Manual on Students' Counselling For College Teachers

Editor: Dr. C.R. Chandrashekar

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MANUAL ON

STUDENTS' COUNSELLING

FOR COLLEGE TEACHERS

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We thank all the Staff and Students of Departments of Psychiatry, Mental Health and Social Psychology, Psychiatric Social Work, Nursing of NIMHANS, Administrators of Department of Collegiate Education (Government of Karnataka), for their contribution to students' counseling programme. We congratulate all the principals and teachers for their interest in organizing counseling services in their colleges.

PREFACE

College students are the cream of adolescent and young adult population. They are under tremendous pressure as they are expected not only to succeed but also become toppers in their classes and courses. At the pre-university level, there is a crazy rush to enter professional courses. Courses like B.A., B.Sc, B.Com attract a few students only. Students who fail to get into the courses of their or parents' choice, get frustrated. Though they join some courses, their morale is very low. They start complaining about the parents, teachers and the society. They are less motivated to learn and complete the course. They may drop out of the course. The deteriorating value system in the society, failure of the political and administrative systems to provide them job opportunities, print and electronic media which on one hand put an unrealistic glamorous life style and on the other hand glorify sex, crime and violence, influence the college students in a negative manner. Families are becoming smaller and smaller and are unable to provide the needed support and guidance. Ambivalence, confusion, helplessness prevail in the student community. There are a few epidemiological studies which quote 15 to 20% of the students having recognizable mental disorders in the form of depression, anxiety, somatoform disorders, adjustment disorders, personality disorders and alcohol and drug abuse. Many more students may be suffering from sub-clinical symptoms, and emotional disturbances. These contribute to the observable behavioural abnormalities in them. Only a few colleges provide counseling services through trained manpower in our state. Students with mental morbidity do not seek Psychiatric treatment because (1) Psychiatric services are not available in an affordable and approachable manner (2) Stigma attached to mental disorders (3) Lack of awareness. Thus majority of the students, who need help, remain unattended and uncared.

NIMHANS has developed many community based curative, preventive and promotive programmes to reduce mental morbidity and to improve mental well-being of people. NIMHANS has designed and developed many innovative programmes to involve non-mental experts, professionals and lay volunteers in organizing primary secondary and tertiary preventional activities in the society. College students being a high risk group to develop mental disorders, NIMHANS has worked out a programme to involve college teachers in counseling and act as referral and support giving agents for those students who are having psycho-social problems.

In 1986, one week seminar was held at NIMHANS to discuss the causes and remedies of problems of college students. Mr. R.Raghupathy, then Hon'ble Minister for Education announced that students counseling services would be organized in the colleges.

In 1995, Department of Collegiate Education and NIMHANS, Bangalore decided to organize short term training course in students counseling for volunteer teachers. These trained teachers would offer counseling services to the needy students as part of their job responsibility without any additional monetary benefits. They would do this work voluntarily. The principal, other teachers and administration would provide the needed facilities and support. NIMHANS agreed to provide the training and experts assistance free of cost. Department of Collegiate Education would appoint an officer to co-ordinate the training programme, select the teachers and send them for training. Inauguration of the training course for the first batch of 23 teachers was done by Sri. D.Manjunath, Hon'ble Minister for Higher Education, Govt. of Karnataka on 17-7-1995. Sri. J.P.Sharma, Principal Secretary, Department of Education, presided over the function. During the last 17 years, we have trained more than 1000 teachers from all over Karnataka State. The trained teachers from Bangalore

urban and rural districts have formed 'College Counsellors Forum' which meets every month and discuss the problems of the students they are counseling, the hurdles they face in organizing these services. The feed back by these teachers is quite exciting and encouraging. In addition to individual counseling, they are also undertaking activities like group discussions on good study habits, how to face examination, how to improve self esteem, career guidance. They sensitize other teachers, and the management regarding their role in counseling and students welfare activities.

I am happy to note that many teachers have informed us that they have changed for the better with the training inputs. Their attitudes and approaches towards their students, family members and colleagues have improved. Many have opined that this training programme should have been organized at the beginning of their services and repeated periodically.

Now I am happy to note that this activity is being included in District Mental Health Programme which is being implemented in more than 100 districts in the country. The training programme in students counseling will be of 6 days duration. The manual is revised and a work-book is added. This will help the team of mental health professionals and District Mental Health team to conduct this programme in many places of the district with the active cooperation of Department of Collegiate Education. I hope that needy students will get the appropriate help and guidance from the trained teachers. This will lead to prevention of mental disorders and promotion of mental health among college students.

Dr. D.Nagaraja
Director / Vice Chancellor
NIMHANS, Bangalore

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1. INTRODUCTION TO TRAINING PROGRAMME IN STUDENTS' COUNSELLING

College students form the cream of student population. Studies have shown that about 50% students suffer from health problems. 15% of the students suffer from mental disorders like Depression. Anxiety, Hysteria, Somatoform disorders, Adjustment reactions, Alcohol and drug abuse. In addition, many more students may have emotional problems related to their family and college life. This gets reflected in their behaviours in the form of

i) irritability, anger outbursts, aggression including ragging
ii) boredom, sadness, lack of interest, hopelessness and helplessness
iii) apprehensions, fears, feelings of inferiority, severe examination fear
iv) conduct – problems like lying, stealing, running away from home, criminal activity, sexual promiscuity and immoral sexual activities
v) Alcohol and substance abuse and addictions
vi) Absenteeism, irregular to attend the class, dropping out from the course, poor performance or failure in the examination
vii) Having medically unexplained somatic symptoms, often getting sick, accident proneness
viii) Suicidal attempts.
ix) Disturbed relationship with family members, teachers, agemates

Thus, students who have these problems have to be identified and helped. Because of a low availability of mental health services in the country and also of stigma attached to psychiatric consultations, these students do not seek help and suffer in silence. Thus, there is a great need for **Counselling services** which are offered by the trained 'Teacher Counsellor', in their own colleges.

