, as the environment suddenly becomes unsafe, threatening, absolutely uncomfortable, and adjustment becomes very challenging till further assistance is provided to the survivors. Thus, in the context of disaster psychosocial support is very crucial for recovery of the survivors that focuses on strengthening resilience and rebuilding well-being.

Psychosocial support is an essential strategy for ensuring well-being and strengthening resiliency among the survivors of disasters. In this context the psychosocial well-being comprises three important domains, namely human capacity, social ecology, and culture and values (IFRC, 2009). Combination or physical and mental health, skills, knowledge, capacity to function contribute toward human capacity or human capital. During the ongoing crisis or after a disaster, facilitating the condition for the individuals to function is essential to regain normalcy and contribute toward well-being. Social connections, networks, relationships, social support at individual, family, and community levels are essential to maintain the social well-being and social equilibrium or regain homeostasis. This systemic balance underpins the realization of equality, justice, and human rights that are critical aspects for maintaining social ecology and hasten recovery. Cultural norms and value systems influence the individual and societal expectations. This influences the level of functioning

and helps to regain confidence, cooperation, and a cohesive atmosphere for disaster intervention. These three domains are influenced by the other external factors that determine the community resiliency, namely the economic, infrastructural resources, civil society engagements, governance, and institutional sub-systems (Bhadra, 2018). Therefore, psychosocial well-being is an outcome of the well-coordinated psychosocial rehabilitation program, that create a platform for other interventions too, for different sectors, like livelihood promotion, construction of houses, water sanitation facilities, common community resources, conflict resolution, peace building, and other (Diaz et al., 2007).

Psychosocial support programs are an empowering process that helps the survivors to work for their own betterment and for rebuilding community lives for well-being. Within the psychosocial support framework various humanitarian concerns, like ensuring dignity, human rights fulfillment, facilitating equal participation, equitable support, strengthening available resources, and capacity for holistic recovery, are crucial for achieving sustainable outcomes. Barker (2003) defined empowerment as "the process of helping individuals, families, groups, and communities to increase their personal, interpersonal, socio-economic, and political strength and to develop influence towards improving their circumstances" (p. 142). The psychosocial support program in disaster intervention is crucial to strengthen resiliency at the individual and community levels. The dynamic relationship between the psychological sphere and social engagement explains the concept of psychosocial support, where psychological and social dimensions influence each other. The psychological dimension consists of the internal feelings, emotional state, and thought processes of a person and the reactions expressed by him/her. The social dimension consists of relationships with human and nature, family, and community networks, predominant social values and existing cultural practices that denotes the social ecological balance (IFRC, 2009).

Thus, psychosocial support programs are a planned intervention to ensure an effective harmony between the psychological sphere of an individual, family, groups, and community with the social or community engagement that has a deep impact on overall well-being and maintaining balance. Simply it is a "process of facilitating resilience within individuals, families and communities" and "promotes the restoration of social cohesion and infrastructure" (International Federation of Red Cross, 2005). The definition given by Aarts (2000) further highlighted that psychosocial support helps in preventing pathological development and social dislocation, thus it is a preventive as well as promotional approach of care for individuals at the micro-level, families and groups at mezzo-level and for community at macro level. An ideal psychosocial support program should include strategies to approach at all these levels and facilitate an dynamic, continuous engagement toward a sustainable outcome. The Inter-Agency Standing Committee guidelines on Mental Health and Psychosocial Support (MHPSS) guidelines (IASC, 2007) defined Psychosocial support as "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder." This document has highlighted four aspects that are essential for the mental health and well-being (1) community mobilization and support, (2) health services, (3) education, and (4) dissemination of

information. These four action points together are important for holistic psychosocial care and support. The community mobilization is essential for engaging the survivors as the key stakeholders in the process of recovery. Initially, the community people may be less involved but through a successful program; it is important to engage them and ensure a community owned process of recovery that empowers the community to achieve a sustainable change. Health services for mental health include provision of psychiatric treatment at the primary healthcare centers, availability of both pharmacological and therapeutic interventions, provisions, or referral services and treatment of the severely mentally ill patients in the hospitals. Further, intervention through formal and non-formal educational engagement is most crucial for providing psychological healing after any traumatic experiences due to disaster, among the children. Here the roles of different stakeholders like parents, civic authorities, teachers, and the school system are becoming very crucial. Facilitating school engagement and additional creative-expressive activities toward psychosocial healing are crucial for the children and adolescents. At the same time ensuring safety, security, and protective measures are essential for long-term healing and development. Another important pillar of psychosocial support is provision of right, timely, useful, appropriate, information to the survivors that are crucial for maintaining well-being. It may be related to basic hygiene practices, distribution of relief materials, visit of healthcare professionals in the area, distribution of compensation, or any other information that are essential for the survivors and closely related to their well-being. Lack of information, wrong or misleading information is always a challenge for the survivors and imposes a lot of stress. Transparent, correct information is required while the survivors face critical challenges after the disaster. Within this IASC–MHPSS the use of psychological first aid (PFA) is recommended as the basic strategy after the disaster. PFA is always designed to be culturally appropriate according to the context. It allows people to talk about their worries to the trained mental health volunteers who are available to listen and facilitate the process of healing by engaging the survivors in various activities to facilitate positive coping, and positive life-style choices. "Psychological First Aid is an evidence-informed modular approach for assisting children, adolescents, adults, and families in the immediate aftermath of disaster and terrorism. Psychological First Aid is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning" (National Child Traumatic Stress Network and National Center for PTSD, 2005). Psychosocial support is also an essential intervention for protection of human rights as it is recommended in the IASC Operational Guidelines on Human Rights and Natural Disaster (IASC,). Similarly psychological well-being through psychosocial support intervention to deal with gender-based violence is highlighted in the IASC guidelines on Women Girls Boys and Men: Different need-Equal Opportunities (IASC,). For inclusion of the persons with disabilities in humanitarian action (IASC, 2019), the psychosocial support is referred as an important component for restoring normalcy during or after a disaster. In many other guidelines also the importance of psychosocial support is recognized and recommended in the disaster response program.

The Sphere Standards are most important for ensuring minimum response in sectors of disaster response, like health care, water and sanitation, housing, food and

nutrition, etc. Sphere Standards has various well-accepted parameters for humanitarian response that explained "Some of the greatest sources of vulnerability and suffering in disasters arise from the complex emotional, social, physical and spiritual effects of disasters" (The Sphere Project, 2018) that must be supported with a planned psychosocial intervention through community based, participatory programming. This considered psychosocial support should be considered as a common intervention for any sector. That means for any health, housing, food distribution, water sanitation program or in any other intervention in different sectors, psychosocial support must be planned and designed to ensure well-being and community owned process of recovery and resiliency building.

The different guidelines and provisions explained above MHPSS often used mental health and psychosocial support together and interchangeably. Psychosocial support is provided to all the survivors through the community level workers under supervision of mental healthcare professionals, and it is a primary level of intervention to ensure well-being and prevent pathological development of any psychological problem. In few cases the secondary and tertiary level of mental health care is required for the survivors where specific pharmacological and therapeutic intervention becomes important to ensure treatment and rehabilitation. The psychosocial support interventions facilitate referral services and further the mental care of these cases is crucial. Involvement of such people in the community level activities is crucial for rehabilitation. Designing appropriate IEC materials for mental health care under supervision of the mental health professional is also essential for appropriate psychosocial support. Therefore, there is a number of overlap between psychosocial support and mental health care with some distinctive inputs as shown in Fig. 27.1.

Therefore, psychosocial support and mental health services work together and adequate coordination of activities from the grassroots level to tertiary level are very crucial. In this whole process training and capacity building play an important role for the efficient implementation of the psychosocial support interventions.

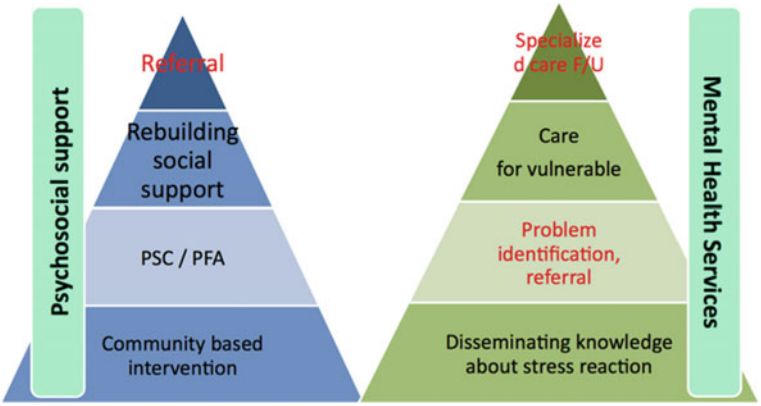

Fig. 27.1 Paradigm of psychosocial support and mental health services in disaster management (Bhadra, 2017)

Dimensions of Health for Well-Being

Good health brings well-being and it is dynamic in nature. The impact of any disaster is grossly seen on health which is a combination of multiple factors that determines absence of diseases and maintaining health standards in all four dimensions, namely physical, mental, social, and spiritual. The concept of health with the addition of mental and social dimension become more comprehensive for designing intervention considering right to health, access to healthcare systems and the determinants of health (Sfeatcu et al., 2014). The physical aspect of health is about maintaining good health and absence of disease or infirmity. The social and psychological dimensions are combined. The social aspect of health demands a society to be healthy "which chewed nationalism, racism, and narrow parochial interests" thus an individual is in a position to maintain adequate functionality adjustment and interaction, while seeking and extending social support (Larson, 1996). Social health contributes toward sustaining good mental health. Mental health is about feeling satisfaction, having positive coping and lifestyle choices for maintaining well-being. Spiritual health is associated with mental health and well-being. The spiritual dimension of health describes the inner peace and happiness. The quality of spiritual life denotes an individual's personal faith, beliefs, and adherence to religious practices and organization (Sfeatcu et al., 2014). There are four domains of connection of spiritual health that contribute towards well-being. "Human connection to God" is characterized by a feeling of affiliation and loving towards God. "Human connection with self" is a source of self-esteem, self-worth, being kind and responsible. "Human connection with others" positively influences an individual's behavior that results in honesty, accepting social responsibility, respect for rights. "Human connection with nature" explains duties towards nature, showing respect and acknowledging the importance. The physical, mental, social, and spiritual dimension of health together contributes toward maintaining well-being and sustainable future (Ghaderi et al., 2018). In any disaster health is always severely impacted that disturbs the psychosocial ecology and the homeostatic that contribute towards well-being.

Disaster always imposes an added burden to the life of the people and on the social support system of an individual, community, or nation. Disasters of grave nature cause higher burden and the health impact prolong, causing various types of disabilities that restrict the process of rehabilitation and recovery of the survivors. According to the situation and nature of disaster designing appropriate strategies for prevention of health impact, promotion of the health facilities is crucial. WHO (2014) in a report entitled "Climate Change and Human Health—Risk and Response: Summary" explained that climate change would increase the threat on health status and increase the burden of disease to a large extent by 2030. It is yet to have a complete projection of the future health impact of population displacement due to the disasters, crop failures, water shortages, and destruction of health infrastructure in natural disasters. It is affirmed undoubtedly that the disasters will be increasing the burden on the public health systems and mental health and well-being will be

a much more serious concern in the context of DALYs (Disability Adjusted Life Years) (WHO, 2014).

Disaster causes significant impact on the public health system and infrastructure. Thus, in disaster interventions strengthening, reforming, and reviving, the public health infrastructure and system are equally important for the well-being and for sustainable changes. The most comprehensive understanding on health care keeping the core humanitarian standards and protection principles at center is explained in the Sphere Standards (2018). Two important dimensions are the health system and essential health care. Within the health system five standards are explained that deal with health service delivery, health workforce, essential medicines and medical devices, health financing, and health information. All these five standards ensure that the health system is well equipped to deal with the disasters at the preparedness phase, during or after the event. The essential healthcare dimension has seven important health parameters, namely communicable disease, child health, sexual and reproductive health, injury and traumatic care, metal health, non-communicable diseases, and palliative care. Communicable diseases usually become a threat after a disaster. Thus, prevention of communicable diseases needs to be ensured through maintaining adequate health safety standards, surveillance of the situation to control any threat of outbreak, as well as to take-up early response. This is most essential for preventing any epidemic and the situation thereby. Similarly, preparedness, diagnosis, and case management are equally important for maintaining good community health in case of disaster. For the child health care, regular vaccination, immunization, and management of maternal and child healthcare facilities are crucial. The problem of sexual violence and sexual abuse in disaster context is not uncommon thus, adopting measures for prevention of sexual violence, safeguarding the reproductive rights, clinical management of the survivors of rape, and other sexual violence are equally important. Specifically, in refugee camps and relief camps issues of sexual abuse are quite common. In case of communal or ethnic violence, sexual offences are even used as a weapon to outrage the modesty of the community. At the time disaster adequate measures for the prevention of the spread of HIV is also essential, as sexual violence increase the change of spread of HIV. Usually disaster leaves a long trail of injuries and physical trauma that may be due to falling of heavy objects or inflicted by physical violence, bullet wound, or cut by sharp weapon. In any disaster trauma care is an important aspect of essential healthcare service as the morbidity and mortality are attributed to the number of injuries. Mental health care and psychosocial support is an essential component for health intervention. Experiencing violence, sexual abuse, and physical trauma lead to serious psychological issues that requires immediate intervention simultaneously. There are a number of non-communicable diseases (e.g., hypertension, cardiovascular disease, cancer, Tuberculosis, thalassemia, geriatric health issues) that require specific attention during and after the disaster. Integrating the care for the non-communicable diseases within the health system is essential to facilitate the maintenance and well-being of the survivors. There are many issues of end-of-life care that require psychosocial-spiritual healing, pain management, acceptance of the reality and helping the family members and caregivers to cope with the situation. The health systems need to be prepared to facilitate palliative

care for the overall well-being. In disaster intervention, preparing the health system to respond adequately is most essential to prevent future problems and pathological development.

Psychological Morbidity Due to Disasters in Short-Term and Long-Term

The psychological symptoms among the survivors of disaster vary according to the characteristics of the disasters. There are a number of studies that reported different reactions among the survivors immediately after the disasters and most of the reactions normalizes over time and in few cases the reactions continue for long (McFarlane, 2005). The psychological reactions to disasters have been explained through the six community phases of reactions that have more theoretical perspective for understanding the psychological situations after the ecological or natural disasters (SAMHSA, 2020). Before the disaster it is the phase characterized by worries, fear, feeling of threat that often causes feelings of loss of control, inability to take suitable steps for protection. If there is adequate information, warning and preparedness the situation becomes less worrying. Some disasters may be quite sudden and may not give any warning. Then the impact of disaster causes severe pain, injuries, and heightened emotions. As the intensity of the disaster event reduces, it becomes a phase of heroism when people try to save and rescue each other. There is usually a lot of active engagement but less successful outcome or low productivity. Subsequently, during the honeymoon phase the survivors become very active and become more optimistic and hopeful with the support that they receive from the volunteers, government for rescue and relief. Next phase is classified as disillusionment, when the hardcore reality touches the life of the survivors as the volunteers and external agencies leave the area. At this phase disappointment, hopelessness surfaces as the unmet needs and daily life problems related to livelihood restoration, housing, compensation start emerging and impose new challenges to get back to normalcy. Survivors develop individualistic focus and make effort to have personal gain. At this phase disagreements in community often emerge. It causes physical and psychological exhaustion and the pre-existing vulnerabilities impose obstacles for maintaining well-being for recovery. During this phase "anniversary experience" happens resurfacing the traumatic memories and ongoing stressful experiences. Last phase is reconstruction that may prolong for years based on the speed and intensity of rehabilitation activities. This phase is about struggle to restart, regain, and resettle in livelihood, house, community, family life, and in personal adjustment. At this time survivors usually regain confidence, but few may have the sense of active victimization or being the scapegoat in the situation may experience higher levels of stress and problems. The "community phases of recovery" was conceptualized in the context of the USA, but has given a generalized understanding applicable globally. Though there are many incidences of disaster where these phases may not be as explained. In slow onset of

disasters like drought, dzud, or in case of perennial nature of disaster, like seasonal flood, cyclone the psychological reactions are very different as people and government get more time to prepare and respond. At the same time, the people often develop their own coping strategies and resiliency to deal with the uncertainties such disasters. Further, in case of CBRN disasters the restrictions and threat of spread of disease, infection or radiation can be so high that people may totally refrain from helping each other or being physically present (Morganstein & Ursano, 2020).

The psychological problems and reactions are related to social situations and the disaster situation. The IASC-MHPSS (IASC, 2007) has mentioned three important considerations regarding the psychological reactions. The predominant social situations that induce psychological problems are (1) pre-existing vulnerabilities of the communities, like, poverty, unemployment, marginalization of certain groups, political instability or oppression, etc.; (2) social problem induced by disaster, like, the death, injury, destruction, separation, disruption of social support, increased gender-based violence, etc.; (3) social issues induced by humanitarian aid, like, lack of information, problem in distribution of relief material, unhygienic relief camp, unequal distribution, etc. The pre-existing vulnerabilities showed that weaker and marginalized sections face more problems and experience higher stress reactions. The impact of disaster varies as per the situation and context, while the disaster induced social problems are due to efficient planning and support by the government and humanitarian organizations after the disaster. Table 27.1 depicted the factors that are responsible for increasing vulnerabilities related to mental health effects due to disasters and the facilitative factors.

The nature of disaster represented the different disaster situations that lead to mental health problems among the survivors. The human-made disaster causes higher and prolonged mental health problems than natural disasters. Further, in human-made disasters where intention to cause harm (e.g. war, terrorist attack, communal violence, ethnic conflict, etc.) is obvious the stress reactions and mental health issues are higher. In certain situations the events of disasters continue for long like, in civil unrest, refugee crisis the ongoing disturbances, persistent threat to the sense of security cause a lot of anxiety and emotional problems. In such a situation regaining normalcy becomes extremely difficult. Usually the communities experiencing perennial disasters like seasonal flood, cold wave or heat wave develop their own coping and resiliency to deal with the crisis. Similarly slow onset disasters usually allow the community people to adopt better coping strategies over time. Some disasters strike all of a sudden (like, earthquakes, avalanches, landslides) with very less reaction time causing higher psychological problems among the survivors. In CBRN disasters the threats are almost invisible, unknown, and spark a lot of physical discomfort that cause a very high amount of emotional reactions and mental health issues among the survivors. The impact of disaster varies according to the nature and intensity of the disasters on the survivors. The severe form disasters cause higher amounts of distress. The pre-existing vulnerabilities expose the survivors to the worst situation during or after the disaster. The aid-induced problems also lead to a number of distressing situations for the survivors, demanding an effective planning and response strategy. There are a number of facilitative factors that are essential to consider in a disaster

Table 27.1 Factors responsible for increasing vulnerabilities related to mental health and protective factors

Nature of disaster	Impact of disaster	Pre-existing vulnerabilities	Aid-induced issues	Facilitative factors for recovery
Human-made disaster-due to human error	Distress (Physical/Mental health/Social/)	Poverty and related issues	Corruption in relief distribution	Positive coping, lifestyle and resiliency
Human-made disaster-due to human intention to cause harm	Bereavement and Injuries (cause disability/recoverable injury)	Gender issues and discrimination	Lack of assessment of impact and support	Reorganizing mutual support systems at the earliest
Natural disasters or ecological disasters	Destruction-loss (belonging, home, livelihood)	Personal issues—disability, chronic diseases and illness, age factors (Children aged), living alone, widowhood, unskilled	Lack of information about relief package, chaos in distribution	Community engagement, planning, and intervention
Prolonged disasters—refugee situation, ongoing unrest	Displacement	Political and social oppression of certain groups	Inappropriate, inadequate supplies	Vulnerability mapping and support
Perennial or repeated disasters	Disequilibrium in the personal, familial and community life	Weak Civic authorities and civil unrest	Lack of cultural sensitivity of the humanitarian workers	Mobilization of different sectoral supports for rehabilitation
Slow onset disasters	Disturbances in various sectors of life (economic, political, physical structure, etc.)	Lack of civil society organizations, poor social support network, corruption	Discrimination, abuse (physical, emotional/sexual) of the survivors	Long-term planning and focus for sustainable development
Chemical disasters	Ecological issues and pollution	Lack of disaster preparedness and awareness	Lack of planning and engagement of the survivors	Strong Government, civic authorities and civil society organizations
Biological disasters	Continuous threat	Lack of resilient infrastructure and system	Intruding into the privacy of the survivors	Political stability and responsible governance

(continued)

Table 27.1 (continued)

Nature of disaster	Impact of disaster	Pre-existing vulnerabilities	Aid-induced issues	Facilitative factors for recovery
Radiological and Nuclear disasters	Exposure to radiation	Living with hazards	False promises and delay in intervention	Legislative provisions and policy development

intervention program to facilitate well-being and reduce the stress reactions among the survivors.

History of Disaster Mental Health

The Cocoanut Grove nightclub fire disaster in Boston 1942 was an event of shock with profound impact on the mental health of the survivors and their families. The psychiatric impact was systematically studied by Erich Lindemann's (1944) and it is considered as one of the earliest scientific evidences about mental health impact of disaster. In this fire about 500 people were killed and the tragedy became further horrific as the emergency exit was closed to prevent people from entering without a valid entry ticket. The study by Lindaman with the survivors and the families who died revealed that the people who talked about their problem and shared about pain, loss, experiences, and feelings were doing better than those who suppressed their feelings and tried to forget. Largely, people reported somatic responses, like, headache, lack of appetite, gastrointestinal disturbances, with feelings of anxiety, depression, and hopelessness. Mostly, these symptoms reduced over months, and few had received counseling sessions of less than twelve, though counseling methods of treatment were less practiced at that time. Particularly, this work of Lindaman showed that individual therapy has an important role and a similar model of disaster mental health work is conducted in India too. In India the first disaster mental health intervention was systematically conducted by HS Narayanan in 1981, following a circus fire tragedy in Bangalore. In this tragedy 70 people died who came to watch a circus show that was meant for school children and majority of the victims were young school students. The study was conducted to understand the reactions of the bereaved families and the social workers visited the families. It was found that families had very high grief reactions, feelings of guilt, anger, depression, death wishes, and deteriorating health. The families who accepted the therapeutic session by the mental health worker coped with the situation better. Further, much of the psychosocial support and disaster mental health work done in India focused on the community interventions and working with the individuals, families, groups, and community at large. The community-based approach in India has proven to be so successful largely because of its emphasis on the communal and spiritual rebuilding. According

to American agrarian philosopher Wendell Berry, the smallest unit of health is the community (Berry & Wirzba, 2002). He further elaborated that individuals are not autonomous, neither self-sufficient, thus healing occurs in the context of family, friends, and community. The concept of a bio-psycho-social medical model (Engel, 1977), which has a strong foundation to understand human beings as a complex product of biological predisposition, psychological development, and social context was propagated by George Engel. Hyper-tension and Diabetes are as many bio-psycho-social illnesses as are depression, schizophrenia, and somatic pain.

After the Bhopal Chemical disaster in 1986, in India an important intervention on psychosocial support and mental health was conducted by the mental health experts. This was one of the worst chemical disasters where forty tons of cyanate gas escaped from the Union Carbide chemical plant in Bhopal was leaked on the night of 2 December 1986. The disaster left 2000 people dead, and about 200,000 survivors suffered long-term consequences. At the time there were not enough mental health experts in the city and mental health consequences of the disaster were less understood. The health workers were mainly facilitating the litigative procedures for compensation. Within weeks the government deployed a team of mental health experts comprising psychiatric social workers, psychologists, and psychiatrists to provide mental health services to the survivors and also to train the medical officers and health workers. The initial reactions of the survivors were mainly, anxiety-depression, reactive psychosis, state of confusion, and grief-reactions. The longer-term consequences included various uncertainties about future, disturbed relationships, broken social units, and multiple problems for rehabilitation and associated psychosocial disabilities (Basu & Murthy, 2003).

The community-based psycho-social support model was evolved in the intervention with the survivors of Orrisa Super-Cyclone, 1999 that killed more than 10,000 people and left survivors with profound devastation. In the psychosocial support and mental health intervention, the local volunteers were trained as community-level-workers (CLH) for providing psychosocial support, and these CLHs were supported by the social workers to conduct follow-up, provide hand-holding. The medical doctors of primary healthcare centers (PHC) were trained to provide mental health support to those with higher mental health needs and give pharmacological intervention as required. Subsequently, after the Gujarat Earthquake, 2001, a similar model was practiced, with special focus for the disabled, amputee, and paraplegic patients, the orphan semi-orphan children, women living alone and other vulnerable groups. A model of caring community was developed by training the community level volunteers (CLVs) and providing handholding support to them by the social workers and psychologists. The CLVs took up various activities, like, regular visit to the vulnerable families, talking to express the fear and worries, developing play groups and entertainment with the children youth, women, and men, and facilitating other logistic support, like, getting compensations, medical checkup, etc. Specific cadre was developed for the care of the disabled survivors and their caregivers as the number of persons with severe injuries leading to permanent disability due to amputation, paraplegia was quite high (Ramappa & Bhadra, 2004). Subsequently, 2002 there was a severe communal rift in various cities and villages of Gujarat.

Through psychosocial support a campaign of peace was initiated to deal with the trauma, and facilitates psychosocial rehabilitation. It was clearly documented that peace building and conflict resolution are possible only when reconciliation between the communities' takes place through a series of discussion, meetings, and community events at individual, group, and community level for psychosocial healing. The peace-volunteers were trained on mental health and psychosocial support to facilitate this trust building process by taking up various psychosocial activities. At the individual level, the volunteers facilitated PFA, encouraged positive lifestyle choices and coping, joining in various community activities, extending and seeking support being a member of the group. Various community prayer meetings, community fare, and fest were organized systematically to encourage maximum community participation within the integrated care model, where psychosocial support was considered as a common program for any other interventions, like, housing, livelihood promotion, education, vocational training, and legal support. In such interventions, there were always provisions of higher order mental health care with pharmacological interventions in case of need. There were established contacts with the mental healthcare institute, psychiatrist, and also the general health practitioners of the area were trained on basic mental health care as frequently psychosomatic problems were presented in such community clinics or primary healthcare centers (Bhadra & Dyer, 2011).

After the Boxing Day Tsunami (2004), mental health and psychosocial support became a main program to deal with the huge challenges of trauma and enormous loss to the communities. From the time of rescue and relief a large number of first responders were trained to ensure psychosocial support in the coastal region of India. All the volunteers who were providing different supplies, medical, and other support were trained to provide basic PFA in the form of facilitating expression of feelings, talking about the concerns, providing needed support, giving authentic information and reassurance to facilitate healing and positive coping among the survivors. Similar approach was adopted in other countries too. In Indonesia, Sri Lanka, and Maldives, there were community-based psychosocial programs which focused on psychosocial well-being, community participation, and resiliency development considering the disaster preparedness, as an important integrated component of the intervention strategy. Subsequently, in Myanmar in 2008 following the deadly cyclone Nargis, community-based psychosocial support was promoted by IFRC program. It is also pertinent to mention that political situation and political leaders always have a critical role in facilitating the program or hindering the care provisions for the survivors of disasters. In Iraq following the civil war (2003) and the continuing civil unrest, and threat to safety increased the psychological vulnerabilities of the civilian population. The survivors had almost no capacity to exert their power and rights. Therefore, every incident of daily living was trying with luck, then with confidence and surety. Further, based on the findings and recommendation of the Iraq Mental Health Survey conducted by WHO, the Ministry of Health made plans for integration of mental health care in primary health care, education, and other developments. A large number of healthcare professionals were trained who worked in hospitals, PHCs, and in community-based outpatient settings (Dyer & Bhadra, 2013).

Disaster causes a number of negative, undesirable, unexpected life events that are highly stressful for the survivors. These events are extended over a longer period of time; thus, it is not only the life events due to disasters, rather the consecutive life events and sufferings during post-disaster situations that cause a lot of psychosocial sufferings, if an appropriate participatory community-based psychosocial support is not implemented. This approach is crucial for developing acceptance towards the personal, familial, and community losses and developing new meaning toward life, with positive coping that facilitates adjustment and acceptance toward the changed situation. Thus, the effort is to ensure an even better situation and the survivors in this process experience a post-traumatic growth that can make them more resilient. Toward achieving this, providing psychosocial support, broad-based capacity building through cascading models, working with individuals/groups/families, organizing support groups in the community, development of community-based organizations (CBO), holding community prayer meetings, and many other such participatory interventions are crucial. Inability to provide these services effectively shows higher disharmony, distress, disabilities, and lack of adjustment and social well-being (Bhadra, 2006; Sekar et al., 2005). Disasters happen and their intensity and severity are increasing over years. Every event of disasters cannot be predicted, but mostly they can be anticipated and planned for reduction of risks and limiting the negative impacts on the people, and places. This involves prior measures for preparation, fulfilling immediate food, shelter needs, physical first-aid, and medical care, as well as consistent on-going emotional support. Traumatic reactions due to disasters are "normal reactions to abnormal events"—everyone experiences them. These are mostly temporary and not pathologic. Individuals cope and recover best when their communities are supportive, caring, and cared for each other.

Resilience Building Program in Disaster Intervention

The focus on resilience building activities in post-disaster interventions is a recognition that, while both natural disasters, such as cyclone, earthquakes, landslides, tsunamis, flood and wildfires, as well as human-made disasters, such as conflicts, war, terrorist attacks and complex emergencies, may be "traumatic" for survivors, the emotional reactions, psychological consequences are not necessarily manifestations of psychiatric disorder (Tiernan et al., 2019). Rather, these are "normal reactions to an abnormal situation," which no one ought to have to endure. Recovery after any disaster involves the social-networks, human connection, and solidarity of supportive communities. Ideally a program in Mental Health and Psycho-social support for resiliency building will remain in the affected community for months or years. Following the Indian Ocean Boxing Day tsunami of 2004, teams remained for several years working with community level workers, teachers, and others. In such situations, briefer repeated training, capacity building workshops may be useful for teaching volunteers, community leaders, health workers, first responders, teachers,

clergy, and others basic skills in psychosocial support, caring for specific population (children, youth, disabled, women), self-care, which can help them, help their colleagues and neighbors (Griffith & Norris, 2018).

