Doing more to promote positive mental health

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The concern felt about those pupils with mental 'problems' distracts attention from the 'healthy' majority. The writer feels that schools should adopt a more conscious role in fostering positive mental health, and makes some suggestions for doing so.

Clinical psychologists and other 'mental health professionals' can reel off signs and symptoms of schizophrenia, behaviour and neurotic disorders, and similar afflictions, but are not very good at commenting on 'normality'. Rutter and his colleagues in the Isle of Wight study indicated that 6% of the child population show psychological or psychiatric disturbance at some time[1]; the question in this paper is *What about the wellbeing of the other 94%, and how can we promote it?* It has to be said we are not good at this.

Firstly, a definition of 'positive mental health' would be helpful. It seems plain that we are discussing how most people live most of the time; any definition is related to norms of behaviour in a given setting of society. As a large generalisation, the mentally healthy person gets along with himself, with others, and with life in general. We have to consider the way a person harmonises his desires, ambitions, abilities, ideals, feelings, and conscience in order to meet the demands of life as he has to face it. Only in legislation do boundaries exist that discriminate mental health and its lack; in practice, as we all know, people vary over time. There are degrees of mental health, and we all, presumably, fluctuate between them continually. For example, people often comment that they know from first waking whether it will be a 'good' or 'bad' day.

What is Positive Mental Health?

A quick caveat seems in order; characteristics of mental health probably vary between adults and children, with the age of a child, and also between different types of child.

Does, for example, the positive mental health of a mentally or physically handicapped child differ in definition from that of his 'normal' colleague? Intuitively one suspects it may, and we should probably guard against big, fat, comfortable generalisations on this topic that really will not do. However, what indications and characteristics define positive mental health in children? I suggest there are five.

1. *Satisfactory Physical Growth*

   MacCarthy, among others, has described how unhappy or anxious children may suffer 'psychosocial dwarfism', whereby growth appears unsatisfactory or stunted with reference to normative charts and data for various age groups.[2] It appears that, in general, linear growth in height and weight indicates

positive mental health. Such cases of 'psychosocial dwarfism' are regular, if infrequent.

2. ***Steady intellectual and social growth***
Similarly, distress or preoccupation in a child caused by an unsuitable environment or lifestyle may also show as 'plateauing', or, indeed, a deterioration in performance on standard measures of intellectual or social development. Courts increasingly accept information based on such measures as evidence of 'emotional abuse' of children under the Social Work (Scotland) Act 1968. Again, as above, it seems likely that linear intellectual and social growth also indicate positive mental health.

3. ***An acceptable view held by the child of his or herself***
In general, the mentally healthy child accepts himself, while maintaining realism about personal strengths and weaknesses. This theme has various facets.

3.1 *The child has a realistic view of what he is good at,* and thinks he has a reasonable chance to use his skills. When he does so, it is in a 'paced' manner. With medium drive, one will probably attain a high and sustained performance, but as drive and anxiety become maximal, performance efficiency tends to diminish.

3.2 *The child can live with his limitations.* For example, by the age of 8 or 9 years, the grossly handicapped child, or, indeed, the subtly disadvantaged dyslexic individual, will begin to ask 'Why am I different?'. Clearly this will require both sensible and explicit answers. In addition any handicap will affect the child's interaction with the environment, probably slowing it down, with considerable residual frustration. The point which determines the individual's mental health is related to how he deals with such frustration.

3.3 *The child should have self respect.* We now know that much depends on his early environment and experience. I am put in mind of the excellent Scottish Health Education Group poster, which I think should be in every family home, school, and clinic, which says *If a child lives with approval he learns to like himself.*

3.4 *The child can exercise reasonable control over his behaviour and expression of emotion.*

3.5 *The child appreciates a need to strive towards autonomy* rather than maintaining the total dependancy of early childhood, and seeks appropriate steps towards independence.

3.6 Probably most important of all, *the healthy child has a capacity for humour* to laugh at both the world in general and himself in particular.