Two to more teachers from each college undergo training in students counseling for week and are required to work as **Student counselors on voluntary basis.** The necessary help and required facilities to run such a student counseling center are provided by the college authorities. The training consists of theory and practice of counseling. The topics covered are: understanding the nature of psychosocial problems of students, helping them to manage these problems and improving their mental well-being. The teachers are given a manual and documentation kit. They are monitored and their services are evaluated. 30-40 teachers are trained in each batch.

OBJECTIVES OF THE TRAINING PROGRAMME

1. To sensitize the college teachers – about:

    a) Modern – scientific understanding of human behaviour
    b) Biological, psycho – socio – cultural development of adolescence and the needs of adolescent boys and girls
    c) Common psycho – social problems, minor and major mental disorders seen in the late adolescent period (16 to 21 years)
    d) Specific needs and problems of college students in their family and college life.
    e) Changing family and social life and its impact on students
    f) Role of parents, family, teachers, educational institutions and society in the care of students.
    g) Impact of stress on health, stress management and positive health.

2. To impart knowledge and skills to teachers in the following areas:

    a) Interviewing skills
    b) Psychosocial management of student's emotional problems
    c) Techniques and practice of counseling
    d) Identify moderate to severe mental health problems in students and make timely referral to the experts.
    e) Follow-up the cases for the required period
    f) Conduct educational activities to improve the health and functioning of the students.

2. UNDERSTANDING HUMAN BEHAVIOUR

Comparatively it is easy to understand animal behaviour. They eat when they are hungry. They fight in self-defense. They do not attack without provocation. They mate when the female is on heat. They protect and care for their younger ones. But it is very difficult to understand human behaviour. It is very complex. We eat when we are not hungry! Some of us are loyal to our spouses. Some have sexual relations with many. We reject our child because she is a girl. We attack our own people on flimsy reasons. We are greedy and keep collecting things which we do not require. We kill other living beings for fun. We hate our neighbour just because he belongs to a different caste or speaks different language. Why? How one stimulus like sex induces fear in one, and pleasure in another, anger in the third and disgust in the fourth? Some individuals react differently to the same stimulus on different occasions. Why?

Our behaviour is an end product of many factors – the brain, nervous system, physical condition of our body, our knowledge, attitude, value system, our mental condition, socio-cultural factors, the situation and many such factors influence and shapes our behaviour. A small change in one factor may induce a big change in the behaviour.

A.BRAIN AND NERVOUS SYSTEM: Every behaviour is designed and executed by our brain. The front portion of the brain is responsible for thinking and social behaviours. The hind brain interprets what we see and is responsible for visual memory. The temporal lobe (portion of the brain above the ear) interprets what we hear and records sound – information. The limbic system of the brain directs our eating, sleeping and mating behaviour and is responsible for different emotions; the hypothalamus and the pituitary gland keep a control over all our internal organs like heart, lungs, kidney, digestive organs, reproductive organs etc.

The variations in the growth and health status of the brain may bring changes in the behaviour of the individual. For example, decreased quantity of dopamine (a chemical substance) in the brain may lead to a state of depression in which individual remains dull, withdrawn, lacks interest in everything, expresses sadness, hopelessness and death wish for no apparent reason. He may even commit suicide. An abnormal discharge of electrical activities in the temporal lobe may make the person to have a staring look, not respond to any stimulus and exhibit some automatic behaviour. He may not recall anything once the attack is over. (This is called temporal lobe epilepsy). Damage to the front portion of brain, may lead to a condition in which the person behaves like a mad person. Vitamin B1 deficiency can led to severe memory impairments. Excess of adrenaline by the adrenal glands prepares the person for fight or flight. He shows either anger and aggression or fear and cowardice.

B. LEARNING THEORY: According to behavioural theories, every behaviour is learnt based on the model behaviours available, past experience, reward and punishment. For example, the child learns to greet the guest through the parents and the appreciation it gets from everybody for that act. The child does not repeat the mischief of troubling the mother for the fear of being punished. No rewards, no punishments or inconsistent rewards and punishments may lead to confused or inconsistent behaviours in the child. Encouragement by the peer group, the model of a movie hero / smoking / drinking and the pleasure (reward) he gets from tobacco / alcohol, make the person to repeat smoking and drinking. Failure, humiliation, fear of having contacted veneral diseases, make the person to lose interest in sex or

to have impotence (psychogenic). A person, who fails in one examination, may anticipate the same and become fearful in any examination or test situation.

C. PSYCHO-ANALYTIC THEORY: According to Sigmund Freud, father of modern psychology there are three distinct entities in the mind. ID is one entity, which is irrational and always works to fulfill the basic needs like hunger, thirst, sex. ID does not bother about realities, norms, good or bad, EGO is the other, which is rational and understands the realities. It tries to control the ID. SUPEREGO is the third entity, which acts like a watch dog for moral, ethical and social norms. Thus with every issue there would be a struggle between ID, EGO and SUPEREGO. What ID needs, Superego negates. What Superego prescribes the Ego may say that it is not possible and suggests a change, which is more realistic to operate. Behaviour depends on what section dominates or what type of compromise or equilibrium is made between these three sections. For example, If ID dominates, over an issue of earning money, the person may beg, borrow or steal, may accept bribe. On the other hand, if Superego dominates, the person may decide to accept poverty and refuse to earn money through dubious ways.