The resilience workshop modules have been used widely in communities impacted by the Bhuj earthquake, Indian Ocean tsunami, the Great Sichuan Earthquake, the Haiti Earthquake, the Japan Triple Disaster, and further designed in response to the "Syrian refugee crisis" in Greece, which involved refugees from Afghanistan, Iraq, Northern Africa as well as Syria (Candilis, et al., 2018; Des Marais et al., 2012; Dyer, 2016, 2019; Sekar et al., 2007). The resiliency workshop is usually conducted in three phases, (1) didactic learning session by experts, (2) group discussion in small groups through breakout sessions, and (3) finally, sharing of experiential learning in large group sessions. This training sessions utilizes recognized stages of group dynamics, a motion of coming-together (inclusion), gradually evolving trust through individual sharing and openness, further agenda setting (establishing the norms for group behavior), and thereby creating opportunities to develop consciousness of feelings and to share feelings and ideas in the group (trust phase). In this process the participants develop an attitude to work together, care for each-other, learn skills and confidence to deliver services in the field. The didactic sessions are crucial for giving information and also an important phase for inclusion of the participants in the larger community. Skill development happens through experiential participatory learning processes in the small groups. In this phase contextualizing the skills according to local culture and context is crucial. The reconvening sessions provide important opportunities for rebuilding community cohesion by presenting the work of the small groups and listening to others. In each half-day of a workshop, there are opportunities for didactic sessions, small-group processing, then large group sharing and integration. As the cycle is repeated on different topics, the group develops and deepens an opportunity for community cohesion.

Human Rights Issues in Disasters

The disaster situations grossly impact the society and there are multiple survival challenges for the survivors. The violation of human rights is not uncommon during disasters, as the regular supportive mechanisms are usually damaged. Human rights are a universal and inseparable part and thus, in disaster situations too, fulfillments of human rights are a crucial demand in the twenty-first century. According to the UDHR, the important dimensions are fulfillment of physical needs to ensure a dignified survival, adequate protection to have a safe and secure life, and having adequate opportunities for development of full potential. While disaster struck a community with widespread disruption protecting human rights became the major challenge. The fulfillment of human rights is dependent on two parameters of "valid claim" and "duty bearers." In a disaster situation while every survivor has a valid claim for living a dignified life, the government and the other humanitarian agencies have an important role for protecting the dignity of each survivor. During disaster other

social issues, like, sexual violence, torture, corruption, inadequacy of support services (e.g., crowded relief camp, lack of water supply, food distribution, etc.), are also quite common. While such issues become very prominent, the violations of human rights become inevitable. There are five important reasons that cause human rights violations.

- **Lack of Freedom of Expression and No Chance of People's Participation**: Violation of rights in disaster situations is linked with the opportunities available to the people to express their views and concerns. Initially after the disaster during the rescue and relief phase some amount of difficulties and chaos is common, but the same need to be controlled and minimum level of comfort and security must be ensured at the earliest. In such a situation, the survivors need to be given opportunities to talk and express their views and adequate measures in due participation of the community is crucial to reduce the discontentment and bring higher levels of cohesion and satisfaction that can ensure better fulfillment of various basic survival needs. Higher community cohesion, mutual support, and cooperation among the survivors, and with the implementing agency, government also facilitates creation of a better protective environment. Lack of freedom of the survivors, coercive strategies to suppress the voice, controlled mass media, lack of freedom largely go against the fulfillment of human rights. Often after the disasters, the voices of the survivors are being suppressed and media entry is restricted to cover up the human rights violation. Specifically, in human-made disasters, under military rule, or in an autocratic regime, the human rights violations during disaster are much higher.
- **Number of Pre-existing Vulnerabilities:** The pre-existing vulnerabilities are always an important challenge in the post-disaster period. The vulnerable population are characterized by having poor social support and become highly dependent on external resources for relief and recovery. The common vulnerability factors are poverty, unemployment, too young or advanced age, physical limitations, chronic disease, etc. The survivors belong to lower caste often suffer from various discriminatory practice and similarly, women, girls become victim of gender discrimination. The trafficking of the young girls for sex trade or boys for child labor is reported in post-disaster situation from many poor communities and nations. Such incidences denote the typical challenges towards protection of human rights of the disaster survivors. The individuals and communities with pre-existing vulnerabilities tend to experience higher amounts of human rights violation. Vulnerabilities are a combination of multiple factors, like, lack of resources, dependable support system, capacity of the individual and systems to withstand the threat, etc. In such a situation, the vulnerable population often fail to receive required support and experience high abuse and many survival challenges. In addition the poor infrastructure, geographical isolation, poor connectivity, and communication also lead to greater amount of insecurity and poor fulfillment of human rights dimensions.
- **Lack of Policy Framework and Disaster Preparedness**: A policy highlighting social justice and equality is important to ensure adequate focus of human rights fulfillment. Thus, having a policy framework in a country to deal with disasters is

very much essential. In consonance with the international guidelines and framework, various nations have developed disaster management acts and policies, but it is seen that the poor and middle-income countries usually do not have adequate disaster management framework and policies to deal with emergency situations. Similarly, disaster preparedness activities focusing on limiting the damage, reducing the sufferings and impact of disaster during the rescue, relief, rehabilitation period are equally important to ensure the well-being and protection of human rights of the survivors. Lack of disaster preparedness, unplanned response, inadequacy of the system increase suffering of the survivors and marginalized, vulnerable populations experience higher amounts of violation of rights. Lack of legal framework leads to lack of accountability and responsibility of the part of the duty bearers, like government, representative members, and government officials, thus human rights violation of the survivor's disaster may increase (Costa & Pospieszna, 2015).

- **Weak Government and Poor Governance**: There are many countries where the administrative system of the government is not effective enough and there are issues of corruption, nepotism, that lead to poor governance. The ongoing civil unrest, the issues ethnic violence, communal riots, genocide, in complex emergency situation absolutely destroys all possibilities of protecting the human rights of the survivors. Similarly, the authoritarian regimes, coercive government commonly disregard the human rights agenda (Rost, 2011). Good governance is most essential to control any emergency situation or disaster that requires quick strategic action, efficient implementation and deriving favorable results to ensure well-being and protection of human rights. Collecting and maintaining authentic data, disseminating authentic information about the impact of disasters, the level of destruction, the support required, figures and figures about the vulnerable groups are vital to facilitate appropriate timely services. A poor data management and manipulation of the critical information are common difficulties in poor governance. While the aftereffect of disaster and post-post-disaster chaotic conditions continue for long the human rights violation become a regular event, as people face a number of survival challenges and become victims of abuse and violence. Therefore, developing a good governance practice is very much crucial for protection and human rights. This included strengthening the democratic institutions, improving service delivery, establishing rule or law, and controlling corruption (OHCHR, 2007).
- **Threat on The Humanitarian Workers and Agencies**: Protection of human rights after a disaster is effectively possible while the government and the humanitarian agencies can reach out to the disaster affected area and extend their support to the survivors. In such situations there are a number of risks that the humanitarian workers face that may be due to natural condition or societal disturbances. Many a time, reaching out to the survivors and providing support become extremely difficult because of difficult geographical terrain, continuing calamities, destruction of the communication system, road ways, etc. But in human-made disasters and complex emergencies there are security threats on the humanitarian workers while they try to reach out and provide support to the survivors. There are a number of

incidents while the humanitarian workers are restrained, abducted, killed while trying to extend support to the survivors. In Afghanistan Médecins sans Frontières (MSF) had to stop operation in 2004 for a long time due to the killing of the aid workers (Runge, 2004). Such incidents are reported from Iraq, Pakistan, Somalia, and African countries, and in many other conflict-stricken countries. These countries are found to be most unsafe and dangerous for humanitarian operations (OCHA, 2011). In such a disturbing situation, protecting human rights becomes extremely challenging and violations of rights are a common feature.

Attaining Sustainable Development Goals (SDGs) Through Disaster Risk Reduction (DRR)

SDGs are impossible to achieve without controlling the events of disaster and conflict all over the globe. The increasing threat of disasters and conflict are the major challenges that are looming over humanity with increasing unplanned consumption and increasing human aggression. The border conflict, internal disputes, increasing military expenses, incidents of war, and war like situation are the major questions in front of the global commitments for SGDs to attain the different targets that are extensive to ensure welfare and well-being through holistic global peace. The Goal 11 of SDGs is "make cities and human settlements inclusive, safe, resilient and sustainable," clearly focused on ensuring safe housing, safe communication and transport, considering the accessibility of the vulnerable groups. Similarly, improving the air quality, green coverage, inclusive development linking to the environment, economy, and social aspect, and further ensuring DRR strategies are important indicators for Goal 11 of SDGs. It is essential to incorporate DRR strategies as an integral component of development for ensuring sustainability. The first DRR plan that recognized the interphase with sustainable development was Yokohama Strategy and Plan of Action for Safer World in 1994. Further the relationship between DRR and Sustainable development becomes further stronger in various other international commitments and frameworks, like MDGs, "Hyogo Framework for Action," Sendai Framework for DRR, and further in SDGs (UN, 2015). The Goal 12 "ensure sustainable consumption and production pattern" is about reducing chemical usage, management of waste, reducing use of fossil-fuel, promoting local culture and developing a sustainable consumption pattern and effective natural resource management that will be most importance to control climate change and reduce the impact of global warming which are the major reason for many of the natural disasters, like, flood, cyclone, drought, avalanches, polar vortex, etc. The next Goal 13 directly targets the issue of climate change and urges to take urgent action to combat climate change and its impact. Developing resilience and adaptive capacity by engaging the community participation is crucial for DRR and sustainable development. Similarly all other goals have direct and indirect connection with DRR that essentially facilitate sustainable development of promote well-being. "Ensure healthy lives and promote well-being at all

ages" is pronounced in Goal 3. Therefore, the connection between DRR and attainments of SDGs is not just a logical connectivity, rather an organic one that explains the need to embrace every possible measure to reduce the risk of disasters while any development has to be made sustainable for ensuring well-being.

Recommendations

In the twenty-first century, social justice and welfare are at the forefront of the global commitments towards sustainable development for ensuring well-being for the survivors of the disasters, conflict, and complex emergencies. The impact of disasters and sufferings among the survivors differs according to the level of development, welfare measures of the nation, and the effective role of the government and humanitarian agencies. The psychological healing of the population after the disaster is a crucial indicator for setting the developmental paradigm that ensures overall well-being and holistic recovery with a clear focus on the vulnerable survivors. To ensure quick recovery and resiliency building among the people some essential steps that are required are highlighted here.

- **Strengthening People's Participation and Democratic Institutions**: Process of recovery is fast and firm while people are empowered and they have chances and abilities to participate in the process of recovery. The empowered community is expected to have adequate knowledge, skills, and resources to respond to the crisis situation, restrict the damage, and bounce back to the normal level of functioning (resilient), or even better level of functioning. Here, the focus becomes "build back better." Thus, adequate programmatic intervention is required to sensitize and empower the masses at different levels, from the grassroots institutions to the higher level administrative authorities and organizations. For the same, empowering the health system, school education, child care institution, public administration, creating wider transparency, and accountability of different authorities are crucial. While the democratic institutions are strong enough the administrative and legal systems become accountable to ensure welfare for all and pronounce social and distributive justice for the survivors of disasters.
- **Nations' Commitment Toward International Agenda For Well-being, Development, and DRR**: While the UN and other international humanitarian agencies and coalitions are tirelessly making efforts for strengthening the welfare mechanism and global commitments for the same to ensure, policy directions, effective interventions, and resource allocation, the commitment of each of the nation toward the agenda for well-being, sustainable development and DRR are equally essential. Many countries with poor economic and social infrastructure, weak governments are often unable to meet the basic standards of living and have a number of existing vulnerabilities that are continuously threatening their well-being. Thus, DRR cannot be considered as a completely different separate set of agenda, rather a regular developmental program to raise the housing,

health, hygiene, education, communication are extremely crucial to reduce the vulnerabilities to disaster.

- **Identification and Reduction of Vulnerable Factors within the Social, Economic, and Political System**: There are a number of vulnerabilities and systemic default that are often ignored and become a critical impediment during the disasters. These vulnerabilities may be poverty, inequality, unemployment, gender discrimination, ethic issues, racism, corruption, weak infrastructure, communication, etc. In the post-disaster situation, such vulnerabilities continuously impose threat to the safety security of the survivors and for the disaster response workers too. Many a time these vulnerabilities are deep rooted in the culture, practice, belief, political system and these are the product of unfair economic and social development. Therefore, these vulnerabilities are often part of the history and characteristics of the communities or nations. Dealing with such vulnerabilities during disaster response becomes absolutely impossible and makes the disaster intervention feeble and less productive. Hence, within the welfare measures and developmental program, it is essential to identify the inherent vulnerabilities and take active steps to dissolve the same.
- **Mainstreaming Psychosocial Support and Mental Health Care in Disaster Interventions**: Though there are a number of policy documents and guidelines for ensuring mental health and psychosocial support of the disaster survivors, yet the mental health is one of the low priority sectors in disaster intervention. Often there is lack of awareness and sensitivity among the disaster intervention workers about the mental health needs of the survivors and mental health condition is perceived as illness. The community-based care and integration of mental health for every disaster interventions is yet to be taken up as key intervention by different humanitarian organizations in their disaster response program. It is important to ensure community participation in the disaster intervention to facilitate community owned processes of recovery. Ensuring participation of the surviving communities and developing provisions for the marginalized groups are crucial for ensuring social justice and human rights fulfillment.
- **Adoption and Implementation of Disaster Management Policies Focusing on Human Rights and Well-being**: Every country needs to design and implement disaster management policies and develop adequate administrative framework for the implementation of the same. It is pertinent to remember that the disasters are becoming global in nature and often are not limited within a geographical or political boundary. Thus, gradually every disease is having a universal impact. Specifically, the global warming and climate change issues have imposed a serious threat of disasters all over the world, and a global action will only be effective while every nation makes an effective plan and commitments to deal with the threats of disasters. Similarly, the health crisis due to pandemic or warfare between nations always have cross-border transnational impact that calls for global action for dealing with the disasters much more proactively to ensure protection of human rights and well-being. Strengthening global commitments for peace and development is essential to create a peaceful border, reduce military cost, stop production of weapons, and nullify the threat of violence.

The Humanitarian Imperative: Ethical Considerations

The humanitarian response to those affected by disaster is motivated by an empathic sense of justice, recognition that under different circumstances, we too might be affected, if not by a war or major disaster, then by something more personal, such as a house fire, a major medical problem, or loss of a loved one. Psychiatrist Janet Lewis has observed that we are either in the middle of a disaster or between disasters and that those of us less affected have a greater responsibility for those more affected (Lewis, 2021). The global mental health movement is predicated on these ethical warrants (Kohrt, 2021), the recognition that those most impacted by disaster may have the least access to the mental health and psychosocial resources to help them recover and cope. Humanitarian workers and humanitarian organizations recognize these unmet needs and do what governments may be unable or unwilling to do. We often see that disaster responders are also impacted by the disaster, either by putting themselves at risk, by the vicarious trauma from what they witness, or by trying to meet impossible needs, working long hours under difficult circumstances with insufficient attention to their own health, mental health, and well-being. The focus on resiliency and well-being is recognition that mind and body are integral aspects of human beings coping with disaster in families, in communities including global communities.

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Chapter 28
Resilience and Well-Being: Case Studies of Four Individuals Who Have Undergone Adversities

Shikha Soni and Amrita Deb

Abstract Individuals frequently confront various kinds of losses during their lifetime such as death of loved ones, financial losses, damage to health, among others. These challenges can have short-term or long-term impacts. Hence, adapting successfully to the impact of these challenges is an inevitable and sometimes an ongoing process in life. While some individuals display maladaptive behavior when faced with such adversities, others display resilience in adapting to them and eventually establish a state of well-being. This chapter presents four case studies of resilient individuals who have faced different challenges such as physical health, relationship loss, domestic violence, and child sexual abuse. There were two male and two female participants with a mean age of 32. The objective of the study was to explore resilience and well-being outcomes among individuals who have experienced adversity. A case study approach was considered suitable as it allows participants to report their subjective experiences, an opportunity that quantitative methods do not allow. Interviews were conducted using (McAdams, 1985) life story approach which covers factors ranging from childhood experiences to personality traits and peak experiences. The findings revealed that all participants eventually established a state of optimal functioning through resilience derived from internal and external protective factors. Major themes identified were negative experiences and emotions, positive emotions, benefit finding, presence of significant others, and pro-social behavior. Well-being was exhibited through positive consequences such as empathy, self-belief, and gratitude after facing hardship. The authors recommend using the case study approach in exploring resilience as individuals have unique coping mechanisms that are difficult to capture through quantitative measures. Additionally, case study approaches may be useful in understanding well-being outcomes in a variety of contexts which are otherwise difficult through preset questions. Finally, implications of the study and suggestions for future research have been proposed.

Keywords Adversity · Resilience · Case study approach · Protective factors · Well-Being

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_28

Introduction

Individuals are shaped by life experiences which influence their beliefs, thoughts, and actions. While positive and negative experiences create an impact on overall well-being, Bonanno (2004) posits that most people experience some or the other serious event at some point in life. According to Obradovic et al. (2012), adversity refers to negative contexts and experiences that have the potential to disrupt or challenge adaptive functioning and development. Most of the time, changes caused by an adverse event may interrupt an individual's life by becoming a risk factor for health, self-esteem, and self-identity (Ward & Higgs, 1998; Wilmoth, 2000). Unexpected adverse events such as loss of a loved one due to terminal illness or accident may leave one traumatized and grief-stricken for long. Such losses are produced by events which are perceived as negative by the individuals involved and result in long-term changes to one's social relationships or cognitions (Miller & Omarzu, 1998). Changes caused by such losses can be viewed both as a challenge resulting in an opportunity for growth, or as a cause for distress and suffering.

Initial research on loss focused largely on negative consequences, which was a result of the predominant deficit-based approach existent in traditional psychology research. This includes work by Viorst (1986) who recognized the cyclical, natural, and pervasive nature of loss in our lives. Furthermore, Erickson (1963) and Bowlby (1960) observed that each developmental stage brings specific losses which one has to overcome; these losses begin at birth and do not end until death. Though death is commonly perceived to be a major loss in life, there are other kinds of losses which individuals face over their lifetime (Ponzetti, 2003). These include tangible losses that involve (1) personal events like loss of one's vision, hearing, mental capacity, fertility (2) interpersonal situations such as divorce, ending of a relationship, death of a loved one (3) material losses such as losing a job, leaving one's country, becoming homeless and (4) symbolic losses such as those related to racism, role redefinition (Ponzetti, 2003). Intangible psychological losses include change in self-worth due to problems at work or job demotion, change in self-control, change in identity due to widowhood or change in worldview due to natural disasters or accidents (Ponzetti, 2003). It may be noted that several intangible losses overlap with tangible ones as the former is an outcome of the latter. Primary loss is the initial loss event which leads to subsequent losses also known as secondary losses (Rando, 1993). Such experiences of loss increase the complexity of the adversity and its impact on the individual's psychological well-being and functioning (Rando, 1993). Hence, accumulation of all losses together may in turn cause extreme distress (Viorst, 1986).

The impact of losses experienced through the events mentioned above is expected to vary for each individual depending on several factors such as their use of resources to counter the loss. Therefore, irrespective of the kind of loss experienced, there are instances of individuals displaying resilience and well-being through adversity. As widely observed, adversity is known to lead to an increase in stressors; however, researchers such as Tedeschi and Calhoun (2004) after recognizing that individuals often find meaning and purpose through suffering started emphasizing on facilitating

personal growth and positive change. Gradually, investigations in this area adopted strength-based approaches to study this phenomenon, thus contributing to the new school of thought that is positive psychology.

A Positive Psychology Perspective to Adversity

While adaptation after adversity has always been a topic of interest, the positive psychology movement has brought about a new approach to it. Evolutionary-based theory implies that negative bias is innate; that is, our brain is wired to focus more on negative experience and such biases are built into our neural circuitry and consequently into our psychology (Rozin & Royzman, 2001). According to Maslow (1954), psychology has been far more successful in looking at the negative side than positive side of situations. Most studies in the past have focused on maladaptive behavior and symptoms of mental illness. Such deficit-based approach is determined on fixing what is broken (Seligman & Csikszentmihalyi, 2000). However, it is observed that changes arising through adversities may direct people toward higher levels of functioning than that which existed prior to the event (Linley & Joseph, 2004). For example, while overcoming the challenges following an adversity, individuals may recognize their strengths and resources which they may have otherwise not acknowledged.

With its emergence as a new field, positive psychology presented a new orientation to social sciences, which according to Seligman and Csikszentmihalyi (2000) concentrated on developing positive qualities and upholding what is right in individuals along with repairing what is wrong. It includes the investigation of processes that lead to flourishing or optimum functioning by uncovering strengths and promoting positive functioning (Gable & Haidt, 2005; Snyder & Lopez, 2009). This helps researchers to explore the brighter side of human nature (Linley & Joseph, 2004). Hence, the value of positive psychology lies in its uniting of what had been scattered and disparate lines of theory and research about what makes life worth living (Peterson & Park, 2003).

Introduction to Resilience and Well-Being

The emergence of positive psychology shifted the focus from deficit to strength-based approach by providing a complete and balanced understanding of human suffering. Positive adaptation with its contexts of risk, significant adversity, or trauma is often reflected in the phenomenon of resilience (Luthar, 2006; Masten & Powell, 2003). Wright et al. (2013) defined resilience as the capacity of a dynamic system to withstand or recover from significant challenges that threaten its stability, viability, and development. Research on resilience dates back to studies conducted with children of parents with schizophrenia which reported that large groups of children showed

healthy patterns (Anthony, 1974; Garmezy, 1974; Rutter, 1979) contrary to expectation. Rather than displaying deterioration due to stressful situations, participants in these studies would often display moderate to high levels of functioning.

With time, studies on resilience began to incorporate various factors and associated consequences such as well-being. Some of these included concepts such as risk, adversity, and protective factors (Wright et al., 2013). While both risk and adversity threaten positive adaptation, they differ in their course of action. Though both factors threaten adaptation, risk is described as an elevated probability of a negative outcome and adversity is an experience of a negative outcome (Wright et al., 2013). Additionally, Wright et al. (2013) add that risk can be either a single risk such as poverty or it can consist of multiple risk factors such as poverty with parental mental illness, parental divorce, and so on. They further outline protective factors, another important component of resilience, defined in basic terms as the predictor of better outcomes particularly in situations of risk or adversity. Research shows that protective factors such as attributes toward oneself, aspects of families, and wider social environment play a central role in developing resilience (Garmezy & Masten, 1986; Rutter, 1987; Werner & Smith, 1982).

Well-being is another important construct in positive psychology. Marks and Shah (2004) defined well-being as more than just happiness. The authors add that along with feeling satisfied and happy, well-being also means developing as a person, being fulfilled, and making a contribution to society. Two common constructs which are widely used to describe well-being are subjective well-being consisting of affective and cognitive elements (Diener, 1984) and psychological well-being focusing on strengths and resources (Ryff, 2014). Dodge et al. (2012) defined subjective well-being as the "balance point between an individual's resource pool and the challenges faced" (p. 230). Figure 28.1 demonstrates the definition of well-being in the context of resilience.

Dodge et al. (2012) and Schultze-Lutter et al. (2016) explain that for well-being to remain stable there should be sufficient resources or resilience in order to meet the challenges or risks.

Fig. 28.1 Well-being presented in the Context of Resilience (Dodge et al., 2012; Schultze-Lutter et al., 2016)

Resilience and Well-Being in the Context of Adaptation to Adversity

Positive psychology research has shown that individuals often show growth following adversity. Hobfoll (2001) and Rutter (2012) claim that adversities are crucial for thriving and also contribute to resilience and functionality. Furthermore, several factors which help in building resilience are also vital for enhancing subjective well-being and positive affect (Hu et. al., 2015). Additionally, according to Schultze-Lutter et al., (2016) well-being is also used as an indicator of resilience specifically when resilience is explored as a process of overcoming difficulties, adversities, and trauma.

There is enough evidence to support the positive correlation between resilience and psychological well-being (Picardi et al., 2012; Sagone & De Caroli, 2013). For instance, several studies have found that resilience and well-being have similar components such as positive emotions, protective factors and increased self-awareness. Studies show that positive emotions displayed at the time of adversity help to facilitate resilience (Bonanno et al., 2001; Fredrickson et al., 2003; Ong et al., 2006) as well as psychological well-being (Boehm & Kubzansky, 2012). Moreover, positive emotions predict increase in both resilience and psychological well-being (Cohn et al., 2009). Isen et al. (1987) found that positive emotions help to promote flexible thinking during adversity which in turn leads to higher resilience and eventually facilitates well-being. Hope and optimism are also important contributors to both resilience and well-being (Duggal et al., 2016; Souri & Hasanirad, 2011). Internal protective factors such as optimism, self-esteem, and happiness or external ones such as work or school achievement and quality of relationships (Brody et al., 2013; Luthar, 2006; Yates & Grey, 2012) are all found to facilitate both resilience and well-being during adversity.

Another group of studies connecting resilience and well-being suggests that individuals with resilience factors such as close friendships, family, and support groups are found to be less vulnerable to sickness, premature death and higher well-being (Calhoun & Tedeschi, 2004; Carlton et al., 2006; Perissinotto et al., 2012). Increase in self-awareness after an adversity is yet another common link between resilience and well-being. Various life adversities have a strengthening impact (Seerey, 2011) and initiate self-growth (Lilgendhal & Mc Adams, 2011), both of which are important aspects of well-being as well as resilience. With growth in self-awareness, features of well-being and resilience such as positive emotions, character strengths, and life satisfaction develop as well (Cloninger, 2004). Thus, both resilience and well-being appear to have common elements that help individuals to overcome adversities. But there have been few attempts to incorporate resilience and well-being together in studies (Schultze-Lutter et al., 2016).

Hence, the present study attempts to address this gap in the literature by exploring resilience and well-being among individuals who have experienced adversity. The case study method was considered suitable for this purpose as it allows the in-depth investigation of subjective experiences in an adequate manner.

Positive Adaptation Through Life Stories

Life stories are in-depth descriptions of a person's whole life (McAdams, 1985). In developing the self-narrative, the individual creates a sense of continuity over time, as well as coherent connections among self-relevant life events, each of which can be experienced as authentic. Such narratives provide meaning and a sense of future direction (Liftons, 1993).

In the context of adversity stories, it is observed that resilient individuals display positive emotions while remembering the deceased and gain comfort from sharing positive memories (Bonanno et al., 2002; Bonanno et al., 2004). Research suggests that such narratives of personal events are beneficial for individuals' psychological well-being (Boals et al., 2011; Waters & Fivush, 2015).

The broad topics explored in this investigation are: (a) adversities faced by the participants (b) resilience and well-being experiences reported by participants.

Methodology

Participants

The present study is part of an ongoing investigation on positive adaptation after adversity. Individuals contacted via support and storytelling groups participated in a quantitative survey. Those who were willing to share more of their personal experience indicated their interest through one of the survey questions and were later contacted for an interview. Approval from the Institutional Ethics Committee was taken. Participants provided consent after they were apprised with information about the study including anonymity, confidentiality, objectives, and methodology.

For the present paper, four interviews were selected from the qualitative sample covering the following past adversities: loss of relationship, loss of physical health, child sexual abuse, and domestic violence. The sample consisted of two male and two female participants with a mean age of 32 years of which two were businessmen, one was a housewife and one was a student.

Case Study Method

Case studies have been used largely in social sciences such as psychology, education, and social work research with a study of a single case or a small number of cases. Case study is defined as an in-depth exploration from multiple perspectives of complexity and uniqueness of a particular project, policy, institution, program, or system in real life (Simons, 2009). Case study method is important to study the subject of concern in depth. It helps in identifying and measuring the indicators in theoretical

concepts, helps in identifying additional variables and fostering new hypotheses, closely examines the role of causal mechanisms in individual cases and their capacity for addressing causal complexity (George & Bennett, 2005). This approach was considered suitable for studying resilience and well-being as these involve a certain degree of subjective experiences. Case study method would thus allow participants to report these unique experiences, an opportunity that quantitative methods do not allow.

McAdams (1985) Life Story Approach

McAdams (1985) life story approach comprises questions where participants were asked to view their lives as a book with a title, chapters comprising significant periods in life, and plot summaries. The life story interview schedule covers various life events including negative and positive life events since childhood till the present, personal ideologies, turning points, and other information which brings together memories regarding these events. McAdams (1996) noted that a life story can be used to create, transform, solidify, or highlight important aspects of life. This technique was considered appropriate for the present work as it is helpful in investigating events that have occurred over a period of time using specific questions. This method also appears to fit well with a case study approach.

Data Collection

Semi-structured interviews for each individual were conducted using nine broad questions as prescribed in McAdams (1985) life story approach. Participants narrated stories of adaptation to multiple negative events in their life. These interviews lasted between 45 and 90 min were audio-taped, and transcribed.

Data Analysis

Interview transcripts were analyzed using thematic analysis as per Braun and Clarke's (2006) guidelines. This method helps to identify, analyze, and report patterns or themes within the data and minimally organizes and describes the data set in rich detail (Braun & Clarke, 2006). These themes represent some level of patterned responses or meaning within the data set (Braun & Clarke, 2006). Thematic analysis was considered appropriate for the present study as this research was exploratory in nature. Since this was a case study approach, it was expected that rich information would be available, so thematic analysis was deemed appropriate as it allows for detailed and complex descriptions from data.

Results and Discussion

Vital information reported by the participants is displayed in Table 28.1. This is presented in the context of key resilience concepts proposed by Wright et al. (2013).

As is evident from Table 28.1, participants have undergone a wide variety of adversities leading to different losses and several risk factors. Despite this, by navigating through internal and external protective factors, they have been able to display a range of positive outcomes. This information will be referred to in discussing the themes revealed from Braun and Clarke's (2006) thematic analysis.

Various themes were identified from the life stories narrated by the participants. Major themes identified were negative experiences and emotions, positive emotions,

Table 28.1 Participant's data presented with reference to the key concepts of resilience as proposed by Wright et al. (2013)

Key concepts	Participant 1	Participant 2	Participant 3	Participant 4
Adversity (Primary loss; secondary loss)	Physical health: Loss of arm in accident; pain and other symptoms stemming from phantom limb syndrome	Relationships: Death of father to cancer, death of grandparents, bullied throughout school, mistreatment by boss; depression and loss of identity	Relationships: Domestic abuse by husband, son is in vegetative state after bike accident; humiliation and depression-like symptoms	Relationships: Child sexual abuse, death of uncle to chronic illness; depression like symptoms
Risk factors contributing to cumulative risk	Lack of finances due to fund restrictions in start-up, loss of father at young age, fear of infection due to crocodile attack	Taking on several family and financial responsibilities due to father's loss at an early age, mistreatment from relatives, unable to accept homosexual identity due to fear of discrimination	Abuse on several occasions for many years, lack of financial support, no support from extended family	Sexual abuse on multiple occasions and witnessing parental conflicts since childhood, authoritarian parenting
Protective factors	Support from parents especially mother, friends, colleagues, pet dogs, strong will to succeed in start-up, practical thinking	Support from sisters, mother, and friends, exploration of music and designing, positive, hopeful attitude	Support from daughter and son's friends, optimism, positive, hopeful attitude	Support from grandfather and teachers in childhood, and husband in later life, being mindful in situations, pursuing psychology professionally

benefit finding, presence of significant others, and pro-social behavior. Minor themes included social comparison, patience, and individual choices.