4. ***Satisfactory relationships with others***
There is general agreement over the nature of these: the emotionally healthy child has ability to give and receive love, and understands appropriate levels of mutual support and 'give and take' in relationships with his family, his peers, and others. He expects to like and trust others, takes it for granted they will reciprocate these feelings, is able to consider the needs and interests of others, respects individual differences, and is able to sustain long term relationships. In addition, the child has a sense of responsibility towards other people.

5. ***A capacity to deal with life***
This part sounds like either a bad joke or the wisdom of the ages reduced to the back of a postage stamp! At the same time, however, there does seem to be a dimension of commonsense or 'street savvy' that distinguishes the child remaining mentally healthy from his more vulnerable peer who may suffer anxiety or breakdown.

The first feature of this parameter appears to be realism in the child. He or she realises when a problem has been encountered and attempts to solve it, while realising that there is little point in an over ambitious approach followed by disappointment. I was reminded of a school somewhere north of Perth where the Head informed me that the establishment attempted to instil a 'positive attitude'. One felt slightly sorry for the children on the sharp end of this experience, but could not realistically deny the point the man was attempting to put across.

Secondly, the mentally healthy child recognises stress and has adaptive ways of either using it to his own advantage or else avoiding situations from which it arises. In the mentally healthy individual, the adaptive use of appropriate mechanisms appears to combine with an ability to 'bounce back' fairly quickly from crisis or shock. In addition, the child can think for himself and make his own decisions. He will maintain his own point of view, and is relatively unsusceptible to moral pressure.

Finally, on this 'Life' parameter, the mentally healthy child welcomes new experiences and ideas, and is, perhaps above all else, adaptable in the face of changing circumstances.

Promoting positive mental health

There is a strong emphasis here on *learning,* and the essential five characteristics suggested above are arguably more applicable to an adult than to a child. At first the child lacks the intellectual, social, and emotional sophistication necessary to take on all these characteristics or operate in the styles indicated. Hence the question arise, *how might we attempt to develop these parameters of positive mental health?* and *which mechanisms (or tricks) if internalised in the individual, will help*

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to protect that person from breakdown? Can we provide an 'optimum' environment for such development? I would cautiously suggest, from what has been already said, that there are two courses worth consideration. These are:

1. Positive action undertaken by ourselves, as parents or professionals, to *provide an optimum environment*; and
2. Teaching behaviour that might lead to internalisation of *appropriate ideas and mechanisms.*

Given these goals, what can we do in a school setting?

Firstly, particularly in primary school, one would emphasise the central place occupied by the teacher in a child's life. By the very nature of his or her position, the teacher is a parent figure, a model for identification, target for confidences, aggression, and displaced hostility, and a source of emotional support. Perhaps the teacher's role could be summarised as follows:

1. Someone to *copy*, providing a model for behaviour, attitudes, and social responsibility.
2. Someone to whom the child *relates.* The youngster expects a personal relationship providing a source of attention, support, affection and discipline.
3. Someone to *advise.*

The teacher may help in a number of ways. Firstly the feelings of the individual child can be released; discussion often brings painful topics into the open. Verbal techniques, or a rather more indirect approach to such topics through other media such as drawing or painting may help – children often indicate sources of difficulty and anxiety through the content of pictures and the colours used. Secondly, straightforward information and classification may help the child immensely. For example, young children of our culture may be very unsure about the facts and implications of death and birth, following perhaps the demise of a much-loved grandparent or even parent, or when their mother is pregnant. Even though this information has been given previously, calm explanation of what is happening, and some reassurance, may help the child immensely. Finally, the teacher can provide general and unconditional support.

Secondary school brings its own different set of pressures and difficulties for early adolescents. These include adjustments to new classrooms, new teachers and subjects, new school rules, and being the youngest and newest in an often fairly large and, perhaps impersonal institution. In addition, the pressure is on for selection and specialisation of subjects, combined with growth of independence and the child's own adjustment to his changing body.