The severe conflicts between Id, Ego and Superego, the unpleasant painful experience which are suppressed into sub-conscious mind, the failures and frustration, internal or external pressure for better performance, become stressful to the individual. It is said that there are defense mechanisms of the mind to manage these conditions. We may use these defense mechanisms either consciously or sub-consciously. These defenses bring a lot of change in our behaviours and many times these behaviours look strange and unusual. Eg.

1. Denial: If reality is very painful and threatening, we deny it, For example
   If a person is told that he is having cancer, he may deny it. He may refuse to consult the doctor again and say that there is no need for him to take any treatment. A boy who was expecting to pass and if he fails, he may say that there could be a mistake in the announcement. A wife would deny the death of her husband in the accident and would believe that her husband would come home.

2. Projection: Here the person attributes his unacceptable and painful feelings and desires to others, like "I don't hate him. He only hates me". "I want to live with my wife. But, she wants to get separated".

3. Displacement: Here the person displaces this anger and other unpleasant emotions to another individual or expresses them in a totally different situation. Eg. The woman who can not show anger on the husband may beat up her children. The worker may damage a machine, when he is angry with the employer.

4. Somatization: The person expresses his distress through bodily symptoms like aches and pains and weakness.

5. Fantasy: What one cannot achieve, what one cannot get, what one is not, the person may slip into a fantasy life, where he can imagine anything and everything. He starts day dreaming.

6. Regression: The person regresses to earlier stage of development and may behave like a child. He may have bed wetting. He may develop baby speech. He expects parents / spouse to feed him, help him in his day to day activities.

7. Undoing: After committing mistake, the severe guilt feeling may make the person confess in front of elders or God. He may punish himself by foregoing the pleasure of eating certain foods. He may start sleeping on the floor, avoid wearing footwear or costly clothes etc.

8. Compensation: A person who did not attend to his father when he was sick, may start distributing fruits to the sick and old people periodically. He may donate money to the poor.

9. Altruism: The person may start doing gratifying service to others. He may sacrifice his pleasure or benefits for the sake of others.

10. Sublimation: The aim of an impulse is changed from that of socially objectionable one to a socially valued one. For example, sublimation of aggressive impulse takes place through pleasurable games and sports.

D. SOCIO-CULTURAL FACTORS: In each culture, there are norms regarding how to express emotions, how to behave in different situations. Roles of individuals are defined and they are expected to behave in a particular way. In our culture men are expected to control their emotions and are expected to remain bold and composed in emotional situations. They are expected to be aggressive. But the women are believed to be emotionally weak and are allowed to express their fear or grief openly. They are expected to be shy, withdrawn and fearful and can plead for protection. They have to be patient and more accommodative. Our culture has many subcultures, in which there are prescribed methods of expressing one's emotions in a particular way. One sub-culture, mourning is done more dramatically like crying loudly, beating chest, singing songs and praising the dead. In another sub-culture, mourning is done in silent way. The role and responsibilities, behavioural patterns, of father, mother, son, daughter, grand parents, brothers and sisters are defined and the person is expected to fit into these roles. The religion, the rituals, the belief in good and bad, heaven and hell, life after death also influence the human behaviour.

3.BIO PSYCHO SOCIAL ASPECTS OF ADOLESCENCE.

"Our youth love fun and luxury: they have bad manners, contempt for authority; they show disrespect for elders and like chattering in place of work. Children are now tyrants, not the servants of their households. They no longer rise to their feet when elders enter the room. They contradict their parents, gobble up their food and tyrannize their teachers."

This is not the anguish of modern parent but the lament of Socrates in fifth century B.C.! His distress seems so familiar to modern parents having to deal with an adolescence boy or girl. Adolescence is the time when the charm, of dependent smiles and tears of the early years begin to wane and the more deadly charm of the rival begins to wax. It is the period between childhood and adulthood that is characterized by biological, and social development. The beginning of sexual development heralds the biological and social development. The beginnings of sexual development heralds the biological onset adolescence, an acceleration of thinking, reasoning, planning and foreseeing capacity and personality formation signal the psychological onset. Socially, it is a period of intensified preparation for the forthcoming role of young adulthood.

Puberty is a physical process of change characterized by the development of secondary sexual characteristics. Adolescence is a psychological process of change. Often these two processes do not occur or proceed simultaneously, leading to stresses and strains. Adolescence is a period of variable onset and duration. In certain societies, the adolescent undergoes a prolonged and confused struggle before he attains an independent adult status.

Adolescence is commonly divided into three periods: **Early adolescence**; (11-14 years) It is marked by the onset of puberty, characterized by the breast development and hip enlargement in girls and facial hair growth and change of voice in boys. The characteristic increase in height and weight occurs. On the average, girls attain puberty two years ahead of boys and complete their physical growth correspondingly earlier. Deviation from the expected patterns of growth eg. Early or delayed puberty, acne (pimples), obesity, and enlarged breasts in boys and inadequate or abundant breast development in girls although not medically significant can lead to considerable damage to psychological well-being of the adolescents. This may result in feelings of inferiority, low self esteem, and loss of confidence. The sex drive is triggered during adolescence earlier among girls than in boys. Usually adolescents, sexuality are directed outward; crushes hero-worship, idealization of movie and or sports stars etc. Though early adolescent is still attached to the family, school experience accelerates and intensifies the degree of separation from the family. The school becomes the real world and the most important relationship is with those of similar age and interests. With the ability of formal thought and abstract reasoning, the adolescent discovers new facts, experiences and feelings. At this age, many adolescents may show remarkable creativity in the areas of poetry, music, art, athletics etc.