Major Themes

Negative Experiences and Emotions

One of the major themes reported was negative experience and emotions. This is not an unexpected finding considering that the occurrence of significant adversities led to the experience of multiple risk factors. Participants reported experiences such as pain, feeling low, suicidal thoughts, and depression-like symptoms. For instance, the primary loss in case of Participant 1 involved a crocodile attack. This led to other secondary losses as cited by him, "From the time I lost my hand, till now…I experience phantom limb syndrome…and extreme pain…it gets very difficult to manage." Phantom limb syndrome is found in at least 42–90% of individuals who have experienced loss of a limb (Reiber et al., 2010). Thus, it is clear that Participant 1's condition is medically common, painful and present at the time of the interview. Therefore, negative emotions under such distressing circumstances are not unexpected. Similarly, two suicide attempts by Participant 3 following prolonged domestic violence, and clinical depression encountered by Participants 2 and 4 as a result of facing several adversities led to the experience of a range of negative emotions such as fear and anger. Participant 4 expressed, "After the incident I felt very low…I was depressed and had insomnia…I would barely talk to anyone…I lost my sleep and would hardly eat due to which lost 12 kg" of weight. According to Babson and Feldner (2010), depression is one of the most common symptoms reported following trauma. It may also lead to sleeping difficulties and anxiety in some instances (Ginzburg, 2010). This shows how primary losses resulted in secondary losses leading to cumulative risks, eventually resulting in negative experiences and emotions.

Positive Emotions

Even though participants reported negative experience and emotions due to adversity, they also reported positive emotions. This is confirmed by earlier findings that experiencing such positive emotions during challenges contributes to better psychological outcomes (Bonanno & Keltner, 1997; Bonanno et al., 2005). A range of positive emotions were reported by participants which they believed helped them to move forward through the adversity. For instance, Table 28.1 shows that being optimistic and hopeful about the future were the most common positive emotions observed across all cases. Participant 1 conveys this in the following statement, "…I never give up, it's the last option" while Participant 4 expressed, "Something bad

happened…but it also leads to something good…I acknowledge the love I have in my life, always." This displays that participants have made the effort to find positive emotions in the midst of negative events which has kept their hope alive toward favorable outcomes in future. This may be understood in light of Valle et al.'s (2006) comment that hope is positively correlated with life satisfaction and serves as a buffer against negative and stressful life events.

In this context, it is important to mention Participant 3's observation that smiling through every situation, be it positive or negative helps her to discard societal judgments and stay happy. In her words, "I smile a lot…I am always very happy." Duchenne (1862) distinguishes genuine smiles or Duchenne smiles from non-Duchenne or courteous smiles. The former is described as involuntary, originates from the emotion center of the brain, and appears around the mouth and eyes while the latter appears around the mouth but not the eyes, is voluntary, and has social functions. In case of Participant 3, the non-Duchenne smile, though not the indicator of genuine happiness, appears to be associated with positive communication that helps her to stay happy, as explained in her words. This is supported by research which suggests that non-Duchenne smiles may be associated with self-reported happiness in adults (Hess, 1995; Jakobs et al., 1999).

Additionally, positive emotions were recounted in the context of happy memories with significant others such as friends and family who helped Participants 2 and 4 to overcome childhood trauma. Similarly, Participants 1 and 3 displayed positive feelings toward their pet dog and children respectively and verified how they were grateful for such relationships. Contentment and social accomplishments derived through engagement with art appeared to contribute positively in case of Participant 2. Hence, positive emotions were reported to be a major theme despite the losses incurred. It may have contributed to favorable outcomes in the participants as also supported by Boehm and Kubzansky's (2012) and Fredrickson et al. (2003) investigations which showed that positive emotions led to increase in psychological well-being and resilience, respectively.

Benefit Finding

Benefit finding in adversity was another major theme reported. Though as an experience, it is similar to positive emotions; however, benefit finding operates strictly in the context of adversity. Participant 1 found benefit in discovering positive emotions toward his pet dogs. While narrating how he escaped a crocodile attack, he says, "When I was deep down inside the lake, I could only hear my dogs barking, so I followed the sound….I am very thankful to them for my life as the visibility was nil due to muddy water." This may be interpreted as finding the silver lining during tragedy as also echoed by Participant 3 who expresses thankfulness toward God for the presence of four supportive individuals in her life. Despite being subjected to domestic violence by her husband, Participant 3 is grateful as she believes that this bitter experience contributed to the love, strength, and respect she displayed in her

parenting behavior. In both cases, there is an attempt to be thankful for one's blessings despite an overwhelmingly traumatic experience. Tennen and Affleck (2002) observed that in traumatic situations, individuals who show gratitude are able to display more resilience than others. Additionally, Participant 3 narration of her experience displays that individuals focusing on the lessons learned after an interpersonal conflict such as how they are resilient helps them to experience joy and positivity (Witvliet et al., 2010).

Another common benefit reported was developing belief in one's ability to overcome adversities after having experienced one. Participant 3 says, "From fire…you either perish or you will live and these low moments teach you a lot…I did not know that I had that much strength." Self-belief was also reflected in participant's comments that they no longer seek external validation. Participant 2 says, "Whenever I doubt myself, I would just go back to my achievements…and I know that if I need any validation, it is from my own self." This is similar to Participant 1's claim, "The change which I noticed is I started believing in myself more…it was validation for me…I started believing a lot in myself." He further adds that earlier he was ignorant of his ability to fight pain, but after facing the accident, he believes he can overcome any pain. These findings suggest that there is an increase in self-belief following adversity. This is consistent with Lilgendahl and McAdams' (2011) finding that various life adversities initiate self-growth in many ways.

Participants also reported various behaviors that they developed as a result of facing the adversity which helped them overcome difficult situations. Participant 2 comments, "Whenever I feel I am failing, I would pick up something new and try to learn…this reaffirms that I am capable of …." This led to him being able to master the sitar and eventually gave a public performance. The benefit of exploring new activities led to an enhanced skill set for the participant thereby adding to his well-being. This is confirmed by findings from a meta-analysis review by Helgeson et al. (2006) which shows that benefit finding was related to lower levels of depression and positive well-being among individuals who have suffered loss. On the other hand, Participant 4 mentioned that conversations with her grandfather helped her to find solutions to problems. Later when faced with an adversity in life, these helped her develop an internal dialogue. It eventually reduced her negative thoughts and provided comfort. In her words, "My internal dialogue is very strong…I tell myself… don't stop and keep moving." This may be understood in light of previous literature on self-talk which claims that it is found to facilitate various benefits in individuals such as self-awareness, self-reflection, self-evaluation (Morin, 2018; White et al., 2015), coping with painful experiences (Kross et al., 2014).

Another benefits found post-adversity, Participant 2 also reported enhanced social relations with his siblings and mother including developing greater empathy for his mother. This is supported by Lim and DeSteno's (2016) finding that links extreme adversity with an increase in empathy. Additionally, Participant 3 despite having faced domestic violence was able to recognize her blessings in the form of support from her son's friends and an opportunity to serve her son who is presently in a comatose state. According to Seligman et al. (2005), counting blessings has been

cited as one of the most effective ways to increase subjective well-being. Additionally, the loss also resulted in an improved relationship between Participant 3 and her daughter. This is supported by Linley et al.'s (2004) finding that enhanced interpersonal relationships and value for others are observed among individuals with past adversities. Additionally, Participant 4's childhood trauma of abuse and witnessing parental discord at home led her to questions, the answers to which she discovered in her academic and professional pursuit of psychology. She recounts, "…because of my loss, I could deeply empathize with others pain and suffering…helping others helps me too…."

From the above-mentioned instances, it is evident that participants found several benefits from the adversities faced. This is consistent with Baker et al. (2017) observation that by prioritizing benefits, individuals practice benefit-focused reappraisal which is similar to finding the silver lining.

Presence of Significant Others

Participants acknowledged the helpful presence of significant others such as family and friends as displayed in Table 28.1. This was found to be a commonly reported external protective factor. Participant 2 recounts the support received from his sisters following the death of his father. In his words, "During this time, my sisters and I bonded really well…we started spending more time with each other since the loss." Participant 3, on the other hand, declares that her daughter who is her biggest strength has been supported through several adversities such as domestic abuse and her son's medical condition. She says "My daughter and my son's friends are my biggest source of strength…I call them my angels." As reflected in Table 28.1, Participant 4 discovered support from her grandfather in childhood and from her husband in later life, whereas Participant 1 mentions finding strength in his parents, especially his mother, "My mother is the biggest influence and strength…my resilience comes from her because…she is a go getter." Thus, it is evident that significant others such as family and friends acted as an external protective factor that contributed to participants' well-being. Such interpersonal relationships are important factors in dealing with adversities as reported in past studies. For instance, Perissinotto et al. (2012) declared protective factors such as close friendships, family, and support groups as key components in resilience and well-being while Sehmi et al. (2019) emphasized on their importance in mitigating mental health difficulties under particularly stressful situations.

Pro-Social Behavior

Pro-social behavior appears to be a frequently reported consequence which in the participants' words has helped them to cope with adversity as well as increase their

well-being. Participant 2 narrates an incident where he used his professional skills to help someone with work. He comments "What helps me cope is how much of a difference I have made in another person's life…if I can help someone, it helps me to improve my well-being and I feel good about it." He firmly asserts that during times when he feels helpless about his situation, he finds satisfaction in being able to help others and make them happy. Volunteering activities such as at orphanages were also associated with feelings of happiness and satisfaction as reflected in Participant 3's comment, "…I feed the kids and dance with them… they wouldn't leave us…. that's how I like to celebrate." Other than volunteering and random acts of helping, Participant 4 also believes that she can reach out to people and help them professionally. She shares, "I started finding comfort through helping others…I started counselling them and being there for them." Grossman et al. (2006) study which found an increase in pro-social attitude among victims of interpersonal violence such as sexual abuse may explain Participant 4's pro-social behavior following her sexual abuse. Likewise, Participant 2 also conveys that there are times when she is unable to deal with her personal issues but feels a sense of satisfaction from at least being able to help others. She refers to this as "… two-way coping mechanism." This may be viewed in light of Wayment's (2004) claim that pro-social behavior is a coping mechanism. He found that individuals while helping others may be able to help themselves to cope with their stress. Similar to these results, other findings by Staub and Volhardt (2008) and Volhardt (2009) have shown the presence of pro-social attitudes and behavior among individuals with a past adversity.

Minor Themes

Some themes were reported infrequently however the participants recounted strong emotions associated with these experiences. These have been categorized as minor themes as presented below.

Social Comparison

Participant 3 derives comfort from the idea that she is living a better life than many others. She compares herself to mothers whose sons have died and concludes that her son even if in a vegetative state, is at least alive. She explains that "…when you see your pain and when you see a bigger pain, your pain reduces and I learned that over time." Likewise, Participant 2 compares himself with other individuals who are unable to get another chance in their career, but feels fortunate that he had an opportunity to change his career. The tendency to compare oneself with others in worse situations is known as downward social comparison (Wills, 1981). According to Wills (1981), downward social comparison by individuals can "increase their subjective well-being through comparison with a less fortunate other" (p. 245).

Research shows that comparing oneself with those who are worse off may help in redefining the situation positively thereby increasing life satisfaction (Buunk et al., 2001; Frieswijk et al., 2004). This is reflected in the participants' experiences as well.

Patience

Patience is another common theme reported in this study. Participant 3 explains how in life one has to sometimes change "tracks" and this "… takes time and patience." She further adds "I did not know that I had patience…but I handled everything calmly…if I wasn't patient, I wouldn't be here today." Similarly, Participant 4 claims that by maintaining patience and calm, one can cope with adversity. This is supported by Fredrickson et al.'s (2008) finding that patience is one of the characteristics of resilient individuals that leads to greater well-being.

Individual Choices

Participants emphasized the importance of individual choices which emerged as a minor theme in the analysis. For instance, Participant 4 claims that "…we are defined by our choices…your life is purely determined by your choices…." Participant 3 added that suffering is also a choice; further explains "…you may or you may not suffer depending on what you choose." This is in agreement with Lundman et al. (2010) finding that to make one's choices and influence life's trajectory in a meaningful direction is a strength that facilitates resilience. Being aware that one has a choice may contribute to the process of overcoming adversity.

The discussion above presents a number of themes that reflect how participants were able to navigate through the specific adversities faced by them.

Resilience and Well-Being: Evidence from Themes

This section discusses evidence for resilience and well-being which are both vital in the context of development after adversity. Themes that emerged from the narratives point toward adapting and optimal functioning. It can be concluded that despite facing multiple adversities and risks participants displayed several strengths. This information directs the discussion toward resilience as portrayed by Wright et al. (2013), as the capacity to withstand or recover from significant challenges. Several protective factors which are essential components of resilience (Garmezy & Smith, 1986) and well-being (Carlton et al., 2006) were displayed through various themes. Some of these include internal and external protective factors such benefit finding

and presence of significant others respectively. Apart from satisfaction and happiness in their current state participants also reported feeling content when engaged in community services. This experience is supported by Marks and Shah's (2004) proposition of well-being.

Figure 28.1 presents Dodge et al. (2012) claim that creating a balance between individual's resources and challenges is necessary for well-being. This figure also incorporates resources that display resilience and challenges as risk factors in accordance with Schultze-Lutter et al.'s (2016) findings. Participants' narratives and the themes analyzed display this balance between resources and challenges. The extreme negative emotions and experiences resulting from multiple adversities were balanced by positive emotions such as empathy and gratitude, prosocial behavior, benefits found through adversities, and acknowledgment of significant others. This process of balance may have contributed to wellbeing outcomes in specific areas.

Highlights from Four Case Studies

A case-by-case presentation of resilience and well-being evidence is provided here to support the arguments made above.

Participant 1

Acceptance of the situation and attempting to adapt to it has been repeatedly displayed by Participant 1. After surviving a crocodile attack where he lost one arm, he trained his other arm to function efficiently so that he is able to live independently. He narrates, "I never feel that I can't do something because I don't have one arm…I just restrained myself…I can even tie my shoelaces with one hand." He was a Formula 1 racer before the traumatic event occurred. He recounts "…the hand which I am wearing now, this is made of the same material as my racing cars …it is a throwback to my earlier life." In sharing this important trivia about his prosthetic hand, Participant 1 made a conscious attempt to create positive associations between past memories and his present situation. Such efforts have also been exhibited in achieving well-being outcomes in other areas such as work and relationships.

Participant 2

After losing his father to cancer, Participant 2 struggled with his identity for several years. While he identified as homosexual, he was unable to decide if he should come out to his family and society. He shares that "My father's death made me focus more on the individual aspect of life…that I am unique and I should accept the fact that I am this way…I should take this in a positive manner rather than faking it." It is important to note that despite identifying himself as homosexual, he never actively thought about his future before his father's death. He is currently pursuing an academic program in design so that he can develop a successful career in it. This is a positive development as he was earlier unable to chase this dream

due to poor self-confidence. He also believes that establishing himself professionally and earning fame and money will help him to outrun societal criticism which he will otherwise be subjected to due to his sexual identity. This narrative depicts acceptance of one's identity, and hope and aspirations about the future as a successful designer which are indicative of resilience and well-being, respectively.

Participant 3

Despite being the victim of long-term domestic violence, Participant 3 is able to recognize several silver linings in the situation and in herself. She specifically mentions her strengths and how she overcomes challenges. For instance, she makes a conscious effort to change her perspective from negative to positive events. She shares, "I am not separated from my husband and I will never get separated…but I feel proud to be a good mother and I feel pity for him…he is not fortunate enough to love and serve his children." Fulfilling the role of a mother by taking care of her children gives her happiness and satisfaction. On the other hand, she expresses pity for her husband as he could not be a good father. This manner of appraising situations appears to have contributed to her process of surviving domestic violence along with the conscious effort toward counting blessings rather than her misfortunes. This presents a case of acceptance of circumstances and maintaining well-being by focusing on the positives rather than the trauma.

Participant 4

Participant 4 recounts finding solace in books through her process of coping with multiple adversities. Additionally, she acknowledges the contribution of her grandfather who would often guide her about handling difficult situations such as not intervening in parental conflicts that were frequent throughout her childhood. Participant 4 also expressed that, "My grandfather was a very good counselor…I think I learnt that skill from him." These accounts show that her grandfather was a key influencing factor in various situations including her choice of career involving counseling and helping others. Additionally, she stated that her strong will to pursue higher studies was also fueled by her urge to move away from her parents, "I really want to move out for studies and see the world…also I am tired of conflicts in my house." In addition to family disputes, she also faced other challenges. In dealing with sexual abuse in childhood from her cousins and in adulthood from her boyfriend, she was able to use internal dialogues and her education in psychology in effective coping. She strongly emphasizes on recognizing her life's goal as an outcome of all what has happened to her. She derives meaning in her life from helping others, "We all need a purpose, some meaning, and some value in life, so…if I can help ten people, it gives me satisfaction."

These instances of positive outcomes presented above display participants' resilience and well-being. This was achieved by striking a balance between their resources and challenges as posited by Dodge et al. (2012). This balanced position includes the presence of negative thoughts and feelings experienced under specific situations. For instance, although Participant 3 is no longer subjected to domestic violence, she still fears its recurrence and Participant 4 occasionally experiences

mental health symptoms. Also, Participant 2 currently striving to make a better future for himself, is still unable to reveal his sexual identity for fear of discrimination from loved ones. Despite such challenges that participants were currently working on during the time of the interviews, there is sufficient evidence in favor of resilience and well-being as well.

Limitations of the Study and Future Directions

Although the case study approach is a good method to collect rich data, the current paper is limited to four case studies only. For more generalizable results, investigations using a higher number of case studies may be conducted. The case study method is recommended especially for strength-based studies as it allows the exploration of subjective experiences including unique mechanisms which are otherwise difficult to identify through large-scale, quantitative surveys. For similar reasons, use of an interview method to generate narratives is recommended for future research. While the McAdams (1985) life story approach has been an effective method in the given context, it is a less explored method in the area of resilience and well-being. Future researchers may consider using the McAdams (1985) life story approach in exploring case studies as it helps in seeking in-depth information.

Finally, resilience and well-being constructs should be explored together in future research as both seem to be interlinked in their contribution to growth through adversity.

Implications

The current study provides an additional perspective to the information presented by the deficit-based models which focus heavily on vulnerability and suffering after adversity. These findings may be used by researchers and practitioners to help participants who have undergone similar experiences. For instance, refocusing and acknowledging positive changes may be a key component of resilience and well-being. Furthermore, mental health practitioners who are working with clients who have experienced loss may help them to identify their strengths. For example, positive emotions along with internal and external protective factors displayed by clients can be discussed during the sessions, as a source of their strength.

Conclusion

Participants were faced with significant challenges stemming from primary and secondary losses. It is not surprising that participants reported negative reactions

such as pain and depression, some of which they were still working on improving during the time of the interview. However, they were able to bring about a positive change in their conditions by using the available resources. Findings pertaining to resources and strategies associated with resilience and well-being may be utilized by researchers and practitioners to help individuals going through similar situations.

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Chapter 29
Psychospiritual Cleanliness and Well-Being: A Relevant Path to Be in Sync with Nature

Nilanjana Sanyal

Abstract The jet-set pace of modern life has essentially met a staggering jolt with the ensuing pandemic put forth by the novel Coronavirus. Mankind is vehemently trying its level best to combat the epidemic and curb the death-toll worldwide as much as practicable. Certain practices of self-discipline are coming to the forefront these days to keep individuals "physically and mentally sanitized." The regime of self-cleanliness is establishing its significance in the present-day situation. Besides, it is nature which is trying to provide a life lesson to its most intelligent and rational inmates to inculcate submission to the Cosmic Power and to gradually develop herd immunity. Developing a sense of gratitude for the givens of life essentials one to develop a fountain of positivity to maintain his/ her state of well-being. The practice of physical, emotional, and spiritual cleanliness helps to foster a state of tranquility, a "feel of being anchored" leading to the maintenance of well-being among *Homo sapiens*. It is then that human beings will learn to cohabit the planetary space with other species peacefully and symbiotically. Wellness is bound to thrive in nature consequently. The chapter engages into a theoretical critical analysis of the varied means of sanitizing oneself on the whole to foster well-being of the society. The cry of the present day is attempted to be addressed so that the earth can be a safer and secure "container."

Keywords Well-Being · Cleanliness · Physical · Emotional · Spiritual sanitization

Introduction

The visuals of the current world are wearing a deserted outlook of globe space in terms of individuals being forcefully posted indoors as the outcome of Corona fear. The health context of the world is crumbling under the death-knell of Corona. The hedonistic orientation of the globe, suddenly having a jolt from this deadly virus, is reorienting its philosophy of self-control, social distancing, and following the regime of self-cleanliness ardently as the most needed practice point. Beings seemed to have

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_29

challenged "nature" to establish their supremacy—nature is taking its turn to take away the "crown" of human "supremacy galore" to re-establish its strength—its reigning power. Corona seems to be the platter to serve certain notices to "Beings" of "what to do" and "what not to do" to survive and enjoy the rhythms of life. The low immunity content in the human body and failure to combat the deadly virus is to a great extent the outcome of lifestyle in the tune of a specific philosophy of being impulsive to suck the instant gratifications of umpteen number of our desires. The consequences are hanging in the canvas in front of us. It is time to change our mind-frame and develop the needed philosophy of being disciplined. Possessing herd immunity is the call of the day.

The lack of discipline in our character pattern is responsible for numerous health hazards. The present-day folio is clearly pinpointing a basic fact of life that beings are lustful but do not have the sense of basic cleanliness. The context looms large the possibility of inviting and encountering diseases like the present one. Hence, Corona seems to be the teacher to open the gamut of knowledge that beings cannot afford to cater instant impulsive wants always—there should reign self-control and maintenance of certain habits of cleanliness to protect ourselves in health points as well as in social rims of life. Greed, lust, competitiveness, cravings of the highest order to have power, position, and prestige are all the nuances of lack of proper knowledge of life. Corona impact can be a starting point of fresh realization regarding life on the whole—how to salute life in gratitude, how to enjoy life in terms of its natural givings, how to cohabit with other living creatures peacefully, and how to exit life in due course with the fullest grace of acknowledging its givings.

The present discourse will try to cover the idea of cleanliness as a stepping stone to usher in well-being in life in post-Corona days.

Gratitude: The Torchbearer of Positivity

Gratitude may be regarded as an affective trait which reflects recognition or appreciation of an altruistic gift. Its origin may be associated with the Latin word "gratia" meaning graciousness, grace, or gratefulness (Pruyser, 1976). Three components of gratitude have been recognized by Fitzgerald (1998):

a. A sense of warm appreciative concern for something or somebody;
b.. A sense of goodwill toward that thing or person; and
c. A tendency to act positively because of the inherent sense of appreciation.

Gratitude is regarded as elemental in contributing to the well-being and mental health of individuals throughout their life. This is because accumulating evidence documents the wide array of psychological, physical, and relationship benefits associated with gratitude. This virtue enables an individual to be gracious of not only being alive but to be able to have varied realizations of one's life. It is one of the major torchbearers of "sanitation at the psychic level" by instilling a sense of positivity within the self. Taking consideration of the current pandemic situation posed

by the novel Coronavirus, it is the psychic "tool" of gratitude that helps one to realize what is essential versus what is not. It tends to provide a sense of feeling blessed even to be able to "work from home" given the prevailing compromised situation and adorn it into the new lifestyle to remain safe. Gratitude inspires pro-social reciprocity and initiates health components in social life. The experience of gratitude and the actions stimulated by them build and strengthen social bonds and friendships, resulting in social resources—becoming wellsprings to be tapped for the provision of social support in times of need. Owing to its all-encompassing positivity, gratitude is likely to build and strengthen a sense of spirituality in the individual (Sanyal, 2017).

Gratitude increases the likelihood of having a "feel-good" mentality in future. It is found to reduce toxic emotions resulting from self and social comparisons. It thereby serves as a "psychic cleanser." It reduces materialistic strivings and prevents the pains of disappointments in the context. Gratitude is a virtue from moral philosophical context. Gratitude, if is practiced as a regular "awareness" within us in a habitual manner, is expected to change our general perspective in life, and will help us develop a niche of positive personal corner of mind to visualize experiences in their own colors and brightness, helping the individual to be calm and accepting in nature, touching the deep silence of Mother Nature and having fulfillment of bliss therein. This is likely to bring forth peace of mind, deeper, more satisfying personal relationships, physical health, and overall happiness (Emmons & McCullough, 2003). Acknowledging the contributions of anything, be it nature or human behavior, weaves within us the frills of being positive and happy. Why don't we become aware of such phenomenon to celebrate our arrival in the world, acquiring so many things, having folds of varied realizations, our existence with all its intricacies, having gratitude to prove our genuineness and humaneness, to be a contributor to others and to act as good "containers" to so many different elements in life? This orientation of individuals is bound to etch positive lines in the world ambience.

When the interrelations of gratitude with well-being are considered, researchers have found happiness-bestowing properties to supplant the positive association. It has been found true with respect to both dispositional and state gratitude (Wood et al., 2010). The positive emotional valence of gratitude has further been supported by a number of theorists (Mayer et al., 1991; McCullough et al., 2002; Ortony et al., 1988; Weiner, 1985). As such, the practice of interpreting everyday experiences, noticing, appreciating, and savoring the elements of one's life has been viewed as a crucial determinant of well-being (Janoff-Bulman & Berger, 2000; Langston, 1994). This may be explained by the broaden-and-build *model of positive emotions* (Fredrickson, 2001), according to which mind-frames of individuals are broadened by positive emotions to help build enduring personal resources of varied kinds, namely psychological, social, and spiritual. It helps people to experience both momentary as well as futuristic optimism. Grateful individuals do not feel deprived in life as they have ample reasons to be gracious of. They also tend to be appreciative of the contribution of others in their lives. This appears to boost their sense of well-being as well. Further, gracious beings appear to be appreciative of simple pleasures in life which are readily available to most individuals. Their psyche hence tends to be filled up to the brim with subjective benefits in life, helping them to cultivate higher degrees of

life satisfaction (Watkins et al., 2003). Social bonds and interpersonal relationships are enriched consequently. Gratitude prompts an individual to invest psychic energy to develop a personal "script" of considering life as a "gift" and be basked amidst the varied "gifts" of nature. This practice of grateful thinking is essentially ingrained with the psychological and overall social functioning of the person as well as his/ her spiritual functionality (Adler & Fagley, 2005; Emmons & Kneezel, 2005; Wood et al., 2010). Grateful beings appear to have a relatively greater sense of having contact with a divine power and have the firm belief that all living beings are interconnected entities in relation to the wider cosmos. Along the same tune, strong association of gratitude has been found to be related to transcendence (Emmons & Crumpler, 2000; Emmons & McCullough, 2003; Langston, 1994). As expected, gracious beings tend to have relatively lower scores on materialistic orientation toward life in general (Kasser & Ahuvia, 2002; Lamberta et al., 2009; Polak & McCullough, 2006; Srivastava et al., 2001). This may be explained by the fact that such individuals enjoy a sense of emotional security and completeness due to their gracious orientation. They have greater sense of intrinsic personal resources of self-fulfillment consequentially. It helps the beings to engage in a form of love in relation to the self as well as others and plays a vital role in the formation of new affectional bonds in general (Roberts, in press). They enjoy rich relational experiences as a consequence and have generative concerns for members of younger generations. As such, a sense of gratitude in individuals essentially serves to cleanse negative emotions and helps the person to be psychologically anchored to the givens of life.

The following fold would attempt to look into the psychological-spiritual impact of yet another purifying practice, namely yoga in our daily lives.

Yoga: The Psychological "Cleanser" of the Self

"Yoga" is derived from a Sanskrit word *yuj* that means union, to yoke, or to join, attach or bind; the merging of the microcosm of our existence in our body with the macrocosm. Philosophically, it involves the individual self, or *jivatma,* to unite with the universal self, or *paramatma*. It produces a state of bliss where there is cosmic union, where, obviously, feelings of egoism and narcissistic feelings do not emerge. It enables the union of the physique with the psyche, and the psyche with the self at the level of consciousness. It means a poise of the soul which aids one to look at life in all its aspects evenly (Iyengar, 1976, 1993). Yoga is thus a dynamic, internal experience which integrates the body, the senses, the mind, and the intelligence, with the self (Iyengar, 2006). It relates to inner communion with the self. The different *asanas* are avenues for training the inner being, such that the body learns to follow one's intentions and follows a disciplined regimen.

It is to be noted that although yoga is essentially a spiritual science, it leads to a sense of physical and emotional well-being. It is *Asanas* or postures which cater to the needs of each individual according to his or her specific constitution and physical condition. They involve different types of movements on the part of the

individual which direct blood and hence oxygen supply to the varied parts of the body which need it most. *Asanas* bring steadiness, health, and lightness of limb. A steady posture brings forth mental equilibrium and restores tranquility of mind by preventing fickleness. The blood supply to each cell is now smooth which enables it to function properly. The total involvement of the individual during the positioning of his body into different postures establishes sound communication between the external and internal selves. One is expected to develop agility, balance, endurance, and great vitality as a consequence. Thus, yoga is called *sarvaanga sadhana,* or holistic practice (Iyengar, 2006). *Asanas* help the individual to acquire physical and psychic equilibrium by curtailing turbulent feelings of pain, fatigue, doubt, confusion, indifference, laziness, self-delusion, and despair that confound individuals from time to time. The yogic mind moves forward in the voyage to the total liberation of the self by practicing "psychic cleanliness." This is brought about by a regular practice of self-disciplining the mind.

The practice of yoga helps in overall growth and development of the psyche by changing dysfunctional attitudes, converting apprehension into courage, indecisiveness, and poor judgment into positive decision-making skills, and the like. Self-esteem and confidence on the part of the yogi get boosted up as a result. As such, it instills a state of well-being in the individual gradually. The consequence is freeing the soul from the bondage of body, mind, power and pride of success, where it reaches the state of *kaivalya* or freedom. "It is then that the seasoned, mature mind transcends frontiers to reach beyond mundane observation" (Iyengar, 2006). It helps the system to reach the highest state of mind, being, *niruddha,* or the controlled, restrained mind. According to Patanjali, persistent practice of yoga helps in the attainment of *niruddha.* This enables the individual to conquer greed, lust, and cravings of varied kinds and help one to reach the peaks of self-realization (Deshpande, 1978).