Eight suggestions

Given the particular development stresses on children, albeit rather different in nature for primary and secondary school environments, I should like to suggest eight strategies and influences by which a school might endeavour to promote mental health in its pupils:

1. **By fostering an *awareness in the staff* about the problems of children. It is extremely easy to become jaded so that original communication with or awareness of, children becomes blunted.**
2. **By teachers intentionally providing *models of behaviour and attitudes* for children to copy, and also being available to the pupils for discussion or, at the very least, amiable contact.**
3. **By encouraging *stable and predictable staff-pupil relationships.***
4. **By teachers providing *reassurance* for children, building self-esteem in the youngsters by treating them with respect and praise. A formula seems to be 'make the child feel good about himself'.**
5. **By teachers strengthening *healthy coping responses* in the children by positive reinforcement through praise and encouragement.**
6. **By the school encouraging a concept of *inoculation against stress.* Each crisis should also be a preparation for dealing with later difficult experiences.**

7. **By teachers preparing the pupil for *foreseen crisis.* For example, the teacher may help a child waiting to enter hospital.**
8. **By teachers engaging, if appropriate, the help of classmates for support of an *individual child who is under pressure.***

All these theoretical, well-meant points depend in practical terms on the well-being of teaching staff and their own positive mental health; indeed it could be argued that such is the nub of the whole business. (The promotion of positive mental health in school staff may or may not be a separate issue, but is probably worth consideration!) Prevention of mental breakdown, deviance, or abnormality rather than cure may lack the virtue of fashion; interestingly, however, recent Health Service circulars have begun to pay some attention to 'prevention' as a worthwhile activity.

References

1. Rutter, M., Tizard, J. & Whitmore, K. (eds.), *Education, Health, and Behaviour.* Longman, 1970.
2. MacCarthy, D., The effects of emotional disturbance and deprivation on somatic growth. In Davis, J. A. & Dobbing, J. (eds.), *Scientific Foundations of Paediatrics.* Heinemann, 1981.

Forum

PSE: Too important for 'experts' alone?

I was very pleased to read Peter Wilson's letter in the September issue of *Forum.* To hear of success is always good for morale.

My own school runs a highly-successful PSE course, with nearly three hours' teaching time per week in Years 1 to 5. We, too, cover a wide range of topics: health, careers, sex education, lifeskills, study skills, and information technology. I also agree that a good PSE course is in an excellent position not only to blaze a trail for itself, but also to influence other healthy movements: profiles, pupil-centred learning, staff development, cross-curricular work, and a skills-based curriculum – in short, to ensure that, in its widest sense, PSE happens all the time!

It is, however, in this adoption of a whole-school philosophy and approach that I differ from Peter Wilson. We took the decision to integrate our PSE course with our tutorial time and to make our tutors (who keep groups for five years) our PSE teachers, and none have opted out of this arrangement. By providing in-service training, full and detailed teachers' notes, and plenty of background material, we have ensured that all tutors are well-briefed; PSE is too important to be left as a mere 'subject' in the hands of a few so-called experts. One of the main problems in secondary education is the subject-based curriculum, and to make sure that PSE is given status and importance we place it in the hands of the most important person in school: the child's tutor.

Peter Wilson also gives the impression that many PSE courses are failures. To talk of 'failure' does not really come into my view of PSE, but, nonetheless, some schools do appear to have more success than others. The major problems seem to be trying to do too much too soon, and the subtle methods used to involve 'volunteers'. I have been fortunate: my colleagues wanted to be involved, and the move from a few 'experts' to a whole-school approach was brought about by staff pressure. I have since seen the philosophy and methodology of PSE spill over into other areas, and this would not have happened if we 'experts' had kept it all to ourselves and not let anyone in on what we were doing. One of the main difficulties some schools encounter with PSE is that they do not practise what they preach. To rely on experts is de-powering. It is not just the pupils who need to be self-empowered.

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