Middle adolescence: (14-17 years) Boys finally catch up to and surpass girls in height and weight. Menarche (the onset of menstruation) takes place in the majority of the girls. Similarly production of semen and nocturnal emission starts in boys. Sexual behaviour and experimentation with sexual roles become common in both of them. Masturbation is a common activity seen in both boys and girls. A strict-religious up-bringing may induce feelings of guilt for indulging in masturbation. Heterosexual crushes are common. Transient homosexual experiences may also occur. Many adolescents need reassurance about their sexual orientation. In the middle adolescence, the peer group assumes a major

role. The adolescent forms significant relationships with the peer group. Sometimes, the peer group has a defined nature like the gang, the athletic team, the social club etc., but more often it is only an informal institution held together by shared interests. Peer can exert powerful influence on the adolescent by affording basic acceptance and support. Social pressure is a powerful force that helps or mars in shaping adolescent character and values.

Late Adolescence: (17-20 years): This is a period of strong feelings and emotions with intense opposite sex relationships. The major tasks of this stage are (1) moving from a dependent to an independent state and (2) establishing an identity. Negativism reappears in this stage. "Don't tell me how long my hair can be. Don't tell me how short my skirt can be". This negativism is an attempt to tell the parents and the world that they have minds of their own. It is also an expression of anger. Parents and adolescents may argue about the choice of their friends, peer groups, school plans and courses etc. Slowly adolescents start imbibing different values from all kinds of sources. By young adulthood, a new conscience is established which strengthens the ability to handle and express feelings and emotions in relationships, as adolescents begin to feel independent of their families. Identity implies a sense of inner solidarity with the ideas and values of a social group. Developing a sense of identity is built on the person's success in passing through the earlier psychosocial stages and identifying with either biological parents or parent surrogates. The adolescent may make several false starts before deciding on an occupation or may drop out of school only to return later to complete the course. Role confusion in this stage of development may manifest in behavioural abnormalities, running away, criminality etc. The major cognitive event of adolescence is the development of the capacity for abstract logical thought which Piaget called 'Formal operations' . In this phase, a person is able to make deductions and derive general concepts. The person is able to constantly accommodate to the changing environment and ideas. There is a normal obligation to abide by established norms but only to the extent that the person is able to recognize what is good and what is bad for the society (Piaget). There is a voluntary compliance to rules based on ethical principles (Lawrence Kohlberg). In the decision to take up a vocation, which is necessary to feel independent and autonomous, there are pressures from friends, teachers, and relatives as well as subconscious forces. The occupational choice depends on opportunities for further schooling, financial background of the person and the family's attitude. Those adolescents who are unable to continue schooling are severely hampered in establishing a satisfactory vocational identity. Many are fated for lives of economic and emotional dependence.

END OF ADOLESCENCE: When the person assumes the responsibilities of young adulthood, the adolescence ends. This involves choosing an occupation, getting married and attaining parenthood.

RISK TAKING BEHAVIOUR: Risk taking behaviours in adolescence include drug and alcohol use, tobacco use, promiscuous sexual activity and accident prone behaviours, such as fast driving, rock climbing and other aggressive games. The reasons for risk taking behaviour relate the fears of inadequacy, the need to affirm a masculine identity and peer pressure.

PARENTING: The parents of adolescents are usually middle aged and they themselves have to make adjustments at that time to work, marriage and their own parents. The adolescents' need for independence may be threatening to the parents. The strong emerging sexuality of the adolescent may trigger anxiety in the parents. The concept of 'Generation Gap' stems from the differences in life experiences and perceptions of life events. Parents need to endure the distressing loss of authority

without losing responsibility. They must be able to set appropriate limits on behaviour while encouraging the independence of adolescents.

Thus remember the following factors which appear to play important roles in the bio-psycho-social development of adolescent persons:

1. Nutrition
2. Growth and sex hormones
3. Parents' attitude, their mental health and behaviour
4. Significant others' (family members) behaviour and influence on the adolescent
5. Teachers, peer group
6. Socio-cultural and environmental factors
7. Diseases and defects of the body and mind.
8. Life events: positive and negative events.

4. **ADOLESCENT SEXUALITY**

Due to ignorance and misconceptions among people the meaning of 'Sexuality' is restricted to genital sex. But 'Sexuality' encompasses one's actions, thoughts and functioning as male or female, the physiological changes of sexual arousal and orgasm which attain maturity during adolescence.

The adolescent boys and girls have to recognise their sexual feelings as normal. Generally they become curious and have intense desire to explore and experiment with sex. They notice wide variety of changes in their body like moustache and beard, hairs in the armpit or around genitals, change in voice, development of breasts, growth of genitals in size, discharge of semen, menstruation etc. Along with these physical changes, gender-related emotions and social behaviours appear. Every adolescent expects him or her to be a perfect and attractive male or female. They compare themselves with others and may feel disappointed about their physical growth. The may develop severe feelings of inferiority and inadequacy. Only a few feel proud and comfortable about their sexual growth and appearance.

Apart from primary social institutions like family, school or college and religious places, adolescents gather information about sexuality from peer group, books and magazines, movies, internet etc. They get tremendously influenced by these inputs and may develop conflicting attitudes towards sex and sexuality. They may not understand about normal sexual expressions. They cannot safely handle issues like pre-marital sex , homosexuality, sexually transmitted diseases etc.

Now-a-days opportunities for free mixing of boys and girls; having boy friend and girl friend, pre-marital sexual activities starting from kissing, petting, to genital intercourse, teenage love affairs, having multiple sexual partners, use sex as a means of enjoyment and recreation have made the adolescents to throw away the social, ethical and religious norms about sex and indulge in 'free-sex'. Thus, at present, the adolescent boys and girls are at high risk regarding sexual misbehaviours like eve teasing, sexual crimes, pre-marital sex, teenage pregnancy, sexually transmitted diseases including AIDS.