It is during this condition that the individual immerses himself completely in the absorption of self-consciousness, allowing no distraction of any kind to contaminate the serenity. It is during the quiet phase of the brain when the intellect is at peace; the individual is serene and balanced, and poised in pure consciousness. It is the yoga practices in the form of posture, breathing, and relaxation which serve to quieten the mind for contemplation of deeper issues, such as the roots of suffering, internal peace, and spiritual insight. Yoga then becomes a "lifestyle." This lifestyle needs to be adorned in the post-COVID-19 world to help face issues of virtual mobility and energy efficiency in a healthy manner. This is expected to help cultivate a healthy lifestyle among individuals so that people move forward to a more sustainable post-COVID environment. In time, one's behavior is expected to become aimed toward balance and peace of mind, and this in turn enriches life and promotes a sense of well-being (John et al., 2007; Mackenzie & Rakel, 2006).

Meditation: The "Psychic Panacea" to Instill Well-Being

Meditation is a form of mental spring-cleaning, or a form of mental purification (Fontana, 2004). It bathes the mind by gradual steps of relaxation which is done by means of developing powers of concentration and awareness. This involves a gradual process of psychic cleanliness. Different challenges of daily living are dealt with more efficiently and effectively as a result. It allows individuals to see into themselves, almost as if a window, hitherto obscured with dust, has been wiped clean. It involves different exercises, some involving connecting with the breath, working with sensations in the body, feelings, and emotions, witnessing one's thoughts, engaging in forgiveness, loving-kindness, social responsibility, and the like (Kornfield, 2005). Meditation uses a number of different techniques, some being, focusing on one's breath, repeating a mantra, detaching oneself from his own trail of thought-process, focusing attention to bring about a state of inner calm, a realm of silence leading to greater clarity and self-awareness. Non-cultic forms of meditation are used for clinical and research purposes to yield prophylactic and therapeutic health benefits. In fact, a plethora of research studies has been found in favour of the same (Canter, 2003). Meditation also cannot be forced, but is instead a conscious state. Individuals need a degree of willpower to remain in the state of heightened awareness that occurs when one meditates. However, at the same time individuals need to relax, letting go of all expectations and desires. The art of meditation involves a delicate balance between the effort needed to sustain concentration, on the one hand, and detachment from all distractions, on the other hand. It is a process where the yogi learns to train himself to gradually focus the mind without struggle, and thereby requires time. The yogi learns to become committed to live in the present moment, gives up living in the past, and daydreaming or worrying about any imaginary future. He gradually learns to modify himself by accepting gracefully whatever comes up. Yoga thereby gradually inculcates a life philosophy within the individual. In short, it means controlling the tendency all individuals have to live in a fantasy world, a world in which one uses the imagination to create a defense against suffering. Thus, meditation allows us to see things as they are, without the masking veil of our likes and dislikes, without fear or hope. It is during meditation that one can disrupt the unconscious progression of thoughts and emotions by focusing on a new object of attention. It is one of the best ways to get free of the grip of "sticky emotional baggage" and connect to our true self, which is infinite in nature. Meditation appears to provide a "mental spa" to the organismic system to relax, rejuvenate and heal. It is of dire necessity to turn inward during the post-COVID days to feel emotionally grounded and maintain a sense of well-being.

Meditation may be of different traditions, involving concentration, mindfulness, and directedness (Kristeller & Johnson, 2005). During concentration, the focus of attention on the part of the yogi is on a particular object, which is frequently a word, mantra, phrase, prayer, or simply the breath. The goal is maintaining focus as much as possible on the particular object of attention. The individual is told to return his focus to his breath or the original stimulus if his mind wanders off

in haywire directions during meditation. In sync with this, mindfulness meditation requires the individual to keep his mind open and attend to whatever comes in his field of awareness without being judgmental. Thus, purposeful suspension of analytic engagement with or "thinking about" the object of awareness takes place in this type of meditation (Trungpa, 1976). An emotion, a physical feeling, an image, an external object, or simply the breath may be the focus of attention in this type of meditation. Mindfulness meditation encourages greater flexibility in the object of awareness. It is essentially free from analytic or self-judgmental thought patterns. Vipassana practice, a variant of mindfulness meditation, often uses the breath as a way to re-engage the attention, should it become caught up with such analytic thinking (Gunaratana, 2002). The person is instructed to remain non-judgmental in his outlook and embrace anything that comes up in his arena of awareness. This is done by applying one's attention to one's bodily sensations, emotions, thoughts, and surrounding environment (Bodhi, 2000; Germer, 2005; Germer et al., 2005; Gunaratana, 2002; Wallace, 2001).

Yet another meditation is focused or directed meditations, where the content carries significance. It is intended to engage a particular aspect of self, but in a mindful rather than analytic or judgmental way. The symbolic mandala may be used as a particular chant in traditional meditation practices. One goes beyond the noisy chatter of the mind that is usually present into an entirely different arena—it being the silence of the mind which brings a sense of calm and inner peace. It is through regular practice that the experiential richness of silence and inner peace begins to permeate in other folds of life of oneself. The individual then becomes a soul radiating warmth and inner light to others, being in harmony with one's true spiritual self.

Meditation traditions generally use primarily one type of practice (concentrative, mindfulness, or directed), but most contain elements of all three. Transcendental meditation (TM) is often accompanied by *mantra*, which is repeated continuously and silently in the mind. However, sustained effortful focus is not emphasized here (Achterberg et al., 1994; Thera, 1962).

Pranayama: The Breath Meditation for Cleansing Self

Pranayama is a specialized variety of meditation where the breath of an individual is systematically directed to the different parts of the body including the brain. The cells remain receptive to the intake of oxygen, and it is during inhalation that each cell of the body is mindfully felt by the person and the body becomes receptive to absorb the life energy in the form of *prana*. The body is at peace with no drastic movements. This helps the individual to become aware of the gradual expansion of the respiratory organs and the breath to reach different remote parts of the system.

During the regimented pattern of breathing in the form of *pranayam,* a sense of peace is enunciated within the body where it has to dip in the solace of quietude, which allows the nervous system to function more effectively. Inhalation involves

receiving primeval energy in the form of breath, and bringing the spiritual cosmic breath into contact with the individual breath. Exhalation relates to the removal of toxins from the system in the form of carbon dioxide. Deep breathing may be used as an example to how one can stretch a little further each day with regular practice (Erikson, 1950; Tornstam, 2011). A new awareness is developed of how to take good care of the body without being obsessed.

Thus, *pranayam* brings about the linkage of the physiological and spiritual layers of the individual. At first, *pranayam is* difficult and requires great effort. Mastery is achieved when pranayama becomes effortless. Just as the diaphragm is the meeting point of the physiological and spiritual body, the retention of energy or *kumbhaka* is realizing the very core of one's body (Iyengar, 2006). When the distractions of the body in the form of movements are controlled, inner silence prevails. It is then that there is no thought and the mind is crystal clear in its experiential richness. Then the individual comes to experience the elevated state of oneness with the self and can attain the level of spiritual bliss. This is of utmost significance for the individual so that he/she may come to terms with life as a whole, deal with its different challenges along a positive light.

Mindfulness Meditation: A Practice for Restoring "Psychic Cleanliness"

The term "mindfulness" can be traced to Buddhist philosophy which relates to the practice of remembering to pay attention to the present momentary experience (Black, 2011; Shapiro & Carlson, 2009; Williams et al., 2004). Its origin comes from the Pali word *sati*, which means having awareness, attention, and remembering (Bodhi, 2000). The practice of mindfulness is essentially a *way of being*. *Purpose, presence, and acceptance* appear to be three essential pillars of mindful awareness. Purpose aspect of mindfulness helps the individual to intentionally and purposefully direct his attention rather than letting it wander around. Further presence of mind helps the person to be fully engaged with and attentive to the present moment. Thoughts related to the past and the future are often recognized as thoughts occurring in the present to disturb one's focus of concentration. This practice of being increasingly aware of the present is an essential ingredient of mindfulness (Siegel, 2018). Finally, the acceptance dimension of mindfulness helps the individual to be unconditionally accepting of oneself by being non-judgmental.

There are a total of twelve *mindfulness qualities,* of which seven had been initially defined by Kabat-Zinn (1990), with an additional five being offered by Shapiro and Schwartz (2000) to address the affective qualities of mindfulness construct explicitly. They may be described as follows:

a. *.Non-judging:* It involves being aware of judgmental qualities and reaction to inner and outer experiences, without censoring or blocking them;

b. *.Non-striving:* It prompts one to be non-goal-oriented and to remain unattached to the outcome or achievement. It helps one in realizing that being one's own self to the genuine extent is more important than achieving any goal in life;
c. *.Acceptance*: It relates to accepting things as they are at present.
d. *.Patience*: It involves understanding and accepting that sometimes things must be given their own time to get unfolded.
e. *.Trust*: It makes the individual to take responsibilities for being him/ her own self and learning to listen to and trust his/ her own being.
f. *.Beginner's mind* leading to *openness*: It involves seeing, feeling and perceiving everything as if for the first time.
g. *.Letting go*: It relates to forgiving self and others by releasing thoughts, feelings, and situations that the mind seems to want to hold on to.
h. *.Gentleness*: Its characteristic features are being soft, considerate and having tender quality.
i. *.Generosity*: It enables an individual to give in the present moment within an ambience of love as well as compassion without any thought of return.
j. *.Empathy*: It relates to feeling and understanding others' perspective in the present moment and communicating this with the individual.
k. *.Gratitude*: It relates to reverence, appreciation, and being thankful for the present moment.
l. *.Lovingkindness*: It involves embodying benevolence, compassion, and cherishing the present moment by the individual to bring about merging of forgiveness with unconditional love.

It is also to be noted that intentional systemic mindfulness (ISM) seems to be another concept in the domain of mindfulness qualities (Shapiro et al., 2002). It addresses both how individuals attend and why they attend to different stimuli in a specific manner.

Psychospiritual Cleanliness Through Non-Attachment Wing of Mindfulness Practice

Individuals tend to suffer because of different expectations that they usually "attach" to their varied feeling-states in response to stimuli impinging the self in the internal or external environment (Grabovac et al., 2011). It may be noted that freedom from suffering may be brought about by means of non-attachment. It is the process of not attaching by attempting to avoid thoughts, feelings, people, things, and so forth since it originates at the most basic levels. It can be brought about by means of practicing mindfulness over the long run. When an individual is mindfully focusing on his breath/ body/ posture/ movement/ thoughts, he is noticing them from the perspective of a neutral, objective observer who has detached himself from materialistic cravings for at least the time being. It involves a style of *accepting* what is present in the "form" as it is. It thus relates to the *here-and-now phenomenon of unconditional acceptance*.

Acceptance is intended to mean an acknowledgment of or a cessation of resistance to something. This practice also has a reverberatory impact on the self-system, thereby making the individual engage in a non-materialistic endeavor. The person gradually extends his self-boundaries in terms of being more flexible and accommodative in nature. Mindfulness meditation is in vogue these days for bringing about further sanitation to the psychic system.

Mindfulness meditation is not about paying attention only to the concept of the breath. Rather, it is about following the physical breath with great curiosity as to its different elemental aspects like its texture, temperature, and other sensation. These may include the cool flow of air at the nostrils or the rising and falling of the abdomen or chest. It may even involve noticing the sound of the breath of one's own self or hearing/ feeling the rhythmic beats of the heart. Mindfulness meditation is also termed as *opening-up meditation practice*. It is often observed that initially, instead of paying attention to each breath, the mind swerves off during mindfulness meditation like a disobedient child. It reaches into the future, worries about the past or judges meditation as a waste of time. Observing the wandering mind is the very first track of mindfulness practice. Mindfulness allows individuals to relate more fully to experience—to absorb the world, and to see the superficial appearance of things and the conditioned ideas one has about them.

The chief characteristics of mindfulness meditation are as follows (Heaversedge & Halliwell, 2010):

1. True compassion, being the gift of mindfulness meditation;
2. Helping to "learn to *be"*— doing less and noticing more, paving the ground for wisdom;
3. Practicing gently, being an approach to life –how one relates to their own selves and the world around them;
4. Acknowledging the mind–body connection;
5. Being in our bodies;
6. Having support in pain management;
7. Encouraging body mindfulness to bring about greater acceptance and commitment, letting go and taking action;
8. Reinforcement of individuals in enjoying mindful relationships; and
9. Encouraging them to engage in a positive way of "being."

One's habitual and reactive patterns of perceiving and behaving can be fostered through meditation practices. They help in generating wisdom and compassion on the part of the individual. Mindfulness training provides powerful cognitive–behavioral coping tools (Astin, 1997). It is found to increase the stress tolerance of an individual (Orsillo et al., 2004). Some researchers have suggested that mindfulness training allows one to develop alternative paradigms and therefore interpret experiences in new ways, so that a stressful situation may be perceived as an opportunity rather than a threat. Roemer and Orsillo (2002) call this "cognitive flexibility." *Mindfulness-based stress reduction* (MBSR) is also thought to cultivate self-regulation, which may contribute to positive changes in both physical and psychological health (Coffey &

Hartman, 2008; Masicampo & Baumeister, 2007). This "self-regulated" psychological orientation is used to describe a kind of learning that is guided by metacognition, strategic action, and motivation to learn. They usually exhibit a high sense of self-efficacy (Pintrinch & Schunk, 2002). Such practices also enable the individual to engage in more *"cognitive defusion."* It relates to the ability to separate one's thoughts from each other and help them to be observed non-judgmentally and let them go away smoothly (Harris, 2009). This practice helps the individual to create a "distance" between him/ herself and his/ her thoughts and to visualize them in an objective manner (Masuda et al., 2004). This may be illustrated in a practice of *visualizing leaves on a stream,* and imagining to place different thoughts that pop up gradually to place on the leaf… The objective of the exercise is to help allow different thoughts to be placed on the leaf—which is flowing on the stream at its own pace. The goal is to help improve the ability of the individual to unhook himself from his/ her thoughts and gradually acquire the skill of detachment (Masuda et al., 2004). Thus, research-based evidence proves that meditation techniques, including MBSR, can cultivate qualities such as compassion, forgiveness, mindfulness, and spirituality inviting the positive psychological components in one's behavioral frame.

The notions of *here-and-now, being kind to one's own self, & commitment* appear to be other ground rules of mindfulness. Mindfulness makes the individual adopt an attitude of compassion toward himself/ herself. It also involves making a commitment to both meditating and practicing mindfulness as a way of living/ being (Frey & Totton, 2015). Mindfulness teaches individuals to be with *what is*, accepting life as it presents itself.

Guided imagery may be used in mindfulness meditation practices as well. One needs to be sensitive to the emotionality of the client while engaging him in such techniques. Guided imagery exercises of being a plant/ tree may be practiced to inculcate positivity in the self. The participant attempts to comprehend that the plant is a part of himself, and he is also a part of the plant simultaneously (which is similar to the perception of the micro- and the macrocosm). The participant is encouraged to feel how the separateness of himself and the plant is transcended and replaced with a feeling of wholeness and togetherness. He then experiences the joy and pleasure of the comprehension of being himself as well as the plant together. This may be represented by the steps as follows:

- Pick up a plant/ visualize a tree in the surroundings.
- See it with open eyes.
- Smell it with closed eyes.
- Feel it with closed eyes.
- Visualize it with closed eyes.
- Try to feel the "plant in you."
- Water the plant and feel the sensations.

- Try to realize that the "plant in you" and your own self as an entity are separate and at the same time connected.
- Try to enjoy this feeling of connectedness.
- Also try to feel the connectedness of the plant with the ground and enjoy your rootedness.

All such techniques help individuals to explore their inner peace by using their breath mindfully so as to notice the silent part of themselves - without getting caught by their myriad thought traces (Grossman et al., 2004). It is like witnessing the calm "eye" of a hurricane of different thoughts that disturb the psyche. The person becomes detached from the confounding thoughts by simply observing them and being a "watchman." The participant is in a safe, peaceful place—breathing in, breathing out. The resultant experience is expected to be a sense of inner tranquility in a cleaner self and "feeling grounded."

Outcomes of Mindfulness Practice

The practice of mindfulness has a number of benefits both at the physical and psychological levels. It helps one to increasingly become aware of the space between noticing experiences and reacting to them by slowing one's system and observing the different processes of one's mind (Black, 2010). This is expected to help the individual to make more intentional and mindful decisions (Black, 2010; Walach et al., 2007). Well-being and voluntary simplicity of an individual are expected to be fostered through mindfulness practice (Brown & Kasser, 2005). Awareness of the individual is associated with conscious registration of stimuli with different sense modalities and the functions of the mind (Brown et al., 2007). Mindfulness leads to increased awareness of one's mind, increased self-control, significantly reduced stress, anxiety, and negative emotions, increased control over ruminative thinking, decreased distracting thoughts, decreased emotional reactivity (Corcoran et al., 2010; Farb et al., 2010; Siegel, 2007b; Way et al., 2010), increased mental flexibility and focus, higher working memory (Jha et al., 2010), increased empathy, compassion, and conscientiousness of other's emotions as well as increased capacity for intentional, responsive behaviors due to higher extent of emotional intelligence (Brown et al., 2007; Masicampo & Baumeister, 2007; Walsh & Shapiro, 2006). As such individuals have a better understanding of their thoughts, emotions, and behavior, and the external context. At the physiological level, mindfulness practice has been researched to be associated with enhanced immune system functioning, lowered blood pressure, lowered levels of blood cortisol, increased brain density and neural integration in areas responsible for positive emotions, self-regulation, and long-term planning, greater resistance to stress-related illnesses such as heart disease (Hanson & Mendius, 2009). Regular practice of mindfulness meditation has been found to bring about neuroplasticity (Davidson et al., 2003; Lazar et al., 2005; Siegel, 2007a; Vestergaard-Poulsen et al., 2009). Such alteration in brain structure may be

associated with positive affective, cognitive, and immune-reactive benefits for the individual that gradually become habitual in nature (Farb et al., 2007; Hölzel et al., 2008; Siegel, 2007a; Vestergaard-Poulsen et al., 2009). The clean self is restored there.

When the mind engages in mindfulness practice, it does not compare, judge, categorize, evaluate, contemplate, reflect, introspect, or ruminate on experiences based on what is known (Brown et al, 2007). Rather, it is open and present with bare attention to any input manifested by a simple noticing of what is happening at the current moment. Mindfulness is a fundamental way of being, of inhabiting one's body and moment-by-moment experience (Shapiro, 1980; Shapiro & Carlson, 2009). It is a practice of the mind, body, and heart (McBee, 2008). Some of the benefits that may be reaped of from one's mindfulness practice at the spiritual level include increased self-insight and self-acceptance, increased level of compassion and empathy, increased control over automatic behaviors, increased acceptance of others, increased sense of morality, intuition, and courage to change, and increased self-discipline amidst others (Brown & Ryan, 2003; Duckworth et al., 2011). Finally, mindfulness practice has been found to be interlinked with the construal of insight, it being the conscious process of making novel connections (Hill & Castonguay, 2007).

Clarity and objectivity appear to be the key outcome of mindfulness. The net result of mindfulness is "*reperceiving"* by means of which there is a subtle turning about in the consciousness of individuals for which what was previously "subject" now becomes "object" (Shapiro et al., 2006). It is to be noted that from proper object-relations and attainment of object-constancy, individuals gradually develop the *ability to "reperceive."* This brings about *empathy* within individuals giving rise to gradual *widening of the self*. The ultimate result is increased objectivity of the self (Chaskalson, 2011). The experience of mindful reperceiving helps in a deeper knowing of thy self, which mingles with oneself to engage in greater intimacy with whatever arises on a momentary basis. The practice of reperceiving, in turn, gives rise to a profound, penetrative, non-conceptual seeing into the nature of the mind as well as the world (Kabat-Zinn, 2003). For this, one needs to have a ripple-free flow of a river in the self-system. The shift from un-mindfulness to mindfulness is almost alchemical in quality, as it involves transmutation to take place in the individual system, making it more tolerant, manageable, interesting, and vital. Its aim is thereby to develop empathy, compassion, self-compassion, forgiveness, and spiritual orientation to the individual. It also helps to reduce burnout reactions. Such practices may be encouraged through mindful breathing, mindful eating, mindful walking, mindful bathing, and the like. In other words, mindfulness can be intriguingly intermingled with the daily chores of one's life to cultivate a healthy lifestyle on the personal front. This is expected to help bring individuals to be in sync with nature.

Mindfulness Practice: A Mode of "Nature-Connect"

Human beings are intricately associated with nature and all other phenomena to such a degree that it becomes really difficult to demarcate distinct boundaries (Van Gordon et al., 2018). The micro- and macrocosm are related to one another. Our physical bodies and mental systems are embedded within the natural embrace in such an interlinked manner that when we breathe in, nature breathes in with us, and when we breathe out, nature also breathes out. This is because we are unitary parts of nature. Health benefits of feeling connected with nature are umpteen. It helps to instigate the realization of sharing the planet with other life forms equally which is the call of the day. The time has arrived to give up the "glory" of reigning as a supreme power on the earth as far as life-form is concerned, and instead to look at all life forms with compassion. This helps people to become attentive to nature, which knowingly/ unknowingly facilitates calm, rest, and contemplation (Pretty et al., 2007). Spending time in nature more provides ample opportunities for bringing the balance to both body and mind. This has been supported by the "biopsychosocial" model of well-being which relates to the connection of mind, body, and nature (Van Gordon et al., 2018). It is nature which is offering us crucial lessons today, and it is of dire necessity to pay heed to them. According to British nature conservationist, educator and urban birder, David Lindo, the lockdowns all over the world, owing to the current coronavirus pandemic, have helped many individuals to "learn to see" nature anew. It is this enthusiasm in people which can inspire change. He states that watching birds is helpful for one's mental well-being (Times of India, July 11, 2020). Encouraging introspection of what nature offers human beings and how can we acknowledge the same through adopting small steps is essentially the call of the day. It is in fact our apathy toward conservation of biodiversity that threatens it so severely. It is only nature-based solutions which can sustain us, as Jeanne Tarrant, who is commonly addressed as the "frog lady of South Africa," states (Times of India, July 25, 2020). We need to address the nature-connect as responsible and conscious citizens of the earth and simply do not have the right to abandon wildlife, according to Vikash Tatayah, who is a conservation director of the Mauritian Wildlife Foundation (MWF). It is worth to remember that the present situation in the context of the COVID-19 pandemic is a spiritual wake-up call in terms of the cosmic fury because of increasing dis-connectedness of human beings with Mother Nature. The pandemic has proved that nature has supreme power, and it can live beautifully without the mere existence of human beings. Hence, the human soul needs to awaken itself in terms of compassion, non-violence, and meaningful existence with other fellow inmates of the world. In fact, mindful listening to nature makes us realize that we are part of its ecological world, as Jeff T. Titon, Professor Emeritus of Brown University has pointed out. Humanity must remain in harmony with nature.

Nature stimulates a spiritual connection of the individual by engaging all our senses. For instance, one may open his/ her eyes and without gazing at any one object in particular in the surroundings, try to both embrace and relax into the entire panorama that is visible of Mother Nature. This meditative technique can help to

cultivate an expansive mental view that is conducive to settled meditation and to gaining insight into the open and limitless nature of the mind. A realization of a spiritual connection or transcendental peace is expected to be experienced therein (Schultz, 2010). Even seeing birds through an open window or hearing bird-songs tend to increase one's sense of well-being and an inner sense of tranquility in an individual prevails therein. It is interesting to note that human beings can connect with other species through music, and it is this moment which offers peak experiences—which is therapeuticc—as distinguished Professor of philosophy and music at New Jersey Institute of Technology, David Rothenberg has pinpointed. Different musicians like Beethoven were famously inspired by nature to create their masterpieces. It is nature which offers us vital lessons for "learning to listen" to the rich, multilayered sounds, which can erase a sense of loneliness on the part of human beings on the whole. Furthermore, the spiritual and holistic side of horticulture therapy sees value in gardening as meditation. It is to be worth noting that even a dead tree could be teeming with life and can provide solace to human beings just by inculcating the practice of mindful observation. The practitioners espouse that it quietens the conscious mind, allowing the subconscious mind to discover solutions to problems and negative thinking patterns. Briefly, those who are attracted to gardening seem to be reflective and "inside-mind" oriented (Sanyal, 2017).

"Mindfulness-enhanced nature connectedness" may be practiced by sitting in a quiet forest and relaxing in order to allow our senses to be bathed by the sounds, smells, and energy of the forest. For instance, the activity of "forest bathing" enables one to allow the sound of wind blowing through the trees, gentle swaying of branches, and chirping of birds singing to gently massage the mind (Nicholls & Gray, 2007; Trace, 2004). This has been found to foster calm and help rebalance our emotions. This nature-connect of beings is philosophical in the sense that people come to know and realize that every seed does not germinate and that we need to adapt to circumstances beyond our control. Hence, living things enliven a garden. In "habitat gardens" trees and plants attract birds and bees, adding birth baths and perches. A shady, quiet spot in the garden can be the niche to sit down, relax, and enjoy.

Hence, the lockdown due to Corona has actually been quite a boon. This lockdown has proved to be just the disruption we needed to establish balance in our very imbalanced lives.

Conclusion

Human beings have stepped into this world with innumerable possibilities of creating meanings in life and thereby enriching this globe with his/ her creative contents. To fulfill this purpose, a sense of physical and mental well-being seems to be the resource reservoir for us. Well-being is just not being physically and mentally fit, but this fitness should bear the sign of maturity having a tune of positivity to interpret the events in life and to curve a positivity lineage track for people around. Well-being is just not a balanced self… well-being is to have the flavor of offering goodness

to others. To have the account of wellness in us, the controlled, sanitized, physical habits, and lifestyle together with a sensitive, empathic mental frame should be the keywords. Nature's beauty in simplicity and glamor is abundant. Beings are part of nature. Wellness scheme is the trademark of beauty therein.

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Chapter 30
Yogic Tradition and Well-Being

Jyotsna Agrawal

Abstract This paper delineates the concept of well-being in modern psychological literature, the variety of pathways studied, and its relationship with meaning and spirituality. It further discusses the cultural criticism of the modern study of well-being and makes a case for insights from non-Western cultures to be included in the mainstream literature. It further discusses the various types of happiness as well as pathways toward them, as discussed in the Indian tradition. These ideas have been substantiated by empirical research, and some of the results have been presented in this chapter. It further presents a yogic psycho-spiritual model, based on thematic analysis of core yogic texts, which may be utilized in future for well-being interventions.

Keywords Yogic tradition · Health · Well-being

Background

Happiness and Well-Being

> The word happiness is commonly used to designate something intricate and ambiguous, one of those ideas, which humanity has intentionally left vague so that each individual might interpret it in their own way. (Bergson, 2006)

Happiness or well-being is the most popular terms used in the psychological literature to denote a good life. These terms are often used as rough synonyms, without following any clear distinction. Even the various definitions of happiness sometimes have vague or even contradictory meanings. The dictionary meaning of the noun "happiness" is feeling pleasure, contentment, satisfaction, or being fortunate.

Undertaking: This paper is an original work and has not been published earlier.

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_30

In general, it is associated with feeling positive emotions (of short duration) or mood (for comparatively longer duration). On further exploration, it has been found that personal meanings of happiness go beyond a pleasant emotional state and also includes one's thoughts and judgments about how one's life is going (Lu, 2001). This is similar to the meaning of the term subjective well-being (SWB), which focuses on the subjective experiences of the people and captures two components: affective (frequency of positive and negative affect) and cognitive (judgment about being satisfied with life). Subjective well-being is also known as hedonic well-being, and emotional well-being, which we will discuss later. In addition, the average positive effect during a specific time period is known as chronic happiness (Lyubomirsky et al., 2005).

Therefore, one's retrospective summary judgment regarding both one's mood and satisfaction, during a certain time frame is captured by SWB. Averaging of all such momentary judgments made at several different times, during a certain period (such as the past two, six, or twelve months), also contributes to SWB. In research, this requires measuring and quantifying reported levels of positive affect (PA), negative affect (NA), and life satisfaction (LS). In the literature, some researchers have treated the terms happiness and SWB interchangeably and others have used them in specific contexts. While happiness may be used to denote lay concepts, subjective well-being is considered a more scientific term. For example, happiness term is often used when studying the personal meanings, lay beliefs, and folk understanding of a good, happy, and livable life, and also for exploring what people value in general.

An individual's personal model of well-being, their ongoing reflection on and interpretation of where one is now, in contrast to where one was, its modifications, all influence their well-being judgments (Rubinstein, 1989). One's life circumstances may influence their mood states, which in turn may provide them with a hedonic summary of recent life experiences (reactive index) and inform them about progress and prospects in important life domains (prospective index), thereby influencing their life satisfaction (Mood-mediation model; Robinson, 2000).

Other models of well-being, which are more objective in their approach, have also been proposed, the foremost being psychological and social well-being. Ryff and Keyes (1995) gave a six-factor model of psychological well-being; the factors being—autonomy, environmental mastery, personal growth, positive relations with others, purpose in life and self-acceptance. Later Keyes (1998) also developed the social well-being model, which has five components: social acceptance, social actualization, social coherence, social contribution, and social integration. The research on the three kinds of well-being (subjective, psychological, and social) have expanded over the last few decades, as the scientific community has responded to the interest of people at large (Kim-prieto et al. 2005) by increasing their efforts to understand the correlates of happiness and well-being (Myers & Diener, 1995; Linley & Joseph, 2004).

The Varied Influences on Well-Being

Genetics, Life Context, and Intentional Activities

For a long time, the scientific community considered happiness and SWB as hard to change constructs. Each person supposedly experienced their regular levels of happiness within a certain equilibrium. Further, after every temporary change to this equilibrium, it was believed that people would return back to this level repeatedly (dynamic equilibrium model; Headey & Wearing, 1989). This idea was also supported by genetic studies which found an inherent set-point of happiness in each individual, which acted like a baseline, to which they kept returning (Lykken & Tellegen, 1996). It was reported that around 40% of the variability in positive emotionality and 55% of the variability in negative emotionality could be predicted by genetic variations (Tellegen, 1988). Another source of pessimism stemmed from the close association of happiness with more or less stable personality traits, such as neuroticism and extraversion (McCrae & Costa, 1991; Watson & Clark, 1997). Similarly, optimistic versus pessimistic attributional styles, regarding an event being internal or external, stable or transient, and/or global or specific, were also documented to be a strong predictor of self-reported happiness (Cheng & Furnham, 2001).

Another set of constraints on happiness were found to be related to sociodemographic factors (such as age, marital status, income). There was a general pessimism about them since one cannot change these easily. In addition, it was found that even when happiness was influenced by certain changes in life circumstances, it was short-lasting. It seemed that humans quickly adapt/habituate to any changes in their lives and happiness level. This theory was known as hedonic adaptation (Fredrick & Loewenstein, 1999), or hedonic treadmill (Brickman & Campbell, 1971).