RECTIONS OF ADOLESCENTS TO SECONDARY SEXUAL CHARACTERISTICS AND SEXUAL EXPRESSIONS:

1. Facial Hairs: Boys worry a lot regarding the on set and appropriate growth of moustache and beard as well as hairs on the chest. They believe that thick hairs on the face and chest are 'masculine' features. If there is delay in the appearance of moustache, beard, the boys develop severe inferiority feelings and suffer. Other boys tease them. The girl feels awkward if she has hairs on her face and exposed parts of the body.

2. Height and muscle growth: Good height, bulky muscles are believed to be the sign of masculinity. Naturally boys worry about their short stature and poor muscles. They go to gymnasium, take part in athletic and sports activities to improve their body. Because of the misconception that beer is good for muscle growth, the adolescent boys may start drinking alcohol and later get habituated or addicted to it.

3. Size of the sexual organ: People believe that long, hard, erect penis is a symbol of masculinity. Boys start worrying about the shape and size of the penis and if they consider that their organ is

small and soft, they get upset. But they do not know that the size of the penis has nothing to do with sexual act and satisfaction. During sexual activity, with proper stimulation, the penis irrespective of its size and shape will attain the required erection for penetration.

4. Seminal discharge: Passing semen during sleep or during the act of masturbation (self-stimulation) is a normal phenomenon. Nocturnal emission heralds the sexual maturity (physical) in boys. But in our culture, it is believed to be 'harmful'. People say that one drop of semen is equal to forty drops of blood, and one should not lose semen. They also wrongly believe that holding semen inside the body, will improve one's physical and mental stamina. "Losing semen means losing one's vitality". Because of these misconceptions adolescent boys become very fearful, guilt ridden following frequent semen-loss. They show either signs of anxiety or depression or both.

5. Size of the breasts: Girls worry about the growth of the breasts. Big breasts are considered to be a feature of attractive feminine body. It is but natural for girls who do not have such breasts to feel inferior and less attractive.

6. Fears about menstruation: Many girls may attain menarche at 11 or 12 years age. They as well as their family members are not ready to accept the event. It is also believed that the menstrual flow consists of 'bad' blood and harmful. The menstruating individual is considered to be 'impure' and 'cause ill effect' on others ("Ashuddha", 'Amangale'). She is treated as an 'untouchable' during the menstruation period. In traditional families, the woman has to sit in a corner of the house or even stay outside the house and cannot take part in any pleasurable or religious activities. Lot of restrictions are put on her. This negative attitude of people regarding menstruation and menstruating women, make young girls to feel sick and helpless during this period. All the girls have to be told that menstrual flow is a natural phenomenon and in no way 'bad' or 'unwanted'. They should be helped to feel comfortable during this period. They should consult the doctors for 'premenstrual tension and pain'.

7. Sexual interests and fantasies: It is but natural for boys and girls to become curious, develop interest in the members of opposite sex and have sexual fantasies with known or unknown persons. They enjoy discussing these issues with peer group. They go through sex literature available, see sex-films. They may imagine of having sexual relationship with a person whom they like. All these activities in some cause severe feelings of guilt and shame. They start believing that they are doing a crime or a sin. They suffer from fear of getting exposed or suffer from depression.

8. Masturbation: Like thumb sucking and nail biting, masturbation (playing with genitals) is seen in childhood period and disappears to reappear again during adolescent period. It may also occur as part of seduction or learning, through other age-mates. As it is pleasurable, it gets repeated and may be associated with sexual fantasies. Almost all the boys and sizeable number of girls do masturbate and find it a convenient outlet for their sexual desires. Psychologists and sexologists opine that it is a natural, safe and harmless activity till the person gets married and has sexual partner.

But unfortunately, in our culture, it is a forbidden act. People are told that it is very harmful and may lead to physical and sexual weakness, shrinking of penis or damage to vagina: As it leads to seminal loss, it may lead to impotency and sterility. There are no scientific proofs for such beliefs. But young boys and girls are caught in between these two forces – desire to masturbate and fear of harmful effects of this act. Finally, they masturbate and suffer from severe guilt and fear.

EXPERIMENTATION WITH SEX:

In order to satisfy their curiosity and sexual urges, the adolescents try to experiment with sex. They look for practical experiences and may try to carry on what they would have read in sex literature or seen in movies / T.V. programmes.

They may choose either willing partners or take advantage of persons whom they come across or even go to commercial sex workers.

Kissing and petting: Kissing and petting are reported to be popular 'harmless' activities among willing partners (partners can be of same sex or different sex) petting may involve 'non-genital' part of body or even genitals. Kissing and petting may end in genital contact and sexual intercourse.

If the adolescent starts taking advantage of other persons to have such activities or if he/she forces oneself on 'un-willing partners, he/she becomes 'dangerous' to others. Sexual crimes are committed. Spread of venereal diseases including AIDS may occur.

Many adolescents who experiment with sex may suffer from severe guilt. They remain anxious as they fear that their acts would be found out by elders. They may not enjoy such activities and they may believe that they are sexually weak and impotent.

Infatuation: An adolescent may start believing that he/she is in love with someone. That person may be a classmate, college mate, neighbour, teacher, known family member or a public celebrity. The person interprets any encounter with that person as love encounters and starts telling that the other person is reciprocating the love. The person decides to go ahead and get married to that individual forgetting all the practical problems and social restrictions. He/she gets pre-occupied with love and stops functioning in all the areas of daily living. If he/she comes to know the real fact that the other person is not reciprocating the love, the result may be a disaster, like suicide or homicide.

HOMOSEXUAL INCLINATIONS AND PRACTICES:

Seen both in boys and girls. A boy getting sexually roused by seeing other boys and girl getting sexually aroused by other girls can create lot of psychological disturbances in them as 'Homosexuality' is considered to be a perversion and a forbidden act. It is a crime in our society. Homosexual contacts and practices are common in dormitories, hostels, sometimes, an individual gets forced by the other to get into such relationship. This may lead to severe emotional disturbances and a blow to one's self image. This may impair the future sex and marital life.

SEXUAL PROMISCUITY

Of late, a number of provocative and sexually stimulating materials, atmosphere and opportunities are being offered to youngsters through the mass media. In the name of fashion, civilized modern activities, western life styles, young boys and girls are coming closer to each other leading to sexual promiscuity. Safe and multiple methods of avoiding unwanted pregnancy have also contributed to promiscuity. Such an atmosphere has the potentiality to force adolescents to commit sexual crimes like molestation, rape, sexual offences against children, vauyerism, exhibitionism, bestiality etc.

SEX EDUCATION:

Adolescents should be helped and guided to understand the biological, psychological an social aspects of sexuality. They should develop healthy attitude towards the members of opposite sex. They should know socially and culturally acceptable ways of expressing their sexual interests. They should understand the consequences of pre and or extra marital sexual activities and the importance of safe sex. They have to prepare themselves for healthy sex life.

The teachers and educational institutions play an important role in educating the adolescents and their parents regarding 'Sexual health'. They can conduct individual or group discussions on these issues and invite professional person like doctors, nurses, health workers, psychologists or family counselors etc.) for proper guidance.

When the teacher acts like a sex educator, he should see that following necessities are taken care of

- Establish warm, friendly, open atmosphere so that students feel free to ask questions and discuss their problems. Confidentiality has to be assured.
- Discuss matters related to sexuality in a direct, and objective way. Shyness, ambiguity, embarrassment have to be avoided. The student is made to discuss these issues like he/she would discuss their other needs.
- The teacher should have all the scientific informations (medical, legal ethical and religious) about sexuality
- The required educational aids have to be made available, (books, posters and slides)
- All efforts and incentives have to be there to guide the students to exhibit healthy sexual behaviour.

WHAT DO ADOLESCENTS WANT TO KNOW?
GARDON AND DIZKMAN HAVE LISTED THE QUESTIONS MOST OFTEN ASKED BY ADOLESCENTS:

1. Is it normal to masturbate?
2. Am I masturbating too much?
3. Do I have homosexual tendencies?
4. Am I abnormal if I have thoughts involving sex with people I know, even members of my family?
5. Are my breasts too small?
6. Is my penis too small?
7. Is the pill or condom safe?
8. How can I get birth control without my parents knowing about it?
9. How can you tell if you have V.D?
10. Is there something wrong with me if I remain a virgin?
11. How can one avoid pregnancy?
12. How can I say 'no' to sex if my friend ask for it?
13. How can I tell if I am really in love?
14. How can I know it I have an orgasm?
15. Is sexual intercourse painful?
16. Is oral sex normal and safe?
17. What about having sex with some one you are not in love with?
18. How can I tell if I am pregnant?
19. Where one can get an abortion done?
20. How can I enjoy sex more?
21. How come I have these unexplained erections?
22. Does loss of semen make one weak?
23. Is a drop of semen equal to 40 drops of blood?
24. Is 'loss of semen during urination true? Is it dangerous?
25. What is the normal length of penis?

5. MENTAL HEALTH PROBLEMS IN ADOLESCENTS

Young persons are often regarded as an invaluable asset of any country. Such an emphasis is obviously based on the potentials of young persons to contribute intellectually, politically and economically to the society. Good overall adjustment and a sense of well being are very crucial factors for their positive contributions to the society. Young age typically represents a 'Transit' between childhood and adulthood. This phase of life is a highly vulnerable period because of simultaneous interaction of Bio-psycho-social factors. Hence young persons form a 'risk group' in the community. Ability to cope and perform in the expected roles in this age group depends on a good "homeostasis" in family, environmental and personality aspects of the young person.

Presence of mental health problems either transient or persistent can significantly affect social relationships and academic performance. High attrition rates in college students and academic under – achievement can be related to emotional factors, though the cause per se can be multifactorial. Cost effectiveness of inputs from Governmental and other agencies for the development and welfare of young persons, therefore, depends on minimizing attrition rates (dropout) ensuring better academic achievement and meaningful contribution to the society. Hence, there is ample justification to sensitize the college teachers towards the needs of college students. Such inputs would not only help promotion of mental health but also create a resource for appropriate and timely help for distressed young persons. In a country like ours, where mental health manpower resource is minimal and grossly inadequate, use of non mental health professionals like college teachers can go a long way in early identification and intervention for mental health problems in students. Experience in the past has demonstrated that sensitization of college teachers about mental health problems in students and imparting 'Counselling skills' has resulted in initiation of actions to respond to the mental health needs of the students, like for Eg. Home visits, individual counseling, suggestions, guidance, referral to psychiatric services etc. One positive development has been the emergence of interest in emotional problems in students and qualitative change in student – teacher relationships.