This brings us to the last set of variables which is about intentional activities. Question abound, whether humans can do certain things to enhance their happiness on a long-lasting basis, and its answers are spread on a broad time–space canvas. This question has been asked in various civilizations, in different time periods of history, by mystics-yogis and philosophers to psychologists. The concepts of an ideal and happy life ranged from reason (in the Greek period) to creative self-expression (in recent times) in the West, and overcoming desires, transcending the sense of separation, and living mindfully in the East (Coan, 1977). It is reflected in the ideas of eudemonia (Aristotle, 350 BC), of human growth leading toward perfection (Sri Aurobindo, 1999) and of human development culminating in mature and perfect action (Werner, 1926/1957). Psychologists continued this tradition by proposing theories on individuation (Jung, 1933) good mental health (Jahoda, 1958), self-actualization (Maslow, 1968), a fully functioning individual (Rogers, 1963), and a healthy mature person (Allport, 1961). The commonalities across these ideas abound, from having a unifying philosophy of life to the capacity for self-extension and maintaining close interpersonal relationships. Recent work in the field of positive

psychology continues this tradition further by scientifically exploring the influences on well-being.

The overall trend indicates two distinct but overlapping perspectives, historically rooted in two separate philosophies, namely hedonism and eudaimonia, with different vantage points, such as being subjective versus objective. The hedonic perspective emphasizes pleasure, while the eudaimonic perspective focuses on living in accordance with one's deeper self and self-expression (Waterman, 1993). Research has shown that they are overlapping but different concepts.

The Hedonistic Perspective

This perspective follows philosopher Aristippus (fourth century), who proposed that the goal of life is to maximize pleasure and minimize pain since happiness is the totality of one's hedonic moments. It is similar to the Lokayata/Charvak school of philosophy in India (one among the nine major schools of classical Indian philosophy). It has remained a controversial idea, never accepted universally. Although in the modern Western world the pursuit of pleasure as a way to achieve satisfaction got a wide endorsement. Hedonism is a subjective perspective since what is pleasurable varies from person to person, and different pleasures may have nothing in common.

The scientific research on pleasure is comparatively recent and sparse. The field expanded with the developments in the study of subjective well-being, especially the hedonic or emotional well-being (Diener & Lucas, 1999). When one views emotional well-being as mere physical hedonism, to some it may seem shallow and frivolous, and not worth paying attention to, while doing the serious study of mental life. On the contrary, the concept of happiness goes beyond the idea of simply having fun and recognizes that people are thoughtful beings, who choose what is important in their lives and pursue those values and goals which may lead to a long-lasting sense of happiness (Diener et al., 1998). It was found that emotional well-being can be tapped by various techniques, such as "savoring" and can also be influenced by engaging in a variety of activities over time (Peterson et al., 2005). Thus, the experience of hedonic well-being has some overlap with life satisfaction and is distinguishable, as well as compatible with the other eudemonic approach to well-being (Kopperud & Vitterso, 2008). It proposed that the chronic happiness level, based on averaging of positive emotions, is more enduring than momentary happiness, while also being somewhat malleable over time, based on the activities people engage in on a regular basis (Lyubomirsky et al., 2005). It was also found that people may vary in their hedonic profiles even with similar happiness levels as captured by the well-being scales, due to the variability in affective repertoire or personal judgments of contentment with one's life. Thus, it was considered that happiness when conceptualized not as a uni-dimensional concept (Argyle et al., 1989), but as a multidimensional phenomenon, with components like achievement, satisfaction, enjoyment (Cheng & Furnham, 2003), cooperation, sensuality (Morris, 2004) can point toward the various

means of achieving happiness, some of which may represent additional contributions to a happy life.

The Eudaimonic Perspective

Fulfilling or realizing one's daimon' (true nature) by engaging in activities that promote one's highest potentials is at the core of the eudaimonic viewpoint, which considers happiness is the only "good" desirable for itself (Nicomachean Ethics, Aristotle, 1985). By exercising one's inherent or acquired abilities, and striving toward realizing them in increasingly better, complex or perfect ways, one can experience joy (Linley and Joseph, 2004). This perspective which takes a more objective position emphasizes developing virtues (a standard of right or moral excellence), both, the virtues of thought through teaching, and the virtues of character through practice/habit. This approach is associated with the whole person and his/her optimal functioning and development, in terms of exploration of one's interests, enterprise, overcoming of obstacles (Russell, 1930) striving for perfection (Ryan and Deci, 2001), developing inner resources and vitality (Van Boven, 2005) and engaging with the existential challenges of life.

In modern research, a hierarchical model of strengths and virtues has been proposed (Peterson and Seligman, 2004), where some scholars consider virtues as independent and emphasize developing individual strengths. Others believe virtues are interdependent, that eudaimonic happiness requires all the virtues, and practical wisdom is the master virtue which is essential for solving problems (of specificity, relevance, and conflict) that arise, whenever strengths must be translated into action in concrete situations (Schwartz & Sharpe, 2006). In general, eudaimonic living is associated with four motivational concepts: (1) being mindful and acting with awareness; (2) behaving in autonomous, volitional, or consensual ways; (3) pursuing intrinsic goals and values (e.g. personal growth, relationships, community, and health) for their own sake, rather than for extrinsic goals (e.g. wealth, fame, image, power); and (4) satisfying basic psychological needs for competence, relatedness, and autonomy, facilitated by the other three concepts (Ryan et al., 2008). Thus, instead of outcomes, the eudaimonic approach focuses on the process of living well.

Research in the field has increasingly found the two approaches, of hedonism and eudaimonia, different but still overlapping (Selnes et al., 2004), leading to the conceptualization of a good life as a multidimensional phenomenon where both are present (Ryan & Deci, 2001; King et al., 2004). Hedonism is subjective and thus is studied by asking people about their sources of happiness. However, in the process, it was found that people report life philosophies that are similar to eudaimonia. This is probably due to internalized social norms of eudemonic nature, which then influences their effect and life satisfaction which makes up their hedonic well-being. A few studies have also shown a differential temporal association, with hedonic activities leading to immediate happiness, and eudaimonic activities leading to delayed happiness, which increases with repeated efforts and has a spill-over effect on other

activities. While hedonic activities are simply pleasure-oriented, eudaimonic activities are meaningful and might also involve ego development/maturity. Association of these two approaches with various other variables like personality and self-esteem has also been found. Waterman (1993) reported a strong positive correlation between those activities which are about personal expressiveness (eudaimonia) and hedonic enjoyment. There were differences between hedonic and eudemonic approaches too, in terms of (1) opportunities for satisfaction, (2) strength of cognitive–affective components, (3) level of challenges, (4) level of skills, and (5) their importance for the person.

In addition, researchers with an eudaimonic stance have questioned the idea that people always try to enhance their happiness, and avoid unpleasant emotions (are hedonistic in their motivation). Instead they have suggested that people may be more strategic and sophisticated in managing their moods (Tesser & Rosen, 1975). The eudaimonic perspective on positive emotions is that: (a) being a fully functioning individual is more important than feeling positive per se, and therefore under certain conditions, people also need to experience negative emotions (e.g., sadness over loss) (b) studying positive emotions as an outcome of eudaimonic living, and (c) fulfillment of psychological needs may lead to positive emotions (Ryan & Deci, 2001). The dynamics of the hedonic versus eudaimonic approach is brought together by the fact that all happy lives may not be good, and all good lives may not be happy. Since a hedonically happy life can be an unhealthy one too, the effect of hedonistic living on the number of years lived happily needs to be taken into account (Veenhoven, 2005). A healthy but unhappy life might happen when some important goods in life are either in opposition to hedonism or require the sacrifice of happiness in their service. These goals when attained are usually associated with heightened happiness. Our happiness level may also serve as a source of feedback regarding our decisions or activities really being an ingredient to a fulfilling life or not. For example, when one is unhappy in a relationship or at work, it may indicate a need for some change. During difficult times, coping by engaging with existential issues or accommodating with the situations, may lead to maturity and happiness. Thus, a happy, mature person is the most desirable option, as compared to a happy but immature person, an unhappy-immature person, or an unhappy but mature cynical person (King et al., 2004). Therefore it may be mentioned that different theorists have proposed different pathways toward happiness, broadly divided into eudaimonia and hedonism. However, there is a lack of complete clarity and convergence of findings as to how these pathways relate to each other and whether they differentially predict affective and cognitive dimensions of well-being. The eudaimonic approach, given its implications for promotive mental health interventions, will be explored further along with the role of meaning and spirituality for the same.

The Eudaimonic Approach Through Meaning and Spirituality

Meaning: Since people quickly adapt to positive events or circumstances, meaningful goals and activities, especially when chosen autonomously can cumulatively and sustainably enhance happiness. Thus, one may say eudaimonic pathway to happiness goes through meaningful activities (Peterson et al., 2005). Meaning can be regarded as one of humanity's tools for imposing stability on life. The essence of meaning is connections, an ability to link two things, even when they are physically separate entities. The famous psychologist Victor Frankl is credited with conducting the pioneering research on meaning in life. Meaning has multiple levels; low levels invoke concrete, immediate, and specific meaning, while high levels invoke long time spans and broad concepts, such as values and principles (Vallacher & Wegner, 1987). Reker and Wong's model of personal meaning (1988) postulates three components of meaning: cognitive, motivational, and effective. The motivational component acts as a partial mediator of influence between the cognitive and the affective component (Halam et al., 1994). Quest for meaning can also be understood in terms of four main needs for meaning, or four patterns of motivation; the need for purpose, values, sense of efficacy, and self-worth. People who have satisfied all four of these are likely to find their lives very meaningful. While there are abundant opportunities to fulfill need for purpose, efficacy, and self-worth, the modern world does not offer people a reliable and convincing set of values. There has been a replacement of traditional values with rationality and there is also a loss of consensus about values (Baumister, 1991).

Empirical research supports the relationship between the presence of meaning in life, with eudaimonic pathways, self-appraisals, and behaviors. On the other hand, the search for meaning seems to be related to hedonic self-appraisals and behaviors (Steger, 2006). Although during times of difficulties, the coping mechanism utilized by those low versus high on meaning differs, but the low need for meaning in life is not pathological (Desormeaux, 2000). In addition, meaning in life can be influenced by having perspective and being able to see the big picture in life, along with experiencing positive affect which can make people more sensitive to meaning related cues and differentiate meaningful versus meaningless activities (Hicks & King, 2007; King et al., 2006). Baumister and Vohs (2005) have also suggested that meaning is necessary but not sufficient for happiness, though the majority of times, more meaningful lives will also be happier ones. Further, cognitive appraisal related to positive meaning in specific circumstances can trigger positive emotions, but such appraisals are influenced by personal histories and goals and thus are difficult to control. However, some common mechanisms can be utilized, such as reframing or infusing ordinary daily events and activities with a positive value, creating or recalling situations that elicit positive meanings (Folkman, 1997; Fredrickson, 2005). Similarly, behaviors related to social and interpersonal relationships and exercise and other physical activities may have the potential for meaning-infused happiness.

Seligman (2002) had brought these two perspectives, hedonism and eudaimonia together to suggest four different forms of the good life. The simplest being

the "pleasant life," similar to the hedonic approach, and it involves the successful pursuit of positive emotions associated with the present, past and future. The next is the "good life," a more complex approach related to using one's strengths to obtain gratification in the main realms of one's life. It is not a permanent state, but a continuous development of individual strengths and values and leads to authenticity; i.e., being true to one's own character. The "meaningful life" is closer to optimal functioning and in addition to a good life, it is an affiliation to something beyond oneself. It emphasizes using one's strengths and virtues in the service of something much larger, where one is free to conceive the larger aspects of life. Finally, the "full life" is related to optimum functioning/authentic happiness and builds upon all these three forms. It consists of experiencing positive affect about the past and future, savoring positive feelings from pleasure, deriving gratification from one's signature strengths and using these strengths in the service of something larger than self to obtain meaning (Peterson et al., 2005). Other researchers have also emphasized the need for balance between these pathways due to the limits of satisfaction, which people can derive from a single life domain. It is proposed that involvement in multiple domains would satisfy the full spectrum of human development needs from survival to growth, while fulfillment of only one kind would not lead to high levels of happiness/SWB (Sirgy & Wu, 2009).

Spirituality: In modern times, the term "spirituality" has been used to denote some kind of subjective religious, mystical, or sacred experience, which is private in nature, although no universally accepted definition is found. It overlaps with religion, which also concerns itself with the relationship between humans and the Divine, although in a much more organized manner. Further, those who do not believe in organized religions may still share many of the components of spirituality, which in itself is a multidimensional concept. Having a personally meaningful framework, deeply committed values, and transformative experiences all are considered to be part of spirituality, and in recent times, with influences from eastern especially Indian tradition and esoteric Western influences, modern spirituality has taken a more psychological approach. Here the psychological ideas related to the human potential for growth and meaning are being emphasized, where one continues on the journey toward a non-material, transcendental reality. The other choice is that of spirituality rooted in ethical, moral values, without focusing on the non-material or supernatural elements.

The relationship between spirituality and well-being has been discussed and debated. One viewpoint considers spirituality as a key aspect of human health and well-being (WHO, 2001), through offering a meaningful framework in life given its focus on transcendence and transformation. However, empirical research on spirituality and well-being, which is often originating in the USA, has found mixed results in terms of both positive and negative associations with mental health. This goes with another, more nuanced perspective on spirituality which proposes that having a spiritual life may not be a necessary ingredient of a pleasant, happy life, but it is an important element of living a good life, and thus of authentic long-lasting happiness. Subjective reports of the benefits of spirituality abound, and there is now support for spiritual and compassionate care for the ill. When it comes to religiosity, many large studies often based on national samples, report that well-being is significantly

associated with religious certainty (Ellison, 1991), the strength of one's relationship with the Divine (Pollner, 1989), prayer experiences (Poloma & Pendleton, 1991), and devotional and participatory aspects of religiosity (Ellison et al., 1989), even after controlling for age, income, and marital status, although the effect sizes are usually not large. Religious behaviors and experiences may offer a sense of meaning in daily life (Pollner, 1989; Steger & Frazier, 2005) and during major life crises (McIntosh et al., 1993), while also providing avenues for social fulfillment through exposure to networks of like-minded people (Taylor & Chatters, 1988).

While religiosity or spirituality can be a source of meaning and an eudaimonic pathway to well-being, it may not always be so. One reason for mixed findings is related to the lack of a common definition. It is also important to note that spirituality is multidimensional, and therefore, one needs to look at the specific components among the varieties of practices within the broad idea of spirituality. One author (Waaijman, 2000) has described four forms of these practices: (1) Somatic practices (related to depriving the body and diminishing its desires and impulses, and purifying it through fasting, etc.); (2) Psychological practices, like meditation; (3) Social practices, focusing on others, and interpersonal aspects while reducing the ego; and (4) Practices helping one to focus on Divine realization and overcoming an ego-centered existence. Various components of religion and spirituality and factors influencing them, need to be studied further. In one study, it was found that while faith maturity and positive image of God contributed to the well-being, negative God-image lowered well-being (Mendonca et al., 2007). Even age and race have been found to have a differential effect on the relationship between religion, meaning in life and well-being, with older African Americans more likely to find meaning in religion than older White Americans (Krause, 2003). Possibilities of common underlying mechanisms, such as extraversion, behind the association between spirituality and well-being need to be studied further.

The Cultural Criticism of Research on Spirituality and Well-Being

The Western ideas of SWB have been criticized on the basis that they ignore cultural perspectives in conceptualizing a good life, that the idea about a "fully functioning individual" is a culture-bound concept (Seligman, 2002) and what is important in one culture may not be equally important in another. In a study with slum dwellers of Calcutta, Biswas-Diener and Diener (2009) found that while they generally experienced a lower sense of life satisfaction than the more affluent comparison groups, they had higher than expected levels of satisfaction due to the salience of and emphasis on social relationships. This suggests individuals from diverse backgrounds face unique issues that invariably influence their experiences, and what is good for one may not be necessarily good for all. Certain constructs may hold a different cultural meaning, and the standards of satisfaction may differ from culture to culture. Even the research

literature indicates substantial cultural variations in (1) meanings of happiness, (2) motivations underlying happiness, and (3) predictors of happiness (Uchida et al., 2004). However, the research on spirituality and well-being has been predominantly situated in an American context. Thus, it is necessary to further explore and examine the magnitude and equivalence of constructs across cultures.

Indian Spiritual Tradition and Happiness

Spirituality- and religiosity-related literature often originate from a Western context, especially North America, where Christianity is the dominant religion that is closely linked with group religious services, social support, etc. On the other hand, in the Indian context majority practice Hinduism, traditionally also known as "*Sanatana dharma*." It is different from the common idea of religion, with diverse conceptualization of Divine, many religious figures, a range of philosophical perspectives, innumerable sacred texts, and a spiritual approach which is a lot more personal and individualized and is considered to be a "way of living." The tradition aims toward individual spiritual experiences, the discovery of true Self, and merging with the universal Consciousness. In this context, yoga is a common term used both as one of the many specific schools of philosophies, and also to indicate towards a for all the collections of techniques for spiritual growth (Larson and Bhattacharya, 2016), thus representing a holistic model of spirituality, associated with well-being and happiness. As we will see, there are a variety of such yogic pathways. Further, a variety of happiness has also been discussed in the Indian tradition, using two broad different terms, "ananda" and "sukha," depending upon one's psychospiritual growth. These will be discussed later.

To understand Indian spirituality and well-being, it is important to understand its specific perspective on reality, whereby all creation is permeated by consciousness. It has offered distinct models to understand cosmos and human nature, such as five sheath of existence (pancha-kosha). As per this model, the human existence is composed of five sheaths/layers or kosha, i.e., physical body (annamaya), vital-life force (pranamaya), mental (manomaya), knowledge (vijnanamaya), and bliss (anandamaya) (Taittiréya Upanishad). As a person's identification with one or other of these layers' changes based on his/her psychospiritual development, their quality of happiness also changes (Salagame, 2006). The other important model is that of Purusha and prakriti. It originates from the Sankhya-Yoga framework, whereby the universe is composed of the dual principle of Consciousness and matter, i.e., the Purusha (pure Consciousness) and the prakriti (primary materiality). The same principle extends to humans, whereby both body and mind are made up of matter (prakriti), while deep within lies our higher Self, or the principle of Consciousness (Purusha). This is in contrast to the Western conceptualization which considers mind as non-material, origin of consciousness and distinctly different from the body.

The real purpose of prakriti has been described as twofold, experience/bhoga, and liberation/kaivalya (Pataïjali YogaSütra). When prakriti-based body and mind gets

reflected in the pure consciousness (Purusha/inner self), it starts identifying with thoughts, emotions, and actions as its own. It then conceives itself as a separate isolated entity and consequently experiences joys and sorrows (bhoga). On the other hand, the process of separation between prakriti and Purusha is called viyoga, and kaivalya is the state of final, ultimate liberation from prakriti, and achieving union with one's Supreme Self (Purusha). Different traditions of yoga aim toward such liberation from the bondages of prakriti, at least from the lower aspects of prakriti, if not absolute freedom from the prakriti. As per Sri Aurobindo (1999), prakriti is constantly engaged in a process of evolution which he calls "nature's yoga." Humans can become aware of such a process and actively contribute toward it, leading to a speedier unfolding of this developmental process.

Types of Happiness in the Indian Tradition

Ananda: As mentioned earlier, the ultimate aim of traditional Indian spirituality or Sanatana Dharma is liberation from the phenomenal material reality and experience of one's true self. This state of liberation is supposed to result in Ananda—the highest form of blissful happiness and peace. Indian Yogi-philosopher Sri Aurobindo (1999) mentions that there is an "imperishable Ananda" in everything including the individual soul, with its source in God. It is a "self-existent bliss" across activities and context and comes from living within. But behind such an ananda is the power of the highest God (PuruShottama), to whom people surrender, and who then transforms the dualities of their life (Sri Aurobindo, 1997). Such a spiritual approach, also known as bhakti-yoga, which leads to a connection with the Divine personality and a relationship of "closest oneness" extends to a feeling of oneness with the entire creation and ananda.

> An entire God-love and adoration extends to a love of the world and all its forms and powers and creatures; in and deep rapture, not the petty ardour of egoistic desire but the ocean of an infinite Ananda.—Sri Aurobindo (1999)

Sukha: It is easy to note that the path of yoga is long and the state of liberation along with the constant experience of ananda is not easily achievable for most human beings. Thus, during the long spiritual journey, when the material nature dominates, a person experiences (bhoga) a range, from happiness to misery, based on their level of identification with this material nature. During this journey, happiness which is experienced is termed as sukha. There are further distinctions between the three types of sukha.

Types of Sukha

As mentioned earlier, since the mind is supposedly made up of material nature (prakriti), it is influenced by the three qualities (triguna) of nature. Thus, the happiness/sukha experienced by our mind, before it achieves spiritual liberation is also influenced by them and are of three types. These are further explained below.

Triguna: The three gunas are known as sattva, rajas, and tamas, as discussed in multiple texts such as Chandogya Upanishad, Samkhya-karika, and Bhagavad Gita. Sattva guna is described as the principle of light, balance, harmony, and purity. It is associated with qualities such as cleanliness, truthfulness, dutifulness, detachment, discipline, contentment, and determination. On the other hand, rajas guna is described as the principle of movement, dynamism, and activity and is associated with desire, passion, agitation, anxiety, nervousness, etc. Finally, tamas guna is the principle of dullness and inertia and is associated with lethargy, and in its extreme even with depression (Wolf, 1998). In nature and especially in humans, these gunas do not occur in their purity. People are generally a mix of these gunas with one or other of these guna dominating at any point in time. Based on these 3 gunas, there are 3 types of happiness/sukha, i.e., satvika, rajasika, and tamasika (Bhagavad Gita). One can consider guna based sukha as a continuum, with sattva and tamas being the two extremes, with rajas in the middle. As the dominant guna changes, the corresponding type of sukha emerges.

Satvika Sukha: Satvika sukha is about getting satisfaction in higher mind and spirit-based things, leading to fullness and peace. It may be effortful in the beginning since it requires self-discipline, letting go of habitual pleasures and can also lead to inner churning; however, the end result is beneficial. While, Satvika sukha does have an influence of ego and desire, but as a person develops freedom from these, it may culminate into ananda (Bhagavad Gita; Sri Aurobindo, 1997).

Rajasika Sukha: The rajasika suhka finds pleasure in body, senses, the action of its willpower, and intelligence. Although it seems desirable at the beginning, it is harmful in the long run, due to increasing bitterness related to satiety, disgust, or disappointment (Bhagavad Gita, Sri Aurobindo, 1997).

Tamasika Sukha: The tamasika sukha finds satisfaction in indolence, inertia, and ignorance. Bhagavad Gita describes that it results in delusion, both in the short and long terms.

Pathways to Ananda Versus Sukha

People, in general, seem to have been somewhat successful in their endeavor to find happiness or "sukha," since modern research across cultures have reported that a majority of people experience happiness at any point in time (Diener & Diener, 1996). However, people and cultures differ in their beliefs regarding what experiences are worth having, which kind of happiness one should pursue and how. As discussed

earlier, Western philosophy and psychology have attempted to answer this question in a specific manner. These ideas often have common elements in terms of a unifying life-philosophy, capacity for self-extension, and sustaining intimate relationships. Similarly, in India, the focus has been on truth (satyam), ethics, and virtues (Shivam), along with beauty (sundaram) (Rao, 2005) and one is also encouraged to cultivate svasthya (a state of being 'settled in oneself'), signifying a subjective state of well-being at the levels of body, life-energy (prana), and mind (Sreelakshmi & Shakuntala, 2006). In the Indian tradition, there is a further differentiation between the three pathways leading to different types of sukha, i.e., the pleasant (preyas), the good (shreyas) paths, and finally, the spiritual/transcendental (nishreyas) path to ultimate bliss (Ananda). The underlying idea is that of a concomitant scope for free-will to choose among these paths, by following a certain lifestyle which may lead to a specific kind of happiness outcome.

Nishreyas, the Path to Ananda: This is the path which is supposed to lead to liberation and to ananda. It requires going beyond ethical and aesthetic pleasures, cultivating non-attachment (anasakti) and equal-mindedness to outside circumstances (samata), developing self-mastery by yogic practices, discovering one's own inner order (svadharma) and finding meaning, joy and excellence in it. Further, it requires uniting with one's inner being (Purusha/antaratman) and cultivating devotion to Divine personality (bhakti-yoga). Sri Aurobindo (1999) mentions that once we connect with the Divine, our inner svabhava, along with ananda, naturally unfolds. This ananda is more intense than satvika or even rajasika sukha.

Shreyas, the Path to Satvika Sukha: Satvika sukha is supposedly reached by the path of goodness, in which one considers social and universal well-being. It is a path chosen by the wise (Kaöhopanishad). We may notice this is similar to the eudemonic approach, as discussed by Aristotle in Nicomachean Ethics (1985), who emphasized realizing one's true nature (daimon) by engaging in activities that promote one's highest potentials and living with values. The path of goodness or shreyas is one that involves the balanced pursuit of three puruShartha–natural order (dharma), wealth (artha), and desire (kama) as per the laws of Manu (Kuppuswamy, 1985). Further, one can reduce tamas and increase sattva, by engaging in penance (tapas), developing deeper knowledge (jïana), having sense control (brahmacharya) and devotion to a higher path (shraddha) (Salagame, 2002).

Preyas, the Path to Rajsik-Tamasika Sukha: The pleasant path has been emphasized by Lokayata and Charvaka schools of Indian philosophy, and it supposedly leads to rajasika-tamasika sukha. We may note again, it is similar to the hedonistic perspective, originating from fourth century philosopher Aristippus, focusing on fulfillment of desires, particularly of sensory nature and maximization of pleasure and minimization of pain (Mishra, 2018; Salagame, 2002). Although, within rajasika-tamasika sukha, there might be a sense of fulfillment of sensual desire (tripti) and feeling pleased with an interaction (santosha) (Salagame, 2002), it is still mixed with ego, thus distorting the ananda. As per Sri Aurobindo (1999), the ego's interaction with nature leads to deformation of field (kshetra) and thus, one experiences dualities. For example, pleasure–pain is experienced when lower prakriti at prana or senses

level deforms soul's ananda, while liking–disliking are experienced when the mind deforms the soul's will.

Empirical Studies on Sukha and Mental Health

Given the importance of happiness in human life, the field of psychology has conducted various studies about happiness using modern methods of assessment. These studies define happiness in a manner that fits the definition of "sukha." On the other hand, ananda has rarely been researched empirically due to inherent challenges in studying it, such as finding study participants who have experienced ananda, its measurement, etc. The current author has been involved in a series of studies exploring happiness and triguna in educated urban Indian adults, using a mix of methodologies. These studies have given deeper insights, as well as validated some of the ideas from ancient Indian tradition.

Experience of Sukha: The popular way to measure happiness in the field of psychology is through the self-report of frequent experiences of positive emotions, infrequent experiences of negative emotions, and generally feeling satisfied with one's life. In one of our studies using these measures, it was found that the majority of people in urban Bangalore were happy (Agrawal et al., 2011). This result was similar to those found in other studies across the world, and thus, it may be considered that at any point of time, most people across cultures (Diener & Diener, 1996), including India (Agrawal et al., 2011), do experience sukha.

Triguna and Sukha: Since currently there are no measures available to directly assess satvika or rajasika-tamasika kind of happiness, one needs to study them indirectly by analyzing the correlation between triguna and happiness. Through this method, we found that sattva was associated with happiness. But both rajas and tamas were related to unhappiness, indicated by a significant correlation with a higher tendency to experience negative emotions (neuroticism) and having low life satisfaction (Nedungottil et al., 2021).

Similarly, in another study, it was found that higher level of satvika quality of anasakti was associated with happiness, while a higher level of ego (ahamkara) whereby rajas is dominant, was associated with both frequent positive and negative emotions. This indicates that while sattva is predominantly associated with happiness, higher levels of rajas may be associated with a life full of the roller-coaster of emotions, with experience of both happiness and unhappiness (Gupta and Agrawal, 2021).

Pathways to Sukha: No exact measures have been developed with respect to the shreyas, preyas, and nishreyas pathways; therefore, one has to use other measures which may cover the construct described under these pathways as closely as possible. Like ananda assessing its related path of nishreyas may be difficult; however, since the Indian concept of preyas and shreyas can be mapped onto the Greek concept of hedonic and eudaimonic pathways, respectively, tools to assess them may be used to assess these Indian constructs. When people were asked about their preferences for

happiness, they seemed to choose a mix of activities to experience happiness, and these activities fit the definition of either hedonic (preyas) or eudaimonic (shreyas) kind of pathway. The choice of these activities was dependent on the context and situation, but on average, people prefer those activities which might be categorized as eudaimonic or shreyas pathway, whereby they give importance to relationships, meaningful activities, duties and living with values. It was also found that taking a shreyas pathway (with importance given to meaningful framework and eudemonic activities) was associated with happiness. On the other hand, preyas kind of pathway, with frequent engagement in hedonistic activities and ignoring meaningful eudemonic activities was associated with negative emotions (Agrawal et al., 2011). This may somewhat validate the description of rajasika sukha (as described in Bhagavad Gita), which is supposed to be pleasant like nectar in the short term, but is harmful like a poison in the long term.

The use of alcohol may be considered as one of the common hedonistic (preyas) activities, even to a harmful extent, in modern times. When a person gets dependent upon alcohol and is unable to stop oneself, it is diagnosed as alcohol dependence. In another study with participants diagnosed with alcohol dependence, it was found that this group had higher levels of tamas. They also had lower sattva, lower positive emotions and higher negative emotions, as compared to people who were not dependent on alcohol (Nedungottil et al., 2021). This finding, too, was on similar lines as described in Bhagavad Gita, where tamasika sukha is harmful in the beginning as well as in the long term. Thus, one may hypothesize that types of sukha may be associated with mental health and rajsik-tamasika sukha may be related to poor mental health or even clinical conditions, while satvika sukha may be associated with positive mental health.

Yoga: A Comprehensive Psychospiritual Pathway to Deeper Happiness

In the Encyclopedia of Indian Philosophies (Vol. 12), Larson and Bhattacharya (2016) mention that the term yoga is often used for all those techniques which people practice to find release from their existential suffering and achieve unity consciousness. In this sense, yoga may be considered as an applied physical-psychospiritual pathway (Nishreyas) rooted in the Indian civilization for finding the highest state of existence and bliss (ananda). The yoga tradition is vast, with diverse living tributaries of knowledge systems (oral and textual). It has grown and survived various challenges, evolved within a system of training under a Guru (spiritual teacher), supported by one's experimentations, observations and reflections—contemplations, and refined by sharing of experiences and debates-discussions. The "time–space framework" is wide, and it is established inside a network of personal, interpersonal, community, and cosmic web (Dalal & Mishra, 2010; Menon, 2005).