WHAT ARE MENTAL HEALTH PROBLEMS:

Mental health problems are a set of clinically recognizable symptoms present in an individual for a period of time and the individual experiences distress due to these symptoms as they interfere with his or her personal functioning like academic work, relationships, social interactions etc. Young persons can have certain problems like excessive fears, sadness / depression, strange behaviours such as being suspicious, inability to trust people, social withdrawal and isolation, drug or alcohol abuse. Such a constellation of symptoms, when persistent in an individual, constitutes a "Disorder". It is important to appreciate that above described symptoms or behavioral problems can be present in varying degrees of severity in the individual. It is interesting to note that such symptoms can manifest outwardly as follows:

a) Poor memory
b) Decline in academic performance
c) Lack of confidence, inferiority feelings, lack of initiative
d) Absenteeism
e) Being dull and withdrawn
f) Poor attention / concentration
g) Subjective sadness, feelings of worthlessness, hopelessness
h) Frequent complaints of ill health resulting in frequent medical consultations
i) Being argumentative / truant / antisocial
j) Aggressive and violent
k) Not being punctual / inability to abide by rules
l) Drug and alcohol abuse
m) Deliberate self harm (Suicidal attempts)
n) Poor impulse control
o) Strange and disorganized behaviours
p) Dramatic and attention seeking behaviours

Though these problems appear innocuous, they might sometimes represent underlying significant mental health problems. It is important to appreciate that such symptoms or problems are often present in the individual in various combinations.

Results of epidemiological studies conducted in the general population reveal that most commonly seen mental health problems are:

1. Depression
2. Anxiety
3. Adjustment reaction
4. Hysteria
5. Somatization (Medically unexplained body pains)
6. Drug & Alcohol Abuse
7. Psychosomatic disorders
8. Psychotic disorders

(Note: Disorders 1-7 are more common than psychotic disorders)

TYPES OF MENTAL HEALTH PROBLEMS:

True reflections of mental health problems of college students should be ideally based on results of scientifically conducted epidemiological investigations. However, such information is not available at this point in time. An attempt is being made to project the profile of mental health problems in college students age group; based on general population epidemiological studies and on clinical experience.

DEPRESSION:

Depression is a condition characterized by

- Sad mood and crying spells
- Lack of interest / energy / motivation
- Decreased attention / concentration / memory / intelligence
- Lack of pleasure / inability to enjoy
- Disturbed sleep / appetite / bowels / sexual functioning
- Thoughts of ending one's life
- Vague bodily symptoms like pain, weakness, fatigue
- Death wish / suicidal ideas - attempts

This condition can be transient or persistent. Depression in an individual can be ranging from mild to severe degree, some times the intensity can be less than mild degree. Such a condition (mild and less than mild degree) is quite common in day to day life of every one of us. This usually follows life events like death, separation, financial loss, failure in examination, strained relationships at home and with friends, failure of love affairs etc. Suicidal thoughts or ideas are common in depression and needs immediate attention. Depression is one of the important causes of inefficiency, under achievement and memory or concentration problems, alcohol and other substance abuse, and suicide.

ANXIETY:

It is a condition characterized by

- Subjective feeling of apprehension, discomfort and fear
- Restlessness
- Feeling of impending danger
- Palpitation
- Tremulousness
- Sweating / dryness of mouth
- Frequent need to pass urine
- Body pains like headache, fatigue, weakness
- Breathlessness

Like depression, anxiety is very common in young persons. It may be transient or long standing. Anxiety may manifest outwardly as poor memory, impaired attention / concentration, discomfort in social situations, and a general feeling of restlessness. Anxiety is a normal reaction in a threatening situation, but persistence of such a state without any understandable threatening situation is abnormal.

ADJUSTMENT REACTONS:

It is state of subjective distress and emotional disturbance, usually interfering with social functioning and performance, and arising in the period of adaptation to a significant life change or to this consequences of a stressful life even like failure in examination, loss of a close friend or family member.
Symptoms are:

- depressed mood
- anxiety
- worrying
- feeling of inability to cope / helplessness
- dramatic and attention seek behaviour
- outbursts of anger and violence, suicidal attempt
- antisocial behaviours

The onset is usually within one month of the occurrence of the stressful even or life change. It lasts for a short period only.

HYSTERICAL – CONVERSION DISORDERS

Symptoms of psychogenic origin often temporarily related to traumatic events, insoluble and intolerable problems or disturbed relationships. This is characterized by sudden onset of bizarre movements of limbs, unresponsiveness, or attacks of possession by god / spirits. Such problems start and terminate dramatically.

SOMATIZATION:

Characterised by persistent and distressing complaints of increased fatigue and exhaustion after minimal physical or mental effort. This is associated with muscular pains, headaches, sleep disturbance, irritability and disturbed sleep and mild symptoms of anxiety or depression. Such phenomenon is seen in males who unnecessarily worry about masturbation or seminal loss. In females such symptoms occur on the background of white discharge per vaginum. Somatization is also a way of communicating one's distresses and draw the attention of others to get help.

PSYCHOSOMATIC DISORDERS:

Long standing emotional distress may lead to certain physical illnesses in vulnerable individuals. These are known as 'Psychosomatic disorders'. Eg

1. Hyperacidity and peptic ulcers
2. Diarrheas and Dysenteries (colitis, irritable bowel syndrome)
3. Asthma
4. Arthritis (joint pains)
5. Obesity
6. Migraine or Tension Headache
7. Menstrual irregularities
8. Diabetes Malitus
9. High Blood Pressure
10. Eczema, Psorasis (Skin Disorders)

PSYCHOTIC DISORDERS:

Characterised by onset of strange behaviours like

- Ununderstandable strange talk and behaviour
- Suspicious
- Withdrawn, poor or no communication
- Increasing social isolation
- Hearing voices when there are none
- Feeling persecuted
- Sudden excitement, over activity, wandering aimlessly, unprovoked aggression
- Excessively cheerful and boastful
- Associated disturbances in sleep, appetite and bower-bladder functioning
- Some time psychotic behaviour can manifest as a progressive academic decline and change in personality.

Psychotic disorders may occur due to alcohol, ganja and other drug abuse. They may appear following head injury, brain fever and fits.