Recent research has also found convincing evidence to suggest that Patanjali's "Astanga yoga" works like an integrative self-regulation module, with both top-down and bottom-up components (Gard et al., 2014; Payne & Crane-Godreau, 2015; Schmalz et al., 2015). Other psychological mechanisms such as meta-cognition, disidentification, deconditioning, and interoceptive awareness might be behind the beneficial effect of yoga on mental health (Vorkapic, 2016). The majority of yoga research has been dominated by hatha yoga (Yang et al., 2009), which covers mainly the yogasana (physical postures) aspect of Patanjali's eightfold path (Gard et al., 2014), ignoring the psychospiritual aspects of yoga, which has emphasized certain attitudes, cognitions, and emotions. Although more and more studies are integrating yoga with various types of meditation (Uebelacker et al., 2010; Mendelson et al., 2010) and/or pranayama the breath-related practices (Pullen et al., 2010). There are many psychological ideas in the yoga tradition directly related to beliefs, attitudes, cognitions, emotions, and life choices. Some of these have been researched individually, but have rarely been brought together in empirical research.

While research body has predominantly focused on the therapeutic effect of yoga, a few studies did explore well-being and positive mental health outcomes of yoga in community population (Chung et al., 2012; Eastman-Mueller et al., 2013; Noggle et al., 2012). In a meta-analysis, Knobben (2013) found few research studies testing the effect of yoga on well-being, with a large impact on emotional well-being, and medium for both psychological and social well-being. Recently, two separate reviews have also reported the publication of newer studies exploring yoga and positive mental health in terms of psychological well-being, emotional well-being, life satisfaction, social relationships (social well-being), empathy, mindfulness, self-compassion, and resilience. But these results seem to indicate a weak positive relationship between yoga and positive mental health (Domingues, 2018; Hendriks et al., 2017). Such weak results might be explained in light of not having any direct intervention pathway in these studies related to cognition, emotions, life choices, etc., based on yogic and Indian psychological traditions.

Salagame (2011), in his review of Bhagavad Gita, Patanjali's YogaSutra, and Yoga Vasishta, found various approaches given in these texts, which may be useful for mental health and well-being. This includes developing a witness stance, self-discipline, detachment, certain motivational and attitudinal orientations, acceptance and compassion. Similarly, Bhavanani (2014) has discussed various dimensions of yoga, along with a variety of therapeutic skills based on yogic philosophy, such as swadhyaya, pranayama, pratyahara, dharna, dhyana, bhajana, vairagya, chittaprasadanam, maitri, mudita, karuna, upeksha, trataka, and pratipakhsa bhawana. Some of these ideas may be usefully brought together to develop well-being programs. Thus, a need was felt to develop a model based on core yogic texts for the purpose of future well-being interventions. If such a model is present, it may theoretically guide various promotive mental health interventions, which in turn may benefit anyone on the mental health continuum (Keys, 2002; WHO 2004), from illness to wellness, from a broad yogic spirituality stance.

Analysis of Core Yogic Texts

To develop a yoga-based psychospiritual model, a thematic analysis of three yoga texts: Bhagavad Gita, Patanjali YogaSutra, and Yoga Vasistha, was conducted. These texts are some of the most important and maybe considered core yoga texts (Salagame, 2011). The process started with multiple readings of these texts leading to individual themes, which were then covered under several overarching broad themes.

The Texts: Bhagavad Gita, translated as "The song of Divine" in English is part of a larger epic, Mahabharata written by Sage Veda Vyasa in ancient India. It also stands as the best-known Hindu scripture encompassing 700 verses, synthesizing the three major paths of yoga, i.e., bhakti (devotion), jnana (knowledge), and karma (action). Gita, a conversation between Lord Krishna and his friend and mentee Arjuna, has inspired generations of philosophers and mystics, from Emerson to Sri Aurobindo. The Yoga Vasishta, written by Sage Valmiki, has two versions, the larger with 29,000 verses and a smaller one used for this study with 6000 verses. It captures the conversation between Lord Rama and a group of sages led by Sage Vasistha. The Patanjali YogaSutra (Patanjali, 2001) is a compilation of 196 aphorisms (sutra) by Sage Patanjali, covering the theory and practice of yoga in four short chapters (pad). Here the focus is on the compilation of steps for concentration and resulting inner experiences and in the process, documenting the helpful and unhelpful factors.

In general, these texts have given a practical approach to spirituality, which anyone can try for themselves. Two out of these three texts have utilized a narrative framework, with dialogue between a "main character/hero" and a mentor (*guru*) figure (Bhagavad Gita and Yoga Vasistha). The narrative begins with the "hero" having a psychological crisis, matching the modern description of anxiety/depression. Subsequently, he is helped ('talking cure') by the mentor through clarifying doubts and teaching a variety of applied techniques (e.g. variety of meditations, breath control/*pranayama*, as well as cultivation of specific virtues and skills). In Gita, amidst a background of war, the hero Arjuna reports symptoms similar to anxiety, and in Yoga Vasistha it is Lord Rama, who forgetful of his Divine status, is experiencing symptoms which may be termed as an existential depression. The third text (Patanjali YogaSutra) is briefer, without a narrative, and focuses on steps for deepest meditative states/Samadhi, resulting in inner experiences and psychic powers. It also discusses states of mind, causes for suffering and helpful and unhelpful factors for meditation. Based on the themes from these three core texts, a model was developed. These themes are interconnected, and each one of them interacts with the other to provide insight.

The Yogic Model

As mentioned earlier, this interlinked model was developed based on a thematic analysis of core yogic texts. As we will note that each of the component is also related

to the other components, and makes a whole framework, which may be utilized in part or full for well-being interventions. However, one needs to remember these components are primarily focused on spiritual growth and positive mental health is merely a by-product.

Perspective: One of the core components of this model is about the yogic perspective on life and the universe, which includes an assumption related to the purpose of creation and its principle components. The overarching perspective is related to the inherent unity of Consciousness. It considers Consciousness, together with primordial materiality (prakriti) has led to the diverse creation in the universe. And thus, creation is considered to be an interaction between matter and Consciousness, and Consciousness is permeated in everything around us. The material component is influenced by the three qualities (triguna), i.e., tamas/inertia, rajas/dynamism, and sattva/light-harmony. Thus the quality of this diversified existence is in a way determined by the proportion or dominance of these three gunas. The resulting creation is considered to be cyclic and also ever-changing. Human existence is also an interaction of both matter and Consciousness. This Consciousness or deeper Self is distinct from mind, which is multilayered and complex, but merely reflects Consciousness. Mind is subtle matter, is influenced by triguna and thereby leads to varied experiences for humans.

The main cause of suffering as per the yogic perspective, is ignorance of our deeper Consciousness or true being, although multiple overlapping models have been suggested to explain suffering (types of cover on this Consciousness, types of suffering, types of mental states, etc.). And overcoming this suffering requires recognition of the deeper Self, by achieving some sense of separation from the material aspects (viyoga). This may be done even while pursuing the entire range of human aspirations (puruSartha; right-ethical action, wealth, pleasure, and existential freedom) based on personal conception. The perspective also takes into account the different kinds of happiness and pathways toward them. It is an experiential journey, with growth across births; thus no efforts on this yogic spiritual path are lost.

Self: In the yogic tradition, two kinds of "self" have been considered, an outer self and an inner self. The outer or lower self is the ego-sense, identified with the body. The metaphor of a pot (or a house) is used to denote how this outer self is just a protective cover for the inner space. The outer self is limited by a sense of separation from others and the larger world. It thrives on having a sense of attachment, possession, and ownership related to people, things, ideas, and experiences. It also mistakenly thinks of itself as being the master of one's world. This outer or lower self can be like an enemy or friend. When one is on a journey of spiritual growth and the discovery of the deeper self, this outer self needs to be transcended.

The deeper self is also considered as one's higher self and is described as the unaffected witness within, identified with the entire universe and being the spark of divinity in humans. While the body dies, the deeper self is imperishable. It is the center of our individuality and is also called "Mahatattva."

The separation from outer and deeper self, through the means of spiritual development, is also known as "Viyoga." This process starts with acknowledging the

possibility that there is a deeper Self to be discovered. Freedom from ego can come gradually by self-observation and self-analysis, where one holds one's behavior "at a distance." One can know about one's limitations, thereby reducing pride and giving up desires, anger, agitation, I-ness/my-ness. At the cognitive level, notions of "I am…" and "this … is pleasure" lead to ego, desire, and subsequent bondage. Therefore, one can deconstruct one's sense of ego-self by contemplating on "I am not …," and confronting this is pleasure with thoughts of "this … is not pleasure." Further, while contemplating on the nature of the cosmic Consciousness, certain deeper self-based affirmations would act like steps on the path. Surrender to Divine and finally renouncing this idea of being a "renouncer," may lead to the highest experience of egoless state where only the subject alone exists.

Divine: A variety of forms and descriptions have been used for the Supreme reality/One Consciousness/God. For example, in the universe, whatever is glorious, beautiful, mighty, etc., is just a reflection of this Supreme power, who is still not limited by these, or a variety of forms have been described, each of which emphasizes a different, though essential qualities in the creation (e.g., knowledge, freedom, forgiveness, truth, self-control, etc.). This power is supposedly present in different states, such as involved with the creation, uninvolved witness of all movements in the creation, and in a transcendent state encompassing other two states and beyond. The Divine is also described as an actor, as well as the enjoyer of the cosmic play, witness and also the one who gives sanction to it and also sustains the happenings in the world. The Divine is still free from all human limitations of actions and their outcomes. This Supreme power is also believed to be all-compassionate, for everyone, without differentiation (e.g., for the titan and the oppressed), but also acts with love through people based on their qualities/abilities.

The yoga of bhakti is the chosen path here, in which one tries to develop a secure attachment with one's preferred God. This is done through the seeking of the Divine, by love–adoration, by finding safety in and worship of the Supreme, and by remembering God, especially in critical moments. It is also associated with developing self-awareness, knowing one's limitations, evolving psychologically–ethically, following a Divine life and doing everything as an offering to the God. This may culminate in finally abandoning all rules and taking refuge in the Divine, and surrendering to the Divine.

Other: Since there is one consciousness behind all the multitude of creations, there is an inherent connection between everything and everyone. Discovering such oneness (sense of Divine in all) is a process and also an outcome of the spiritual path. This has to be done by following social–ethical codes of non-harming, truthfulness, non-stealing, sense control, and non-greediness (Yama). Further, one needs to cultivate the interpersonal attitudes of harmony and universal goodwill, such as loving-kindness and friendliness (maitri), appreciative joy (mudita), compassion (karuna), and equanimity (upeksha). One not only develops the discipline of speech, in terms of soft–pleasant and truthful speech, but also of working toward social welfare (lokasamgraha).

Action: The term "karma" has been used to denote creative movements in yoga. The right karma is that action, which allows the expression of one's inner nature.

All actions and their outcomes are supposedly influenced by many variables (e.g., causes of action, its types, etc.), which interact with a variety of motivations behind the actions and the operations of the universal forces (e.g., the principles of trigunas). When ones' action is based on one's inherent nature and context (such as at the right time), and when one acts with persistence while being devoted to a higher cause, it leads to liberation from the bondage of karma. Such actions become "dharma" or the right action and lead to the greatest good and subsequently to authentic happiness. It has also been mentioned that such excellence in one's action leads to growth or "rising upwards."

In this model, the emphasis is on finding one's inner nature (svabhava), one's right action (swadharma) and working for the well-being of everyone (lokasangraha). One needs to discover and choose the right action for oneself based upon one's inner nature and context. One also needs to focus on the work at hand and not get troubled by the outcomes or its thoughts since one has "right to action, not to its fruits." Another important idea here is that of "sacrifice," where one offers one's action to the universal forces, which supposedly bring the results, and thereby a cycle of interchange between God and man occurs. One's actions can be done with equality of will and in harmony with the Divine will (not working for one's desire and ego). One can start with renouncing the fruits of action and go on to do everything for the sake of Divine as one's offering. Working as an instrument in the attitude of karma-yoga, finally one can reach the state of complete union with Divine, with the help of faith and surrender. Before that stage comes, one can try to work in a self-aware and selfless manner by renouncing the claims of doership and with focus, firmness, excellence, doubtlessness, discretion, in silence, purity, non-violence, and self-control. There is emphasis on working with the right attitude and principle, like a witness, holding away, balanced, without desire and expectations, without like–dislike, jealousy, and by removing dependency and attachment for good–bad outcomes. Freedom in inner contact, along with equality and acceptance for whatever outcomes come in one's way, and knowing that behind everything is the equal witness self, is encouraged. This is known as "mahakarta."

Experience: A model has been offered in yogic texts, where identification with one's actions and experiences leads to a conditional mental consciousness, in both wise and unwise people. Such conditioning of mind, in turn, creates a desire for similar experiences, which leads to the movement of prana (life force/breath) along with attachment/clinginess to a mental idea or fantasy. This works like a seed for the mental tree and consecutively may create more thoughts, feelings, and actions. In addition, when we identify with such movements in mind and that of prana, it builds our ego. The ideal state is that of equality in varied experiences (sama), when one does not hate or yearns for anything and enjoy all the natural experiences of life. This happens when the inner self (soul) remains a witness to happenings of the three gunas, without making arbitrary distinctions and without getting affected by the dichotomies of pleasure-pain, fortune–misfortune, etc. It enjoys the playful engagement in natural action by developing non-attachment. Such a state leads to a sense of freedom. In this state, only rasa (savoring/taste) from varied experiences remains, and even that ceases when the Supreme is seen or experienced.

To develop this state, one needs to develop a witness attitude (sakshi bhava), observing the play of gunas, along with turning one's senses and attention inwards (pratyahara, through techniques such as trataka, japa, nada yoga, kirtan, etc.) and inner yoga (antaranga, dharana, dhyana, Samadhi, together with samyama). Yoga practice, along with enquiry, is required. One needs to recognize that the craving for pleasure is never fulfilled since desire never ends and contemplate on cultivating dispassion. Similarly, there is a need to regulate the breath, since it signifies the movement of life force, by enquiry of cause of movement, the practice of pranayama, by sense control, and self-discipline. A variety of practices from hatha yoga, such as bahiranga yoga and mudra have also been suggested. Self-observation and contemplation (swadhyaya), surrender, abandoning all notions (sankalpa) have been emphasized. Another powerful technique is that of offering as sacrifice one's sense experiences, sense objects, vital force, etc. Other techniques are related to focusing on opposite thoughts and feelings, especially when the mind is disturbed, sometimes removing one's attachments in a sudden action, and cultivating positive interpersonal qualities. The texts discusses in detail giving up craving, desire, likes and aversions, lust, anger, grief, delusion, greed, violence, etc., since it will decrease the bondage of the phenomenal world. The spiritual tapas/heat of such efforts will supposedly burn the conditionings on the mind (samskara) and unfold higher consciousness and powers. Given the importance of experiences and emotions, the texts further go into detail about other ways to cultivate even-mindedness or samata, such as engaging in austerities, the study of spiritual texts, gaining knowledge, cultivating focus through concentration, focusing on a passionless person, sleep-yoga, and other kinds of meditation on preferred objects (by rituals, pooja, chanting, kirtan, prayer, deity, enquiry, etc.). It also emphasizes personal discipline (niyama), silencing the mind (antar-mouna), self-analysis, and self-discipline. Disengaging one's identity from experience, going beyond dualities, increasing the quality of sattva and decreasing rajas-tamas, not being agitated or making others agitated and developing equality in varied experiences, are other suggested practices. Engaging in virtuous, meritorious acts and being solitary, decreasing one's material possessions, deconstructing one's ego, self-purification will also lead to decreased sorrow and direct knowledge. This path will lead to the state of Mahabhokta.

Positive Qualities: In the path of growth, the development of a variety of positive qualities and values has been emphasized, such as harmonious relationships (e.g., friendliness without attachment, goodness, magnanimity, gentleness, aversion to fault finding, not making others agitated, honesty, non-violence, forgiveness, not having any ill-will, along with veneration of one's teachers), a certain approach to life (courage, peacefulness, wisdom, fearlessness, steadiness, equanimity, not getting agitated, equality, truthfulness, steadfastness, self-control, rising above discord and finding the harmonizing principle, desirelessness, purity, absence of perversion, endurance, intelligence, contentment, straightforward, doing the right things, goodness, etc.). These positive qualities have been variously termed as Divine qualities or daivik/satvik qualities.

Conclusion

The paper discusses parallel ideas on happiness and pathways to happiness in modern Western literature and ancient Indian tradition. The Western literature has proposed subjective versus objective happiness and hedonic versus eudaimonic pathways. The Indian tradition has discussed a range of happiness from ananda to three types of sukha. Although few are able to take the path of ananda, many more can be encouraged to gradually move from rajasika-tamasika to satvika sukha, by choosing the difficult but good path of shreyas. Empirical studies from both traditions have been presented. Modern research has shown that, although more than half of our happiness is tied to genes and circumstances; however, there is still much scope for intentional activities that can change our level of happiness. When people take the eudaimonic path or that of shreyas to find satvika happiness, it may need deliberate effort, and they may have to gradually let go of many of their desires and ego needs, and balance them with concern for others. It may also lead to inner struggle and difficulties related to managing outer changes, but in the end, it may be worthwhile. On the other hand, rajasika-tamasika sukha may seem attractive at the beginning but will lead to more unhappiness later and may even be unhealthy. Thus, we need to follow the rule that "prevention is better than cure" and develop mental health programs to promote satvika sukha and carry such training programs in schools, colleges, workplaces, and other community organizations. This will also lead to the prevention of unhappiness and mental health problems due to choosing rajasika-tamasika sukha. This Yogic model seems to have potential for promotive and therapeutic interventions (Agrawal, 2021), although more studies are needed.

Recommendations

Since there are interesting parallels between Western and Indian models of happiness, the Indian model also needs to be given attention.

The relationship between various types of happiness and mental health and well-bring variables needs more study.

Given that yoga-based empirical research has ignored the psychological aspects, the yogic psychospiritual model proposed in this chapter needs to be tested as an intervention.

Long-term yoga practitioners need to be studied qualitatively for psychologically significant changes and may even be followed up for many years to get deeper insights into some of the phenomenon described in the yogic texts.

Acknowledgements The author would like to express appreciation to Dr. Sushrutha for his valuable inputs to portions of this manuscript.

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Part VIII
Future Perspectives

Chapter 31
Well-Being of Child Victims of Sexual Abuse: Perspectives from a Physiopathological and Criminal Justice Delivery Viewpoint

Lina Acca Mathew

Abstract Child sexual abuse (CSA) is a universal phenomenon with grave repercussions upon affected individuals. This phenomenon differs from country to country and depends upon the types of CSA used in the study, the definitions used to analyze these types, the area of study, and the quality of data obtained. This paper discusses some commonly used definitions of CSA, as seen in the Report of the World Health Organization (1999), Article 18 of the Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, and the Report of the Ministry of Women and Child Development, Government of India (2007). This paper also discusses structural barriers to research on CSA. Various studies on the physiopathological effects of CSA in victims as well as effects of the legal system on children are analyzed. The focus point of this paper is to examine the need for the law to safeguards the well-being of child victims of sexual abuse in India.

Keywords Child sexual abuse (CSA) · Child marriage · Victims · Effects · Mental health · POCSO · UNCRC

Introduction

Twenty years after the adoption of the *United Nations Convention on the Rights of a Child 1989* (*UNCRC*), Indian child sexual abuse laws were still considered largely archaic, as the *Indian Penal Code 1860* (*IPC*)—the general criminal law of the land-punished certain instances of child sexual abuse under the offenses of obscenity and obscene publications corrupting young persons, sexual assault by outraging the modesty of women, rape of women (confined to penile–vaginal nature only), unnatural offenses—of homosexual or bestial nature as well as the offense of words and gestures outraging the modesty of women. The number of reported cases is continued to be sparse, and in comparison to the actual number of crimes being committed, the reasons being that victims of child sexual abuse (CSA) hesitate to report incidents due to the sensitivity of the matter. Law enforcement agencies were

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_31

not obligated to report, and without support from social welfare organizations and the press, the victim and family would not receive community backing, resulting in failure to prosecute. The absence of solid community backing spilled over to law enforcement personnel, which hindered prosecution of the offender at the initial stage itself. The lack of the prosecution taking up a proactive role due to the accusatorial nature of the criminal justice machinery in India would be another reason for this sorry state of affairs.

Police operations in the UK and the USA in the early 2000s found child pornography material being uploaded from India. Various incidents of child sexual abuse perpetrated through electronic means by Indian professionals residing in the USA came to light during this period, and the American media highlighted the problem of an absolute dearth of studies in India regarding the incidence and prevalence of CSA. It was these points that pushed social crusaders and NGOs to lobby on issues regarding collection of statistics documenting the extent of abuse and enacting stronger laws.

Historical Development of CSA Law in India

In India, CSA has been an age-old problem. Customary religious practices endorse female child prostitution from historical times (Ditmore, 2006). CSA in the guise of marriage was the norm in India, based on customary practices. The protection granted to ethnic customs extends to the protection of child marriage (UNICEF, 2009). The *IPC* did not provide any categorization of crimes of sexual abuse of children. Also, *IPC* does not criminalize child marriage, which is also a cultural phenomenon in various parts of India. In 1929, a special law called the *Child Marriages Restraint Act 1929* was enacted in order to restrain child marriage through meting out mild punishments to three categories of persons—the adult male offender who marries a girl, the parent/guardian of the child getting married, and the performer or director of the marriage ceremony. However, the question regarding the validity of a child marriage was not answered, and the enactment remained silent on the matter.

More than fifty years later, the position remained the same. An innovative step was undertaken by the state of Goa in enacting a regional statute, the *Goa Children's Act 2003,* with specific provisions criminalizing instances of CSA. It categorized and defined three sexual offenses against children—"grave sexual assault," "sexual assault," and "incest." However, the provisions of *IPC,* which is the general criminal law, would prevail over this statute in cases that dealt with rape of a child wife.

In the meantime, the *Commissions for Protection of Child Rights Act*, *2005,* caused the creation of a National Commission for Protection of Child Rights in 2007, which was gradually followed by State Commissions for Protection of Child Rights in the Indian states. A new enactment, the *Prohibition of Child Marriages Act 2006,* gave voidable effect to child marriage upon attaining the age of majority, perhaps to prevent unsettling cultural practices of child marriage in certain regions and communities in India.

As part of the reformative drive, in 2007, the Ministry of Women and Child Development (MWCD), under the central government, spearheaded an official study on abuse of children in 13 states in India.[1] This official study entitled *"A Study on Child Abuse: India 2007"* found high incidence of CSA. About 53.22% of children were subjected to one or more forms of CSA. And, 21.90% of children were subjected to severe forms of CSA. The highest incidence of CSA can be seen in categories of children on the street, children at work, and children in institutional care. It was distressing to find that people known to the child or those in a position of trust and responsibility comprised half of the abusers. In most cases, no one was intimated by the victimized children.

Topics revolving around sexuality are still shrouded in secrecy in India due to the conservative attitudes within families. Many cultural practices revolve around ensuring the safety of virgin girls, while ignoring the safety of boys. A child may not even realize the fact of abuse when CSA occurs.

The 2007 official study defined the term "sexual abuse" with reference to children and categorized nine types of sexual abuse into four severe forms and five other forms of sexual abuse. The findings in this study, and many gruesome incidents of grave sexual assault and murder of children, added pressure upon the central government to bring about wide sweeping reforms in child rights law. The central government finally settled upon enacting special federal statute law dealing with various types of CSA called "*The Protection of Children against Sexual Offences Act 2012*" (*POCSO*), which entered into force on November 14, 2012. This legislation was a welcome step as it defined and criminalized new sexual offenses against children.

From December 2012, immense pressure was exerted upon the government from all over India for stronger measures to protect women, as part of the mass protests against the heinous crime of gang rape of a female student in New Delhi which resulted in her subsequent death. Thereafter, a judicial committee under former Chief Justice of India J. S. Verma recommended a series of amendments to Indian criminal laws. The root cause of crimes against women in India was pinpointed on failure of governmental and police services. As a result of their report, the *Criminal Law (Amendment) Act 2013* was enacted to amend *IPC, Indian Evidence Act 1872, Code of Criminal Procedure 1973,* and *POCSO*. This amending statute replaced the earlier offense of "rape" in section 375 *IPC* to include various types of body penetration of sexual nature. The amending statute also inserted the additional sexual offenses of sexual harassment and voyeurism. A clarifying section was inserted into *POCSO* stating what the law would be in case of conflict between *IPC* and *POCSO* provisions. Later on, the statutory exemption for husbands in case of rape of a child wife in section 375 *IPC* was struck down by the Supreme Court in *Independent Thought* v. *Union of India* (2017).

[1] Kakkar et al. (2007).

Prior Research on CSA Law

Several aspects of existing law on CSA have been analyzed and provided in this section. For example, Adenwalla (2000) pointed out the sad fact that sexual abusers of children in India are allowed to escape on mechanical grounds, which leads to the presumption that the child victim is at fault. The duty imposed upon the Law Commission to comprehensively study the problem of CSA was ignored. Adenwalla further stated that law has a role of encouraging transparency, accountability, and deterrence within family and institutions. In another study, Jaising (2005) outlined Indian legal responses to non-consensual sexual experiences of young persons. Jaising (2005) stated that existing laws on sexual offenses are restricted to penetrative sexual abuse of penile–vaginal nature alone. This is accentuated by courts which hesitate to widen the interpretation of the word "penetration" to include a meaning that goes beyond penile–vaginal intercourse. Other forms of sexual violence are outraging the modesty of women, incest, exploitation in custody home, yet the crime of incest is not defined or criminalized. Jaising (2005) points out the fact that male children are excluded from the purview of sexual offenses. Also, the *Child Marriage Restraint Act 1929* is ineffective in addressing the issue of child marriage. The Indian government has declared its inability to comply with its international obligations under the *Convention on the Elimination of all Forms of Discrimination against Women 1979* which makes registration of marriages compulsory. As teenage consensual sex is on the rise, it becomes problematic to convict a minor for rape. Jaising suggested that a simultaneous process of sensitive and effective legal reform is necessary in order to recognize the special vulnerability of adolescents due to their age. Jaising suggested that the terms "sexual violence" and "coercion" could be comprehensively defined and understood, based on adolescent experiences and on international and national law developments. These definitions should take coercive fiduciary and non-fiduciary relationships experienced by adolescents into consideration. On the other hand, Bajpai (2006) examined National Crime Records Bureau statistics and social science evidence and made a case for evolving a right to protection against sexual abuse and exploitation. Bajpai (2006) remarked that child marriage is valid under Indian personal laws, though void under the civil legislation and Parsi civil law. Rendering child marriages as legally void would cause suffering to the bride, as she would have to face the social stigma of already having been married, and she would also be unable to receive maintenance as her marriage is not legally recognized. Bajpai (2006) presumed that women are not punished under the *Child Marriage Restraint Act 1929*, perhaps because they do not play a role in finalizing and performing marriages, and also the main objective of the Act is prevention rather than punishment. Kannabiran (2009) used case studies in order to conduct an analysis of IPC provisions on sexual assault from a woman's perspective. The language used by courts regarding rape was examined, including the historical case of the death of an 11-year-old child—bride Phulmoni, pursuant to rape by her 35-year-old husband[2] which exemplifies the fact that adult husbands were handed light sentences, if incarcerated at all. It was found that Indian court language

[2] *Queen-Empress v. Hurree Mohun Mythee* (1891) ILR 18 Cal 49.

constructed females as property which are to be possessed or commoditized, as in patriarchal informal justice systems. Similarly, Raha and Giliyal (2013) examined the impact of *POCSO* upon the problem of child marriages, read along with the *IPC* as amended in 2016 and the *Prohibition of Child Marriages Act 2005*. The *Prohibition of Child Marriages Act 2005* renders child marriages voidable and not void. Raha and Giliyal (2013) found that if children below the age of 18 enter into consensual sexual intercourse, they would have to resort to marriage in order to escape from a minimum term of ten years rigorous imprisonment under POCSO. So far as the upper age of children is concerned, Agnes (2013) did not agree to raising the age of consent of girl children from 16 to 18 years on the basis of the sociological fact that the rise in the standard of living and increased education fueled by safe public spaces lead to increase in the age of marriage for females.[3] Agnes (2013) points out the legislative reluctance to declare child marriages as void even after the *Prohibition of Child Marriage Act, 2006,* due to the lack of cultural uniformity and socio-economic factors consisting of impoverishment among the urban and rural poor, lack of access to education for girls, and consternation regarding sexual offenses. These issues are faced by the backward castes, the *Dalits* and Muslims rather than the elite and middle classes. Law is unable to facilitate community-level interventions to prevent child marriages. Agnes (2013) remarked that a campaign for stringent laws would only weaken the negotiating power of young girls who wish to contract marriages of choice, while strengthening patriarchal power. Moirangthem et al. (2015) did a study to identify various problematic areas in the law regarding consensual sexual activity between adolescents and an adult, issues relating to medical examination like consent, and who should conduct such examination in the absence of a female doctor, cost of treatment, training of medical personnel, the role of a mental health professional, etc. It was opined that when two consenting adolescents engage in sexual acts that may constitute penetrative sexual assault; it should not be an offense under *POCSO*. Bajpai (2015) traced the history of child rights law and professed five "important" aspects of the new *POCSO* enactment—"(1) CSA has been criminalized in a gender-neutral definition; (2) a comprehensive definition of acts that constitute CSA has included penetrative, non-penetrative, and non-touch forms; (3) the amount of punishment has been graded on the basis of regular and aggravated offenses that take into account custodial forms of CSA; (4) a detailed procedural mechanism is set up, including special courts which are capable of recording evidence and conducting trials in a child-friendly manner; (5) a child is enabled to report cases, with the burden of proof shifted upon the accused. Bajpai (2015) suggests that POCSO can be improved by including provisions for rendering support services to child victims and lowering the age of sexual consent from the current 18 years as there is a tendency to misuse this by police or parents.

[3] Agnes (2013) cited the instance of the rape of a girl in rural Karnataka in January 2013 while she was on her way home from school which led to the denial of access to education of 400 girls due to security issues. This would lead to early marriage despite the minimum age for legal marriage being 18.

Difficulties Within the CSA Discourse—Definitional Vagueness, Underreporting, and Risk Factors

Worldwide studies have identified main factors which show higher risks for abuse such as inadequate parenting, unavailability or absence of parents, substance abuse by parents, parental conflict among themselves, punitive parenting, social isolation and emotional deprivation, gender, age, physical disabilities. Increased vulnerability of victims can be found when associated with factors of dependency, institutional care, and communication difficulties. However, studies show that race and socio-economic status are no longer considered as risk factors for CSA (Finkelhor, 1994a; b; Putnam, 2003; Ronan et al., 2009).

Certain categories of children fall within the high-risk category regarding the likeliness of being abused. Such victims face numerous consequences, which vary depending upon the individual. More adverse consequences occur during situations where there are other factors involved including incestuous abuse, continuing episodes of abuse, the use of force in abusive situations, strategies used by the perpetrator to obtain secrecy, multiple perpetrators of abuse, and absence of maternal support for the victim (Corcoran & Pillai, 2008). Such survivors undergo psychopathological effects upon health and are also pursued by feelings of shame, being segregated and ostracized within the family and by the community in general, in addition to the trauma of "rape by the legal system." It is essential that child-friendly procedures in collecting evidence and trial are ensured in tune with the internationally recognized principle of best interests of children and other principles endorsed by the *United Nations Convention on the Rights of the Child 1989.*

Definitional Difficulties of What Constitutes CSA

Standard definitions of the term "child sexual abuse" exist within the WHO definition[4] and the Council of Europe definition of the term.[5] In the Indian context, the MWCD Report (2007) was the first official document that used the term "child sexual

[4] World Health Organization. (1999). Report of the Consultation on Child Abuse Prevention. Geneva, March 29–31. Document WHO/HSC/PVI/99.1 at p. 62.

CSA is defined as

"the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or that violates the laws or social taboos of society. CSA is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to the inducement or coercion of a child to engage in any unlawful activity, the exploitative use of a child in prostitution or other unlawful sexual practices, and the exploitative use of children in pornographic performances and material.".

[5] Article 18, Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, CETS No. 201.

abuse," which was defined as inappropriate sexual behavior with a child, including acts of fondling the genitals of the child, causing fondling of an adult's genitals by the child, sexual assault which includes intercourse, incest, rape, sodomy, exhibitionism and pornography, committed by a person like a babysitter, parent, neighbor, relatives, extended family member, peer, older child, friend, stranger, or a day-care provider, who are related to the child or are in a position of responsibility for the care of a child.

Sexual abuse was classified by this report into two types into severe forms and other forms.

1. Severe forms of sexual abuse include-
   a) assault, including rape and sodomy;
   b) touching or fondling a child;
   c) exhibitionism: forcing a child to exhibit his/her private body parts; and
   d) photographing a child in nude.
   2. Other forms of sexual abuse include:
   a) forcible kissing;
   b) sexual advances toward a child during travel;
   c) sexual advances toward a child during marriage situations;
   d) exhibitionism: exhibiting before a child; and
   e) exposing a child to pornographic materials[6]

An examination of the MWCD Report (2007) shows higher prevalence of abuse of boys than girls. There may be reason to believe that these statistics are erroneous because one of the "other forms" of sexual abuse discussed in the report was "exposure to dirty pictures," of which the number of boys disclosing category of abuse was higher compared to girls in all sample states. About 66.1% of child respondents viewed these "dirty pictures" from their friends or classmates, with the second highest rates of 13.1% of child respondents shown dirty pictures by uncles or neighbors. It is pertinent to note the fine distinction between the process of discovering sexuality and abuse, so the act of viewing pornographic images with peer group members does not classify as abuse.

Diverse definitions add to the confusion surrounding the type of activities that would constitute "sexually abusive activities." There is confusion in definitional discourse on development of children and adolescents and their growing sexuality; hence, the bewilderment about what would constitute normal sexual behavior. These definitional hurdles stem from the lacuna involving:

Sexual abuse involves: "a) engaging in sexual activities with a child who, according to the relevant provisions of national law, has not reached the legal age for sexual activities (this does not apply to consensual sexual activities between minors); and b) engaging in sexual activities with a child where use is made of coercion, force, or threats; or abuse is made of a recognized position of trust, authority, or influence over the child, including within the family; or abuse is made of a particularly vulnerable situation of the child, notably because of a mental or physical disability or a situation of dependence.".

[6] *Supra*, n.5.

(1) no uniformity in perception on the age of the end of childhood;
(2) no unanimity on whether the definition of CSA should include non-contact experiences or exclude non-contact experiences;
(3) no unanimity in determining the appropriate age difference between minors engaging in consensual sexual relationships; and
(4) no unanimity regarding the behavioral contexts for deciding abusiveness.

As societal norms about children and sex rapidly change, this becomes partly responsible for these lacuna in the discourse on definitions of CSA (Vizard, 2006), which is an important aspect to take into consideration while discussing a comprehensive definition for the Indian context.

A major problem in the definitional discourse is the lack of clarity between where abuse begins and "experimentation" ends (Cashmore & Shackel, 2014). Such vagueness in CSA legislation would lead to problems in bringing offenders before the criminal justice system, due to the clearly perceivable active participation of victims in the crime. Another important aspect of this definitional hurdle is the age gap between the victim and offender when the child victim and the offender belong to age groups within a five-year gap. This aspect becomes particularly relevant in India, as the weakness of *POCSO* lies in the absence of contextual considerations to decide the abusiveness of a sexual behavior. Presently, even where the element of coercion is absent and when there is no significant age difference between the two partners, and such consensual sexual relationships between minors themselves and between minors and adults is criminalized under *POCSO*.

It is also debatable whether "other forms" of CSA should include peer exposure of children above a particular age to pornographic materials, as has been done in the 2007 MWCD study. This definitional difficulty is manifested as *POCSO* does not provide exceptions in instances of non-coercive experimentation between children of the same age group.

Difficulties in Disclosure of CSA

Studies indicate vast underreporting of crimes against children. Estimates on child sexual abuse of Indian children who have experienced some form of CSA put percentages between 18 and 50, with higher incidence of girls. Incomplete statistics occur as disclosure is not the norm, and doubts and aspersions are cast upon those who do actually report. Hence, the prevalence of CSA is considered to be more than common perception (Carson, Foster & Chowdhury, 2014; Deb & Mukherjee, 2009; Iravani, 2011). This is because even when experiences of victims in developing countries are gathered, views of children are largely excluded, partly because of lack of funding (Dunne et al., 2006) and also because of the unwillingness of governments in recording and documenting the incidence and nature of child abuse.

There are several problems faced by researchers which act as hurdles in achieving consensus regarding global trends. These are.

1. ***Absence of Adequate Data about CSA***: The absence of adequate data becomes aggravated by the existence of myths that increase difficulties regarding disclosure and underreporting of CSA.

There has been a greater number of data on CSA from Caucasian, Western, and Christian countries and a comparative dearth of such data from middle-Eastern, African, or Far-Eastern countries (Finkelhor,1994a; b). Studies indicate that lack of resources, the extremity of the phenomenon of CSA, political and economic problems, and lack of a research culture and research experience contribute to absence of research on child abuse in the African context (Lachman, 1996; Finkelhor1994a; b; Lalor & McElvaney, 2010). This finding is reflective of the situation in developing countries including India.

2. ***Existence of Myths about CSA***: Many myths on CSA prevailed in India, predominantly that CSA is a Western phenomenon that was superimposed on unsuspecting Indians, a belief that could be partially explained by a conservative social structure in India in which discourse on sex and/or sexuality is given least importance. Another myth persists that girls need to be kept safe, rather than boys. Indian culture gives utmost importance to female virginity. Cultural and social practices based around safeguarding female virginity prior to marriage include child marriage, segregation of unmarried males and females under the watchful eyes of elders, and negation of marriage prospects of females who lose their virginity (Beinart, 2011).

Such myths effectively stave off allocation of resources for prevention of abuse and rendering assistance to victims, as well as serve to dissuade victims from disclosure fearing negative outcomes. These myths mostly tilt legal outcomes against the victims. Categories of persons who can be negatively influenced by such myths are the mandatory reporters consisting of professionals and care providers and also judges who are involved in trial and judgment. Hence, it is of utmost importance to identify these myths about CSA in order to disseminate accurate information, provide requisite support to victims, and assist efforts for prevention and intervention in CSA cases (Cromer & Goldsmith, 2010).

3. ***Underreporting of CSA***: Disclosure of CSA by victims is infrequent and usually occurs after significant passage of time (Paine & Hansen, 2002). Difficulties in disclosure occur due to inability to understand the nature or the act due to young age and/or communication inabilities faced by the child (Berliner & Conte, 1990), usually leading to development of survival techniques.

An Australian study reported that 48% of women never disclosed their childhood sexual abuse. Among those who disclosed, this disclosure occurred for half of them after a minimum time period of ten years (Fleming, 1997). A national study in the USA among 416 women and 169 men who were sexually abused as children found that 33% of women and 42% of men had never disclosed the abuse, and a further 24% and 14% disclosed the abuse after a minimum period of one year (Finkelhor et al., 1990). Differences in prevalence rates between males and females can be due to

definitional differences regarding the nature of CSA, assessment methods of abuse, and diversity in the characteristics of research samples (Spataro et al., 2001).

Reasons for Underreporting

It is likely that available statistics are underestimated because of underreporting (Chen et al., 2010; Kogan, 2004; Priebe & Svedin, 2008). Hence, it is necessary to examine the reasons for underreporting:

1. **Safety Issues around Disclosure**: The fear of harm from the perpetrator and the fear of upsetting adults are primary factors leading to underreporting. Victim statements in victim surveys show submissiveness on the part of victims during perpetration of the abusive acts (Cawson et al., 2000; Davidson, 2008). In some societies, CSA victims may be murdered in the form of "honor killings" upon suspicion, even without disclosure, which is indicative of the fact that assumptions of guilt of victims is highly likely to govern their actions (Cromer & Goldsmith, 2010).
2. **Gender Variations in Disclosure**: There are differences in the pattern of disclosure between the two sexes. Male apprehensions regarding disclosure centered around the fear of being considered as homosexual. Also, being considered as victims would go against their male ego. Women apprehended not being believed or being blamed for their actions (Alaggia, 2005). A study involved 145 men and 151 women who were asked to divulge about disclosure at the time of the abuse, and about the length of time for disclosure. This study found that women were significantly more likely than men to disclose the abuse at the time it occurred. It also took men significantly longer time to discuss the abusive experiences of childhood later (O'Leary & Barber, 2008). Factors that promote male under-reporting are societal conceptions of masculinity revolving around independence, sexual prowess and self-reliance, and perceptions of rejection and denigration caused by weaknesses like vulnerability, fear, dependency, and homosexuality (Spataro et al., 2001).
3. **Cultural Limitations**: Collectivist cultures, as found in Asia, value group needs above individual needs, which may result in suppressing the redressal needs of a family member in order to protect family honor and prevent shaming the family name. Cultural variations and myths on issues of sexuality and sexual restraint influence disclosure. Hispanic cultures endorse taboos around premarital loss of virginity by girls and homosexual experiences by boys, which leads to non-disclosure (Stoltenborgh et al., 2011). Such taboos also exist within Indian cultures.

"Structural barriers" to Disclosure

There are various difficulties in gathering data on CSA due to reasons of sensitivity of the topic, difficulty to accurately measure its depth, barriers faced by victims in reporting the matter, barriers in access to justice, and the false understanding that CSA is a new phenomenon. Contributory risk factors that are exacerbated by poverty and resulting social or family strain are early marriage of victims, human trafficking, sexual coercion, forced first sex, and males as victims (Veenema et al., 2015). A common worldwide problem is overcoming the barriers in collecting data. There is a need to study the factors that inhibit disclosure, in order to promote disclosure and to continue to hold steadfast to the testimony despite mounting pressures upon the victim to recant. Three broad categories of such factors preventing disclosure of CSA were studied by Collin-Vézina et al. (2015). These consisted of: (1) barriers from within, comprising of strategies of victim-blame which are internalized, protective coping mechanisms, and young age contributing to immature development; (2) barriers in relation to others, comprising of familial violence and dysfunction, power dynamics, victim's understanding regarding the impact of disclosure, and a fragile social network; (3) barriers in relation to the social world comprising of labeling, sexuality taboos, dearth of available services, and cultural limitations or time period limitations. Overcoming these barriers would require major structural adjustments in the legal framework including addressing economic barriers that interfere with interventions and investigation.

Prevalence Studies and Identification of Categories of Children at Risk of CSA

Studies on barriers to disclosure indicate the need for structural changes in the system to promote disclosure.

(I) **Statistics based on Gender**

These systematic reviews of prevalence statistics on the basis of gender in the USA, UK, and Australia are followed by prevalence statistics of meta-analyses from a global perspective.

(a) **Systemic Reviews on Country Basis**

(i) **USA**: Townsend and Rheingold (2013) reviewed six studies in the USA regarding contact sexual abuse of children. It was estimated that girls had a prevalence rate at 10.7% to 17.4%, while boys showed a rate at 3.8% to 4.6%. Finkelhor et al. (2014) studied three national telephone surveys of youths in 2003, 2008, and 2011 of similar design and found that among 17-year-olds, 26.6% of girls and 5.1% of boys experienced sexual abuse and sexual assault. Adult perpetrators were involved at 11.2% for females

and 1.9% for males. High risk rates featured among late adolescent girls, rising from 16.8% for 15-year-old females to 26.6% for 17-year-old females. Risk rates rose from 4.3% at 15 years to 5.1% at 17 years for males. It was concluded that self-report surveys reveal high rates of sexual abuse and sexual assault at the hands of both adults and peers in late adolescence. It pointed to the advantage of conducting assessments among older youth due to the phenomenon of high continuing victimization during the later teen years.

(ii) **UK**: Radford et al. (2011) reported that 16.5% of respondents aged 11 to 17 years disclosed experiences of contact and non-contact sexual abuse. Almost 5% (4.8%) experienced sexual abuse involving physical contact prior to the age of 11 years.

(iii) **Australia**: Andrews et al. (2002) did a secondary study and found that the prevalence rate for male was at 5.1% and for females at 27.5%. The onset of abuse began at an average age of 10 years, usually before the age of 12 years. Mostly, the child knew the offender (75%), with a family member being the perpetrator in 40% of cases. In another telephonic study by Dunne et al. (2003), it was found that for the category of non-penetrative CSA, 15.9% were males and 33.6% females. With regard to penetrative CSA, 4% were males and 12% were females. In a retrospective study, the incidence of CSA was 19.3% and 30.6% for male and female, respectively (Mills et al., 2016).

(iv) **India**: A study conducted by the Ministry of Women and Child Development, Government of India in 2007, reported a high incidence of CSA, that is, 52.94% for boys and 47.06% for girls. A study carried out by Deb and Walsh (20,212) in Tripura reported that 18.1% of respondents were subjected to sexual violence at home, with a majority of victims being girls.

(b) **Studies of Meta-analyses**

Pereda et al. (2009) conducted a meta-analysis of international data, finding that CSA occurred in the lives of approximately 20% of women and 8% of men. Stoltenborgh et al., 2011, conducted a global metal-analytic review of population-based studies of CSA, combining prevalence figures of CSA reported in 217 publications published between 1980 and 2008, through self-reported as well as informant studies. The study found cumulative prevalence rates at 18.0% for girls and 7.6% for boys, prior to age 18. It was found out that self-reported CSA was higher among females (180/1000) than among males (76/1000). Asia reported the lowest rates of self-reported CSA for both girls (113/1000) and boys (41/1000), while Australia reported the highest rates for girls (215/1000) and Africa reported the highest rates for boys (193/1000). Lalor and McElvaney (2010) conducted an analysis of studies in 11 countries, and found the rates for penetrative CSA higher for female children, ranging from 0.3% to a high of 18%.

Table 31.1 NCRB reports (2014–2018) showing crime rate

	2014 (%)	2015 (%)	2017 (%)	2018 (%)	2019 (%)
Sections 376 IPC	3.1	2.4	2.3	2.1	1.1
Section 354IPC	2.5	1.9	1.9	1.8	0.9
Section 377IPC	0.2	0.1	0.1	0.1	–
Section 509 IPC	0.1	0.8	0.1	0.0	0.0
Offenses under POCSO	2.0	3.3	7.3	8.9	10.6

In another study, Barth et al. (2013) reviewed 55 prevalence studies from 24 countries published between 2002 and 2009. Prevalence rates ranged from 8 to 31% for girls and from 3 to 17% for boys. This study found that nine girls and three boys out of 100 are forced-intercourse victims.

(II) **Statistics Based On Economic Development**

The level of economic development of a country is known to influence prevalence statistics. Stoltenborgh et al. (2011) studied the effect of economic development on CSA prevalence statistics and found that low-resource countries had higher prevalence rates for boys than high-resource countries, whereas in the case of girls, there were no major findings regarding the effects of economic development.'

Veenema et al. (2015) examined 44 publications in 32 low- and middle-income countries since 1980 regarding the incidence and characteristics of all forms of child sexual assault. It found that CSA is an endemic problem in low- and middle-income countries and is prevalent among all children, both female and male, from all social classes.

From these studies, it can be concluded that low socio-economic status of a victim and low economic development index of a country can be eliminated from the risk factors of CSA. This problem is universal, irrespective of economic status. However, a distinction has to be drawn between low economic status as not being a factor for CSA and low economic status which acts as a deterrent for disclosure, reporting, and consequential legal and community interventions. Low economic development index of a country can mean absence of funding or decreased funding for governmental interventions in this area leading to lack of adequate community support mechanisms.

National Crime Records Bureau (NCRB) Reports on CSA

The Table 31.1 consolidates the data in Indian police stations regarding incidence of crimes against children during 2014–2019. A perusal of the NCRB reports from 2014 onward shows a clear departure from previous years, proving the seriousness of criminal justice machinery with regard to crimes against children.[7]

[7]National Crime Records Bureau (2014, .Chap. 6, pp. 174–201).

For POCSO offenses, incidence for the year 2017 was reported at 32,608 with a 7.3% crime rate. Incidence for the year 2018 was reported at 39,827 with an 8.9% crime rate.[8] Incidence for the year 2019 was reported to be 47,335 with crime rate at 10.6%.[9]

Effects of CSA: Psychopathological Effects upon Health and Revictimization Effects Through Interaction with Legal System

Long-term and short-term ramifications on the health of victims of CSA occur, not only through the trauma of the physical abusive act and its consequent mental fall-out, but also through interaction with the legal justice system starting from reporting of the offense to conviction of the offender, as well as dealing with the after-math. Policy is required to empower health services to deal with the various physiological as well as mental health effects of CSA and the removal of structural barriers that block access to such health support services.

The following sections deal with the two issues of physiopathological effects and effects of interaction with the legal system in detail:

(A) Effects upon Health—Physiopathological Effects

These include both effects on physical health and mental health of CSA victims' short-term effects and long-term effects as well as externalizing and internalizing problems (Chen et al., 2010; Paolucci et al., 2001; Trask et al., 2011; Wyatt & Powell, 1988).

Short-term effects of CSA include depression, suicide, sexual promiscuity, sexual perpetration, and academic underachievement (Paolucci et al., 2001). The long-term effects of CSA include depression, low self-esteem, anger, anxiety, obsessions and compulsions, sexual dysfunctions, self-mutilation, suicidality, dissociation, substance abuse problems, relationship problems, multiple psychiatric disorders (Chen et al. 2010). Children with a history of CSA report externalizing problems like sexual behavior problems, hyperactivity, aggression, attention deficit/hyperactivity disorder, higher levels of hyperactivity, and aggression and high prevalence of conduct disorder. Internalizing disorders are depression and anxiety, like phobias, separation anxiety disorder, and obsessive–compulsive disorder (Trask et al. 2011). Carson et al. (2014), Chatterjee et al. (2006), Carson et al. (2013), Deb and Sen (2005), Deb and Walsh (2012), Krishnakumar et al. (2014), Priyabadini (2007) and Sahay (2010) have conducted studies in India showing high levels of trauma and post-traumatic stress among children who are subjected to sexual abuse. Ultimately, some victims even end up as perpetrators (Salter et al., 2003).

National Crime Records Bureau (2015, Chap. 6, pp. 176–207).

[8]National Crime Records Bureau (2018, Vol. 1, p. 6).

[9]National Crime Records Bureau (2019, Vol. 1, p. 307).

In a homogenous group of maltreated female children who were all subjected to intra-familial abuse involving genital contact or penetration, Trickett et al. (2001) found that differences in the experience of abuse are of importance in acute as well as long-term behavior problems and adjustments. However, Negriff et al., (2014) warned that all sexually abused youth ought not to be combined into one group, as this would reduce the variations of their experiences and the discount; the impact of these different characteristics may have upon the development of subsequent problems.

(B) Effects of Interface with Criminal Justice System: Revictimization and Mental Health Issues

There are few studies on the effects of interface between CSA victims and the legal system. Campbell (1998) found that 67% of rape victims who were assisted by advocates had their legal cases dismissed, and 80% of the time the decision to dismiss was made by legal personnel who went against the victim's wishes to prosecute the offender. Another finding in this regard was made by Cluss et al. (1983) that rape victims whose cases were not prosecuted were less distressed than those whose cases were prosecuted. Rape victims were frustrated by the overall response of the criminal justice system, even while holding positive attitudes toward investigating officers (Frazier & Haney, 1996). While studies show that rape victims may seek assistance from legal, medical, and mental health systems, but a growing body of literature indicates that these agencies deny help to such victims. If at all they do receive help, such help often makes them feel revictimized. Such negative experiences from legal, medical, and mental health systems are termed "the second rape" or "secondary victimization" (Campbell & Raja, 1999). These findings would also seem to be applicable to children. A study by Mudaly and Goddard (2006) reported that children found the experience of being protected by services to be more traumatic than the alleged abuse. Williams (1984), Campbell and Raja (1999) comment on negative, judgmental attitudes toward the victim by police, prosecutors, judges, and doctors which lead to victim-shaming and inappropriate behavior or language and result in secondary victimization or retraumatization.

Connon et al. (2011) conducted a study on aspects of the criminal justice system that caused most distress to children. Contact with the defense lawyers, the experience of court attendance and testimony, the deemed fairness of court procedures and outcomes, and repercussions of court delays on emotional state, and personal safety are highly stressful aspects for children who go through the criminal justice process. Mitigating methods include the need to address systemic delays for court procedures, creation of a child-friendly environment, establishing systems to prevent children from contact with the offender, psychological support services for not only children but also their families and specialist training for police and lawyers in CSA.

Positive impact upon long-term emotional outcomes can be brought about by easing the burdensome process through disclosure, evaluation, and examination and also with social workers and police by providing access to mental health support for both the child and the non-offending family members (Deb & Mukherjee, 2011; Heger, 2014).

All these studies re-iterate that the sensitization of various actors in the criminal justice system is necessary in order to ensure a seamless transition and recovery to the victims of CSA.

Another important actor who has a role to play in the criminal justice system is the mental health professional who would include doctors and psychologists. The role of mental health professionals is crucial while interviewing the child in court. Cases of CSA seldom exhibit definitive signs of genital trauma; hence, special skills and techniques for evaluation of a CSA victim are required during recording of history, forensic interviewing, and medical examination (Moirangthem et al., 2015). It is incumbent to involve mental health professionals in follow-up treatment by providing in victim counseling, family therapy, and rehabilitation in order to mitigate short-term and long-term harmful mental health consequences.

Mental health requirements must receive active consideration in legislations on child rights; it would benefit children as a long-term remedy if therapists are included in the legal framework. Routine blunders committed by lawyers cause risks of trauma to child victims, which can be reduced by including and institutionalizing mental health support services (Sharma, 2005). Therapeutic jurisprudence in the area of child rights should underlie the importance of mental health considerations as an inseparable component of law (Bajpai, 2015).

The role of a mental health professional need not be confined to areas which directly connect with the criminal justice system. In fact, it is necessary to provide mental health support systems in places where a child has first contact, namely the school. Legally mandating every school to employ psychological counselors having specialized training in childhood trauma, including sexual abuse, along with vocational and social skills training go a long way in mitigating adverse outcomes of CSA. Yet, only 9% of schools in India provided counseling services (Bhatnagar, 1997). Other studies by Jimerson et al. (2009); Ying et al. (2012) reported that there is no data regarding the number of school psychologists in India. School psychology services are not accessible to the 379 million children in the world's most child-populous countries—China, India, and Indonesia. Deb and Walsh (2012) comment that meeting a goal of providing at least one trained psychologist in each school will call for tremendous professional effort and political will.

Additionally, access to counseling services ought to be provided at grassroots levels itself through local self-government institutions. Strategies ought to be devised to empower workers in existing governmental machinery at grassroots levels itself, in order to ensure smooth transition and recovery for victims and families while navigating the criminal justice system.

Conclusion

A perusal of the nature and impact of CSA from international and Indian literature outlined earlier shows a dearth of large-scale evidence-based studies in India. Definitions of CSA in India may differ from the international understanding, and

disclosure and reporting depend heavily upon socio-cultural contexts. Studies have shown that boys and girls are equally vulnerable to abuse, especially during adolescent years, irrespective of socio-economic background. Studies have also shown that most sexual abuse occurs between 10 and 15 years of age.

The effects caused by CSA in India have not been studied by authorized governmental agencies. The MWCD Report reported the incidence and prevalence of various forms of child abuse, yet did not examine the effects of such abuse. The study by Raj and Manikandan (2013) portrays the reality of sensational journalism, which neither fails to glean data on the socio-logical and psychological aspects of the offenders nor seeks to investigate the impact of cases of CSA on society.

Various studies and meta-analyses detailed earlier evidence of the negative impact of CSA on human development. CSA leads to increased sexual promiscuity, setting off a victim-perpetrator cycle and results in poor academic performance. These negative effects occur irrespective of the age, gender, or socio-economic status of the victim. An active involvement of multiple healthcare providers along with social workers and the police would lead to better physical and mental health outcomes and lessen trauma to children passing through the Indian legal system. There is also an urgent need for access to mental health support for both the child and the non-offending family members. This will help to make disclosure, evaluation, and examination by the criminal justice system easier. Policy ought to examine mechanisms to provide trained psychologists at school and at grassroots levels of local self-government systems. Policy must address removal of structural barriers that block access to justice and devise multilevel community support services in the area of health care in order to assuage the various physiological as well as mental health effects of CSA.

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Chapter 32
Delay in Disposing Legal Disputes: A Study Factoring Mental Health and Way Forward

G. Subhalakshmi

Abstract Be it any legal systems, civilization recognizes the right of every person to seek redressal through Courts. The conventional understanding of the dictum "access to justice" by the common man is access to courts; because he believes that is where he can get justice. Justice has a broad connotation which is administered according to the laws and procedures; and by the courts. While justice is considered as the constitutional mandate, the courts through the interpretations uphold and enhance the justice of not just the individuals but also the society at large. It is undoubted and unquestionable as to the role of the justice delivery system in dispensing and administration of justice. However, with the increase in population and the technological advancements the workload of the judiciary has increased drastically and the courts have become inaccessible due to various barriers. And the aggrieved has to undergo complex and pricey procedure in the process of litigation. It does not stop here as the aggrieved may have to wait for years together fighting to get justice for his grievances and may even lose his life's time. This paper tries to examine the impact created by the prolonged, never-ending legal disputes affecting the aggrieved emotionally, financially, and mentally causing turbulence and striking the mental well-being of the personnel. Further, the paper aspires to bring out the factors that cause delay in the justice delivery system and the effect of such delays in the mental health and well-being. It is pertinent to quote, "justice delayed is justice denied" which means that an unreasonable delay in the administration of justice causes unconscionable denial of justice.

Keywords Legal disputes · Delay · Mental health · Justice · Investigation · Timely disposal

Introduction

The term "Justice" has a broad connotation that means and includes the very basic understanding of protecting the individuals' rights or the right of the person to seek

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S. Deb and B. A. Gerrard (eds.), *Handbook of Health and Well-Being*,
https://doi.org/10.1007/978-981-16-8263-6_32

redressal through the courts. The term also has a very comprehensive meaning as to render the dues of a man. Now, how can one receive or access justice? The traditional understanding of the dictum *"access to justice"* by the common man is accessing the courts; because he believes that is where he can get justice. While justice is administered through courts, so are the courts governed by laws and procedures. And the basic objective of the courts is to deliver justice through the laws and procedures. Every civilized society has two sets of laws, viz. procedural and substantive. The procedural laws take care of the actual procedures and enumerate the guiding ways and means to carry out the rules as prescribed by the laws. The substantive law details the rights and duties of the citizens and the basic principles detailing the conceptual framework of the laws. In a democratic country like India, there exist three strong wings: the executive, legislature, and the judiciary in strengthening the nation-building and administration of justice. No doubt as to the role of the justice delivery system in addressing the citizens' rights and in dispensing justice. However, the increase in population and the evolving technological changes augment the crime rates, add to piling of cases amplifying the workload of the judiciary and make the courts inaccessible.

As this route toward justice is always long and twisted not knowing if it is actually successful; the common man is quite hesitant in choosing this bumpy route. The aggrieved person already suffers from too much mental agony and pressure just to make up his mind to resort to a legal dispute. And after this, the aggrieved is yet again exposed to heaviness and anxiety to understand as to what actually happens in the process of these legal disputes. Firstly, he is not aware of the technicalities of the procedures and secondly he has no idea as to finality of such processes; leaving him with no option but to wait and watch his legal counsel, to get justice for all his grievances. The aggrieved at times loses faith in his counsel and switches over to another advocate wherein the effort needs to begin once again. This psychologically affects not just the individual but the entire family, indeed not just one family but all the families involved in the legal dispute.

In recent times, there is an increasing interest in well-being and some of the researchers have also pointed out the change in the approaches and the thinking of people. One of such a significant approach is the *"capability approach"* (Sen, Inequality Reexamined, 1992) discussed by Amartya Sen and Nassbaum renowned researchers in economics. This approach has been influential in opening up debates about the set of capabilities that enable individuals to do and to be the ones which they have reasons to value. Though it is an economic concept conceived during the 80 s, it was crucial in setting the alternative approaches to modern economics. According to this concept, the focus was shifted from the traditional approaches to the modern approaches of well-being. And the main crux revolves around understanding what an individual wants to do and to be. While enumerating on this, Sen and Nussbaum had identified that right to the self being one of the major indices based on the capabilities.

With this backdrop, this chapter tries to discuss the importance of the justice delivery system as a whole in redressing the peoples' need and how the unwanted delay distracts the process. While enumerating the same, the chapter shall discuss legal disputes and its nature for the convenience of the readers and shall also enlighten

the constitutional provisions to set the ground for a legal understanding and further elaborates on the Justice delivery system in India as it is a dire need to understand the prevailing system in addressing the legal issues. Further, the chapter shall also bring out the various causes or factors for the delay in disposing of cases and the impact such delays create on the mental health and well-being of the aggrieved. The chapter aspires to come up with possible suggestions in this regard.

Methods Adopted

The methodology adopted in this study is doctrinal, descriptive, and analytical. This work mainly depends on the primary sources like Constitution of India and secondary sources like books, articles, and journals. It is basically a theoretical work which is built up from the information gathered from books, journals, and decisions of courts of law. Important decisions of High Courts and Supreme Court have been incorporated wherever necessary, in order to throw light on this area. The internet has been a key source in collecting the views and opinions of various jurists and eminent writers. Dailies and magazines are also used as valuable information for the study.

Understanding Legal Disputes

Everyone is desirous of protecting his/ her rights, properties, and reputation. It is actually simpler and easier to understand a dispute because one can identify the moment he witnesses such dispute. However, this understanding is very narrower as at times disputes are invisible too until and unless it is convoluted and explicitly brought to light. It is important to understand how such disputes were dealt without a proper and formal system to tackle the same. So, when one considers the earlier times, a group of elderly people of a community or place gather together in resolving the disputes that arise between people of that community or place. They unanimously decide based on the facts and circumstances of the incident and award penalty or fines based on the capacity and resources of the defaulter or the one who is at fault. The parties to the dispute agree to such decisions and the decisions are carried out seriously. When days passed by, with the improvement of living conditions and the movement of people from suburbs to urban created more demands and people became more self-centric and materialistic. Once the urge to possess more began, the value of others started deteriorating and that is how people started disputing over the ownership or possession of properties and hurting others for the same. Amidst this feud, the value of morality and ethics started vanishing.

At the same time, there was a need for a just institution and with the formal setting up of the institutions, that is legislature, executive, and judiciary; the judicial wing was expected to address and handle these particular issues for the welfare and the

interest of the people. The hierarchy of the judicial system with the District/ Sessions Courts at the bottom and High Courts at the middle level and the Supreme Court at the apex clearly envisages that the structure envisages catering to the needs of the people by addressing their legal grievances and ensuring their rights. People always have a great hope and faith in the justice delivery system. The hierarchical arrangement too ensures that justice can be delivered right from the grassroots levels.

Black's dictionary circumscribes "dispute" as "a conflict or controversy, especially one that gives rise to a particular lawsuit" (Black's Dictionary, 1999). If, by any means it appears or seemingly appears to cause harm or hurt a person or his property or reputation; the aggrieved always have the right to raise a legal dispute in the court of law. The courts are considered to be the last resort to help the aggrieved persons in meeting out justice. With much hope and confidence people approach, the courts to settle or regain the gone properties or redress the harm caused by a person. However, these legal disputes are mostly considered as those twisted with complexities and dragging investigations and procedures which actually makes the aggrieved to lose confidence and pull them down. People are often terrified with the technicalities and are rather anxious enough to resolve the disputes.

Justice: A Reading Through Indian Constitution

As known well, reading of any constitution will be a complete understanding, only when the preamble of that constitution is read and understood in the right spirit. To have a thoughtful notion of justice; it is pertinent to view "justice" as mentioned in the Indian Constitution. After thorough judicial deliberations through the *Berubari case* (AIR, 1960 SC 845) and *Keshavanatha Bharathi case* (AIR 1973 SC 1461) there exists no aorta of doubtfulness as to Preamble being an integral part of the Constitution. And the preamble is not just considered as the introductory portion but is elevated to the integral and the very essence of the complete constitution. It is interesting to note that "justice" takes the first place and the very objective of including the term "justice" is to secure and guarantee to the people of India—social, economic, and political justice. The Preamble fulfills the purpose and objective of enacting and giving the Constitution to its people. There are two understandings as per the Constitution; one, though the state is sovereign and such sovereignty lies with the People of India; two, though the people delegate the sovereign power to the different wings of the Nation, they retain the fundamental rights. And while writing for the majority in *Minerva mills case* (AIR 1980 SC 1789), Justice Chandrachaud emphasis the nexus and the significance of Fundamental Rights and Directive Principle of State Policy and that the Directive principles of State Policy (DPSP) enumerated under Part-IV of the Constitution are the mandatory ends of government that can be achieved only through the permissible means envisaged under Part-III (Fundamental rights) of the Constitution.

Again, while discussing the concept of justice, it is significant to refer the illustration given by Amartya Sen in his book *"The Idea of Justice"* wherein he illustrates a

story of three children claiming over the flute that was lying on the ground; to discuss the complexity of attaining a just state. (Sen, 2009) In this, all the three independently have a valid and justified reason to claim the flute. One claims on the basis of being the only one who knows to play the flute (utilitarian notion); the second one claims on the basis of being the maker (libertarian notion), and the third one claims being the poorest among the three (egalitarian notion). Now, based on these notions, which one shall win the flute? It is difficult to derive a conclusion because all three are based on different schools of thought and in the absence of any two arguments, the third one seems to be rational and just. This illustration depicts the social arrangements and the solution to this is based on the nature of society or the society in which one is living in. And thus, the key to this lies in the understanding of the Indian Constitution.

Looking into the words and reading the same as intended by the framers of the Constitution, it is evident that the very first thing aimed by the state was to render *"Justice"* to its people and through this Preamble people, i.e., *"We the people"* shall establish a "*Sovereign, Socialist, Secular, and Democratic Republic"* and in connection to this, the state is committed to provide and secure *"Justice, Liberty, Equality, and Fraternity"* to its people. Therefore, the terms used by the framers clearly exhibit the intention of the Constituent Assembly in consciously selecting the words to keep up the highest human values. Further, the words of Justice Lahoti in his book demonstrates the spirit of the Indian Constitution by bringing out the interrelationship among the four key terms justice, liberty, equality, and fraternity as:

> Unless there is justice, liberty is meaningless, nor would liberty survive without justice. Justice and liberty would secure equality. Also justice and liberty in their interplay would express themselves into 'equality'. 'Fraternity' would be merely a nightmare or only wishful thinking but for justice, liberty and equality. The four words placed in that order is a philosophical travel how the Constitution shall work. Of all the four concepts the most significant is justice. (Lahoti, 2004)

The diverse social structure is the strength of India and is the distinctive feature of Indian Society. Though the Indian Constitution has recognized and placed the three facts of justice to exhibit its significance, the experiences in reality; specifically during the late nineteenth century and early twentieth century proved that mere guaranteeing of these rights would be inadequate to secure the same. And to overcome this inadequacy, detailed arrangement of provisions relating to justice, liberty, and equality were made. Further under Article-38, absolute importance was given to justice by conferring a mandate on the state to promote the welfare of the state and to secure and protect the social order that is to establish an egalitarian social order under the rule of law. (Kashyap, 2008). And article 38 acts as the operative part of the promises made under the Preamble. Also Justice K. Ramaswamy, in the case of *Samatha V. State of Andhra Pradesh* (1997 Supp(2)SCR305) while deliberating on the meaning of "socialist democratic republic" observed that "Establishment of the egalitarian social order through rule of law is the basic structure of the Constitution".

The nature of the Indian State as introduced in the preamble of the Indian Constitution is quite interesting as the terms have very significant basis. The adaptability of the ideals through the inclusions and the varied amendments made in different times

proves the accommodative and versatility of the Indian State to balance the emerging trends and the interests while maintaining the principles that define the Indian State in the Preamble. Isn't it crystal clear why the Indian Constitution is considered to be the longest written Constitution in the World and how Indian Constitution has been able to maintain and preserve the ideals of liberty, equality, and fraternity enshrined in the Constitution reflecting the principles and the intention of the framers of the Constitution? It is such a pleasure to feel the significance of the Indian Constitution building a strong bonding with its people. It is surprising to know that despite the fact that Indian Constitution was enacted 70 years back, it still perfectly fits the current day situation.

Justice Delivery System in India

India being the second thickly populated and one of the largest democratic countries faces the formidable task of disposing millions of cases. The face value of a system can be protected and saved only when justice is done and justice delivery in an effective and efficient way shall be the basis for good governance and upholding rule of law. The structure of Indian democracy rests on three pillars—the executive, the legislature, and the judiciary—and is based upon the concept of balance of powers where each organ has separate powers and functions. The prime duty of the legislation is to make laws, the executive to execute those laws and the judiciary to enforce those laws. While administration of justice is the essential function of the state, it is the power exercised by the state through the Judiciary to enforce the rights and to punish the wrongs.

The justice delivery system means and includes many, viz. aggrieved persons, alleged wrongdoers, lawyers, police, prosecutors, and courts. So, it is ultimately with the Courts to administer and uphold justice in the right spirit. Separation of Judiciary from the other two organs of the state makes it Independent. The Constitution of India expressly provides for appointment, qualifications, and removal of judges, and the powers and functional autonomy of judiciary. This makes it evident that the Judiciary is not subordinate to either of the organs. And the entire judicial system runs with the rules and orders of the Supreme Court.

When one speaks about the judicial process, it is clear that judicial process involves the following:

- A right claimed by one party or the same denied by another party,
- Hearing of parties in the court,
- Trial and judgment that follows by the end of the trials, and
- The operative part of the judgment that will be executed.

Some of the key and general functions of courts are:

- Administration of Justice,
- Adjudication of Civil and Criminal cases,

- Deciding on questions relating to Constitutionality,
- Advisory functions,
- Functions of administrative in nature,
- Protection of Fundamental rights in the form of Writ jurisdictions, and
- Overall guardian on Constitution

Justice system has two modes:

1. Criminal Justice System which includes investigating agencies, like police, prosecution, courts, and defendants,
2. Civil Justice System which includes plaintiff, respondents, government machinery, and the Courts.

Some important roles of District Courts and Subordinate courts are mainly to carry out the proceedings of civil cases in accordance with the Code of Civil Procedure and criminal cases in accordance with Criminal Procedure Code. Apart from this, there are also a varied number of specific tribunals in addressing the specific cases like administrative tribunals, labor courts, IPAB, Green tribunals, Consumer forums, and so on and so forth.

Factors for Pendency in Cases

The greatest test is the immense excess and the postponement in transfer of cases. The pendency in High Courts and Trial Courts is consistently expanding. Despite increasing the strength of judges to nearly four times from 1950 to 2019, pendency still haunts the Supreme Court of India. A mere look at the data reflects how the number of cases filed in the apex court rose from 1215 in 1950 to 58,669 till June 1, 2019. And the sanctioned strength of judges in the Supreme Court was eight in 1950 and now it is 31. However, the increase in the number of judges has not had a significant effect on its pendency. The key reason for this mounting of pending cases can be attributed to shifting the role of the SC from adjudicating cases of constitutional significance into a regular court of appeals. According to legal experts, most of the cases that the SC is handling on a daily basis are either appeal from various high courts or cases of gross violation of an individual's fundamental rights (Sarda, 2019).

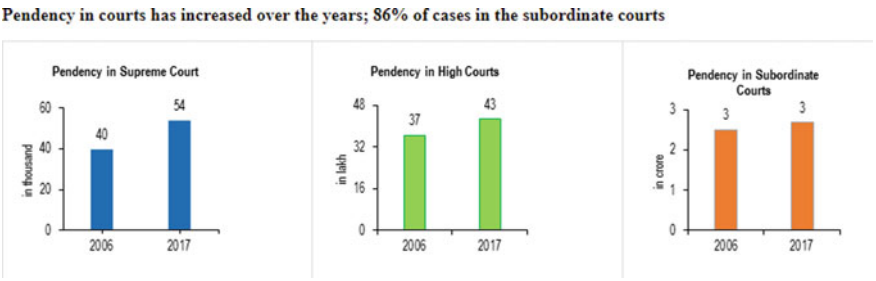
Courts across India face numerous challenges in delivering justice to the common people on time. The below mentioned are some of the main factors or reasons that contribute to the delay of disposal of cases in the Indian context.

- Inadequate number of courts and judges at all levels across the country.
- Lack of adequate monitoring system of cases to track the pendency
- Increasing awareness in the public regarding their rights
- Lack of Information Technology prowess
- Lack of proper court management system
- Misuse of Public Interest Litigations and Right to Information system by frivolous cases,

- Capacity constraints are a big reason
- The count of Special Leave Petition (SLP) cases in Supreme Court contributes to about 40% of the pendency.
- Large number of Appeals from lower courts
- Frequent transfer of Judges
- Increasing number of caseloads including false complaints due to enactment of new laws one by one by the central and state governments without considering the present manpower and infrastructure.
- Lack of coordination among various law enforcement agencies.
- Inefficient investigation by investigative forces
- Procedural lacunae and unwanted wait period delaying the process
- Irresponsible behavior of some section of people that is, approaching court for minor disputes which could be resolved through discussion.
- Unpredictable costs involved in prosecuting or defending a case in a court of law.
- Costlier counsel charges
- Intentionally delays by the advocates dilate the case.
- Big breaks and vacations
- Clerical support staff demanding favors or money to process the case file.

Pendency in Courts

The below mentioned is a statistics provided by the PRSIndia on the pendency of cases in India that clearly brings out the ratio and the pendency status in Supreme Court, High Court, and the Subordinate Courts.



Source: https://www.prsindia.org/policy/vital-stats/pendency-cases-judiciary

Note: Data for 2017 includes data up to April 2018.

- As of April 2018, there are over three crore cases pending across the Supreme Court, the High Courts, and the subordinate courts (including district courts).
- Of these, the subordinate courts account for over 86% pendency of cases, followed by 13.8% pendency before the 24 High Courts. The remaining 0.2% of cases are pending with the Supreme Court.

- Between 2006 and 2018 (up to April), there has been an 8.6% rise in the pendency of cases across all courts. Pendency before the Supreme Court increased by 36%, High Courts by 17%, and subordinate courts by 7%.

With this being the situation, the recent passage of the Supreme Court (Number of Judges) Amendment Bill, 2019 increased the number of judges from 31 to 34 (including the Chief Justice) is a welcoming step to tackle and can also be considered as a meaningful remedy to the situation. Further, it is pertinent to note and reaffirm that speedy justice did not only a fundamental right but also a prerequisite of maintaining the rule of law and delivering good governance. In its absence, the judicial system ends up serving the interests of the law-breakers. Judicial reforms if given a serious consideration, effective justice can see the light of the day and can improve India's status in the judicial process in the world organization.

Delayed Justice Cases

Some of the notable delayed justice cases can be attributed to the trial of the 1993 Mumbai blasts that lasted 14 long years and even when concluded, the case remains unfinished since the trial of Mustafa "tiger" Memon and Dawood Ibrahim, the main accused in the case could not take place. (http://www.rediff.com/news/2007/jul/31guest.htm). And in Bhanwari Devi Rape Case, in spite of huge public support and a nationwide campaign for justice for the gang-rape victim, Bhanwari Devi, the Rajasthan High Court had only one hearing in 15 years spanning between the rape and the year 2007. By then, two of the five accused were already dead. The case was also refused to be transferred to a fast track court but till 2012 the case was pending. (http://archive.tehelka.com/story_main34.asp?filename=hub131007A_MIGHTY.asp) And in the Bhopal Gas Tragedy Case, the tragedy took place in 1984. It is widely believed that a lot of injustice has been done to victims with the case taking over two decades to arrive at any decision, which was too little and too late in 2010. The then Union Carbide Corporation Chief Warren Anderson, now 93, was absconding in the case.

There is always delay in the matter of investigation. Police generally delay in submitting the charge sheet in time. To illustrate, if it is not completed within ninety days then the accused can get bail as per procedure. After bail in many cases accused abscond for many years by avoiding arrest. Further, if he is financially sound he can easily avoid arrest and trial for many years. And with regard to civil matters, the procedural bottleneck causes immense delay in disposing cases. Procedure is not simplified for ensuring speedy trial.

In the Salem *Bar Association case* (2005 SCC 6 (844)) the Hon'ble Supreme Court has given many directions for speedy trial of cases. But by subsequent rulings the Supreme Court relaxed strictness. As a result, cases can't be disposed of within a time schedule. And Lawyers cooperation makes it even more crucial. After filing a civil case, the time limit prescribed for filing an objection is one month. But the court can allow three months and more than three months for just grounds. After

filing pleadings both parties can pray for amendment to invite further delay. If the unnecessary prayer for amendment is disallowed then a revision petition will be filed before the High Court and record will be called. Sometimes prayer filed for appointment of survey commission and objection given to report. If an order is passed rejecting objection then revision will be filed. So, it is evident that at times unnecessarily prayers are filed for amicable settlement knowing well that case will not be compromised. On the date of hearing party will remain absent an upright bold judge if decides to proceed with the case ex parte then absentee party will file petition for restoration of case by setting aside exparte order. If the prayer is rejected then revision petitions are filed in the High Court. If the expert's final order and decree is passed then again a petition is filed to vacate the expert order. After passing of decree in contested cases party files 1st appeal then 2nd appeal thereafter special leave petition or revision.

The Daksh report in 2016 (Kumar, 2016) listed out the causes of delay but at the same time expressed that it is not possible to take control of all or every reason for the delay as it mostly depends on the capacity and the ability of the judges to dispose of the cases. Further, it is not also very easy to fix the time frame and bring all the cases under such time frames. In fact, the number of hearings and the time taken to dispense shows that there exist serious problems in the cases management; especially in procedural laws. Therefore it is evident that even if the proceedings delays are only provided to extend the fullest possible way to help the aggrieved and have a clear end toward justices. Though the delays are not wanted there is room for a great reasoning to delay at every level and at every personnel in the justice delivery system. With this backdrop, the following section shall bring out the impact created by these delays on the mental health and well-being of a person.

Impact of Delay on Mental Health

The above discussions enumerated the details and factors for the delay in disposal of cases and the pending cases. Some of the common mental health problems include depression, general anxiety disorder, panic disorder, attention-seeking, and phobias and so on. Some of the grave effects of the delays might lead to problems like delirium and dementia. An individual's socioeconomic status affects mental health and the inequality treatment is also a factor that causes mental disturbances. Though the delays may not directly lead to mental health issues, it definitely contributes to be a cause or a reason for the mental health issues. The mental health problems are quite a lot in number and depending on the exposure or the pressure created and the individuals' capacity to conceive the happenings, the impact on the mental health and well-being varies.

Depending on the nature of the cases, the impact on mental health can be best understood. These delays not just affect the mental health or well-being but also the physical well-being of a person. The mental disturbances thoroughly cause turbulence in the physical well-being. To illustrate the same, in civil cases, if a person files a suit

and approaches the courts to obtain his property or money, he is definitely affected during the waiting period. He suffers from hypertension and anxiety, and it is also not in a single direction. Based on the outcome of the proceedings, suddenly he might feel very much motivated and eagerly awaits the judgment and at the same time, if the sequencing of proceedings drags on and leaves him no idea as to the process or status of the suit; the same shall completely disturb his thinking. It is obvious that he suffers from sleepless nights leading to fluctuations in blood pressure and anxiety. The aggrieved does not even know if he or she can succeed in the case, as the technicalities are as complex as possible.

Further, the common man does not even know the court practices or the approximate timeline and completely depends on the Counsel for his case. The advocates create big hopes and assure victory. Being carried away by these words the aggrieved confidently spends a lot of time, money, and effort for the case. It is disheartening to know that when such cases take years together on the property, and finally, it costs more than the property itself to pay the advocate fees. There are instances wherein the party may not be in a position to make the fees leading to taking over of the property by the advocate itself in lieu of the fees. So ultimately when one thinks of what remains, it is just the deteriorated physical and mental illness of the aggrieved for having chosen this legal route. Further, even if one succeeds his or her property suit, when one equates the success of the suit with that of the property gained; it is definitely a big loss if not in terms of money definitely in terms of relationships. Post-disputes of the relationship between the parties are strained that might lead to family disturbances and relationship problems affecting the children and the younger generation in the family and no doubt this might lead to yet another legal dispute making families and friendship depart while the disputes become never-ending.

In criminal cases, every individual is presumed to be innocent until proven guilty and the basic philosophy behind prosecution is that any crime committed is considered to be a one committed against the entire society and not just the victims. The state acts for the victims. There are of course many involved in the investigating roles, viz. police, prosecution, defense counsels, medical experts, technical support, and forensic experts. In the stage of trial and witness examination, many people are involved in examination in order to draw and converge at the point of justice. When many individuals are involved in a process, it is justifiable for the delay. However, expediting such procedures and processes are very crucial in the administration of justice and to a greater extent facilitates disposals of cases without much unwanted delays.

The entire criminal investigation depends upon the police team and the directorate of prosecution that indeed drags on the timeline. The procedures in a criminal case take different turns at different levels with the enforcement authorities stretching out the closure of a case. During this time, the guilty develops heavy stress and strain as to his guilt. What if he was truly innocent! To prove his innocence he has to undergo a greater pressure and waits for nearly the term of sentence. The effect it creates on the person can be many, viz. anxiety, restlessness, distress and depression, loss of personal contacts or interaction with others, and it goes on and on leading to bad mental health and indeed physical health too. The mental conditions of a person

vary with the status of his guilt like being charged with an offence, being arrested, being sentenced, or being released. From the time one gets charged and arrested till the term of the jail; i.e., term of sentence the stress and depression increases drastically. In cases where one proves to be innocent, isn't it the violation of his rights intruding the mental wellness of the person? Thus, the pendency or the delay in the legal proceedings adversely affects the person and makes it difficult to turn back to normalcy. Further, the moment one is charged with an offence or the moment he is involved or related to a commission of an offence or wrongdoing, he is always looked as a guilty attaching a stigma to the person. This very impression chases him for life and is unable to come out of this so-called created societal pressure on his personality.

The severe effects that follow might create a greater sense of panic and danger to the entire family. These pressures might also lead to delirium, a condition of confused thinking and reduced awareness that might indeed lead to dementia, a kind of memory loss. The increased anxiety and uncertainty might even cause self-harm and suicide. Though self-harm is not connected with suicide, there is strong possibility that it might lead to suicide. The distress that a judgment might create is actually less when compared to the fear of sentencing or the delay in the verdicts. While the legal luminaries and legends view from the lens of judicial and legal reforms, the mental health aspect of the parties involved in a suit is a forgotten fact and not given much importance. Whatever be the result or outcome of the legal dispute, it creates an impact just for the reason that the victory was delayed keeping the aggrieved anxious through the entire time or the for the reason that the aggrieved lost his side leading to increased stress and pressure hitting the well-being of the individual and his entire family. Thus, the aftermath of the legal battles resulting in failure or success definitely leaves behind the trances of worries, loss of money and property, and the invaluable inter-personal relationship adjustments. Therefore, it is very much essential that while looking for a way ahead in bringing reforms to the legal system; due care and concern should be given from the mental health perspective like providing psychological support to the aggrieved and the needy during the pending of such legal disputes.

Conclusion and Recommendations

It is undoubted that the stigmatization of a person makes his entire lifetime miserable. The pendency of cases flares up the situation, and in fact, this is a global challenge and across the country legal professionals and policymakers are struggling to come out with proper solutions so that a victim gets the justice on time and perpetrators are penalized as per the law. Deferral in the move of cases in law courts has invalidated the purpose of assurance of question, for which the all-inclusive community comes up to the courts. Thus, there is a need to find instruments like mediation to render social value to needy individuals and down and out who require their grievances evaluated through law courts. It is the perfect open door for all-inclusive communities to take

their own drive to pick their cases rather than depend upon a technique which causes delay and is inadmissible. Besides making the working of the legitimate compelling, there is quick moving toward the need to supplement the present structure of courts by strategies for Alternative Dispute Resolution frames. The question of the elective debate determination forms is to have quick and powerful transfer of gatherings' preferred question through gathering. It is the best advantageous time for empowering Alternative Dispute Resolutions. Some of the dire need changes and factors to be taken care are listed below.

- **Attitudinal Change with the Law Enforcement Authorities**: For speedy disposal of cases Lawyers and Judges will have to change their attitude. Lawyers will have to understand that by causing delay general public will lose faith in justice delivery system and will go to Kangaroo Court by avoiding court of justice. Ultimately they will be the loser. In India, only 25% people come forward to seek redress in the court. Others bear pains but keep them away from the court. There is no denying that many lawyers are sincere and hardworking with integrity. They maintain professional ethics. Bar Council of India is working as a watchdog to regulate the conduct of lawyers.
- **Stringent Actions for Abuse of Professional Ethics**: To ensure speedy delivery of justice Bar Council is to be vested with more power. The Advocate's act is to be amended and strictly enforced to arrest professional misconduct. For the negligence and deficiency of lawyers many justice seekers do not get justice. Litigants should be encouraged to claim compensation in consumer's court. If Doctors are made liable to pay compensation to patients for their deficiency of service why not lawyers. Bar Council should enquire and find out for whose fault the case was delayed and justice denied. Erring lawyer is to be punished.
- **Monitoring or Tracking Judicial Accountability:** Fixing up a Judicial accountability commission is to be formed to enquire into the conduct of erring judges for whose fault justice is delayed and denied. Faulty judges should be punished. There should be a maximum time limit for disposal of case, appeal revision. In consumer's protection, a maximum three months time limit is given for disposal of cases when laboratory test is not required. In case a laboratory test is required then the maximum time limit is five months. But, no time limit is given for disposal of appeal or revision. Apart from this nothing mentioned in the statute to enforce the time limit. So the judges can easily violate the provision.
- **Redesigning the Procedural Laws**: To ensure timely justice all procedural laws are to be simplified and a definite maximum time limit is to be prescribed for disposal of case, appeal, and revision. The Judicial accountability committee and Bar Council of India should act as a watchdog to enforce timely justice to the public. In criminal cases, investigation should be completed within maximum time limit. Separate investigating team of police is to be formed. People of India have lost faith on the conventional and traditional justice delivery system because of complication and delay.

- **Encouraging Alternate Dispute Resolutions**: Alternative justice delivery system is initiated for the resolution of disputes. Some of them being arbitration, mediation, conciliation, and negotiation. These processes are quite simple and parties-friendly in nature. Many permanent and temporary Lok Adalat are constituted for disposal of cases. People are encouraged to settle disputes through compromise. But government departments are not coming forward to settle the people's grievances through conciliation and mediation. Mediators are not trained and neutral.
- **Lok Adalats as Alternatives**: Many permanent and temporary Lok Adalat is constituted for disposal of cases. The National Legal Services Authority, Act 1987 was enacted with the prime objective to provide free legal services to the poor and needy and to constitute Lok Adalats for amicable settlement of disputes. Peoples are encouraged to settle dispute through compromise. In India, Lok Adalat is one such approach to settle the issue outside the court. Indian Lok Adalat system benefitted a large number of litigants to come out from the hassles of a courtroom complicated process. Some of the significant benefits are payment of court fees, providing an advocate for the legal proceedings, providing certified copies of orders and translation copies.
- **Research on Courtroom Management**: Researchers should be encouraged to carry out more research on judicial proceedings and better courtroom management and behavior of all concerned during the trials. The findings and recommendations of all these studies would be immensely helpful for the judiciary for timely disposal of cases (Brazil 1981). Appointment of management professionals in Indian Judiciary for management of cases would be good initiative for monitoring and faster disposal of cases. In other words, case management by management professionals is about the "progress of cases" before the court must be monitored and/or supervised. The role of the court is simply to respond to processes initiated by legal practitioners (Rao, 2004).
- **Usages of Information Technology (IT) in the Judiciary**: For faster and efficient management of cases, judiciary can adopt an e-court approach at every level for resolving the cases first. Monitoring and tracking of cases through IT would ensure timely attention to all cases. In fact, increased use of IT, case management has helped the judicial system to bring about substantial procedural and operational changes in the Indian judicial system.
- **Strict Regulations and Targets**: Fines should be imposed for seeking adjournments on flimsy grounds and specific annual targets must also be set to dispose of the piling cases. Fixing accountability on the concerned should be given due care and serious note in order to aid the effective disposal of cases.
- **Recommendations from Various Committees**: Different committees have put forth suggestions in this regard like;

  (a) The Parliamentary standing committee has recommended states to provide land for the buildings of courts and defined timelines for the computerization of all courts, as a step toward E-courts.

(b) The 120th Law Commission of India has suggested the appointment of efficient judges as Ad-hoc judges for speedy justice.
(c) The 11th Finance Commission suggested the establishment of fast track courts for the disposal of pending cases in 2005, they were made for 5 years after which it was up to the state whether they wanted to continue it or not, few states continued them. Till 2011, 32 Lakh cases were disposed of by these fast track courts.
(d) The 13th Finance Commission has suggested the appointment of professional court managers as for the efficient and quick justice, professional staff is required.
(e) The eCommittee of the Supreme Court launched a mobile application called National Service and Tracking of Electronic Processes (NSTEP) for sending notice and summons.

- Psychological Perspective

(a) Creating more awareness about humanity and changing the people's mental setup regarding a person regardless of being convicted or acquitted.
(b) Nurturing relationships and emphasizing the human values in family and education institutes and workplaces.
(c) Human-centric approaches should be given priority rather than materialistic concerns.
(d) Inculcating moral values right from the family, followed by educational institutions and the workplaces.
(e) There is a need to understand human emotions and create awareness of people through the media.
(f) People need more importance of emotional intelligence and resilience about people and society and self.
(g) Psychologically supported as part of justice dispensation.
(h) Giving proper counseling and guidance for the ones who face some problems during legal disputes.
(i) Extending psychological support along with legal support is much needed.
(j) Community programs for the ones in jail term in order to take care of his distress during the term.
(k) Counseling support to the convicted so that they do not fall a prey to recidivism.
(l) Proper counseling during the pendency of litigations.

To conclude, though there are many functionaries who are involved right from the point of initiation, continued by the investigation procedures, submission of relevant documents or evidences, and so on and so forth; every functionary involved during this procedure should act in a responsible and diligent manner keeping in view and prioritizing the right of the aggrieved and perform their expected duties in a judicious manner. By doing so, the fading trust of people by reason of the delayed justice can be very well regained. It is completely true that delayed justice is denied justice. And in recent times, the people have become more educated toward their rights

and also highly dependent on the judiciary for justice. People have a greater trust and faith in the judiciary and it is the responsibility of the judiciary to uphold the trust and hope that its people have in the institution. Judiciary can no longer keep prolonging, stretching, and stacking up the cases as long as 10 years and plus; as the very fact of such delay is causing injustice to the needy. Hence, it is already time to make necessary reforms and strengthen the courts to dispense justice quickly and properly. It is a piece of ideal to life and individual freedom, a key right of each subject under Article 21, to get quick equity and fast trial, which additionally is the crucial prerequisite of good legal organization.

Some of the reforms in judiciary like fast track courts, e-courts, and enhancing the technical support systems have definitely taken justice to the doorsteps. Further, the current pandemic situation has exposed the virtual world to the common people. Similarly, the courts were functioning through virtual courts proving that irrespective of any kind of danger or disaster justice will never be denied to the people. Therefore, mere situational pressures may lead to possible advancements in technology. Though possible steps are taken to deliver justice, accessing justice has always been difficult for the common and the people below poverty, making justice a mere dream. However, the novel corona pandemic has taught a lesson that anything's stops and life still exist despite the threatful circumstances and people are equally striving hard to fight back the situation. Further, delay or pendency of legal disputes creates an everlasting impact on the person's physical and mental wellness, and it also in turn affects the entire family's well-being. Strong changes in the justice delivery system coupled with a psychological support system help the person from wanted and unwarranted legal clutches and its aftermath effect.

Ensuring Speedy Justice for a Healthy Well-being is definitely the need of the hour!

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