TREATMENT FOR MENTAL DISORDERS:

1. Drugs: Antidepressants, anxiolytics and antipsychotic drugs are prescribed in selected moderate to severe cases. The drug has to be taken regularly under medical supervision. The duration of drug treatment is individually determined by the doctors.
2. Electro convulsive therapy is given in a few selected cases of severe depression and psychosis
3. Individual and family counseling and guidance.
4. Healthy recreation and relaxation activities like yoga, meditation, sports, music, fine arts and other creative activities.

Earlier the treatment, better is the outcome. One should not hesitate to go to psychiatric department and consult the psychiatrist. The old beliefs that mental disorders are due to **evil spirits, blackmagic, past bad deeds** should not be entertained. With appropriate treatment, help, support and encouragement, youngsters with mental disorders to recover. They can continue their education. They can lead a normal and useful life.

Suicide

Suicide and attempted suicide are symptoms of emotional distress, which are usually associated with severe life events and certain psychiatric disorders such as depression, substance use, personality disorders or conduct disorders. Suicidal behavior is “a desperate cry for help” or a way of showing one’s anger and frustration, which includes suicidal thoughts (suicidal ideations), and suicidal actions (suicidal attempters and completers)

Suicide: is the act of intentionally taking one's own life. Every year more than one million people commit suicide, accounting for 1 to 2 per cent of total global mortality. Suicide is a leading cause of premature death, especially among youth.

Attempted suicide, Deliberate self-harm: are terms used to describe behaviors through which people inflict harm upon themselves, with non-fatal outcome. This is also called as Non-Fatal Suicidal Behavior. Suicidal attempts are approximately 25 times more frequent than suicidal deaths.

Epidemiology: As per the National Crime Records Bureau (NCRB) of India, more than one lakh persons (1,13,914) in the country lost their lives by committing suicide during the year 2005. Approximately 312 people commit suicide every day. One in every three suicidal victims is a youth. Above reported statistics is actually a tip of the ice berg, because of inefficient recording/capturing data and underreporting of suicide. Most common methods adopted in India as per NCRB are poisoning, hanging, self immolation and drowning.

Many studies have shown that at least 10% of the adolescents report attempting suicide at some time. A study conducted by Sidhartha and Jena in 2006 involving 1205 adolescent students of two schools from New Delhi reported, one year suicidal ideation (last year) was 11.7%. They also found that physical abuse by parents, feeling neglected by parents, history of running away from school, history of suicide by a friend and death wish were found to be associated with non-fatal suicidal behavior.

Process: Suicide is typically seen as the fatal outcome of a long-term process shaped by a number of interacting social, economical, cultural, situational, psychological, and biological factors. The life situation preceding suicide is typically characterized by an excess of adverse life events and recent stressors. Usually, suicide is a process in which chain of events will lead to the final act of committing suicide, and usually this process is triggered by a precipitant.

A person may show various signals like not taking personal care, withdrawn behavior, decreased appetite, decreased interest in almost all activities, increased amount of substance use and even they may verbalize 'directly' plans of harming self (by saying 'life is not worth living' 'Wish, I would have not been born' 'I will kill myself') or 'indirectly' ('every thing will be all right within few days' 'saying good bye' 'meeting the loved ones before the act' 'donating all their favorite articles/things to others').

Suicide is usually preceded by months/weeks of death wishes, suicidal ideas, feelings, behaviors, plans and subtle warnings. Thus it is preventable if these pre-act symptoms are identified in time. Please note the following:

- Half of all who commit suicide; would have attempted suicide at least once previously.
- 15-25 % of the suicidal attempters will attempt suicide again within a year.
- Hopelessness, depression, and substance use are strong predictors for suicide.
- Family history of suicide in first degree relative.
- Sudden change in behavior can be noticed (like decreased socialization, aggressive, suspicious, fearful, crying spells, academic decline)

These kinds of indirect data will provide an opportunity for suicide intervention before it occurs. Only if you are trained in identifying the symptoms of depression and risk factors, you can prevent majority of the suicide.

Common causes for suicide: They are social, environmental, role modeling, psychological, and biological.

Social: financial problems, poverty, life events, loss in social status, humiliation
Cultural: religious cult, group belief (terrorist), religious belief
Family discord: family discord, loss of loved one
Environmental: stress, academic pressure, exam failures, physical illness
Psychological: low self esteem, impulsivity, pleasure seeking
Role modeling: from media, imitation of other behaviors
Biological: brain injury, decreased serotonin, and hereditary
Physical illness: like HIV, cancer, sudden loss of vision or limb, any illness which causes social stigma.
Mental illness: depression, substance use, psychosis, personality disorders

People at risk for having suicidal behavior:

- Younger age,
- Ongoing and /or recent life events (like loss of relationship, failure in examination, financial loss),
- Past history of suicidal attempt,
- Loss of social status / reputation in the society.
- Family history of suicide, Poor family support, broken family, physical abuse by parents, feeling neglected by parents and loss of loved ones
- Loss of romantic relationship or discord in a relationship
- Chronic medical/surgical illness like HIV, cancer
- Mental illness like-depression, substance use, anti-social behavior, psychosis
- Evolving personality disorders,
- Poor social integration (lack of confiding relationships/long standing relationship problems), poor problem solving skills,
- Aggression, hopelessness, impulsivity, sudden change in behavior, sudden decline in academic performance, conduct problems like truancy/ stealing/ lying

Acute Precipitants: The most common precipitating factors for suicide in adolescents are humiliation by their parents/friends/relatives/teachers, discipline for misdeeds in front of others, exam failure, arguments or fights with the loved ones and the loss of romantic relationships, severe financial constraints.

MANAGEMENT OF SUICIDE

Suicidal attempt:

- Immediate hospital referral to save the person's life.
- Alert the higher authorities of the college immediately.
- Inform family members immediately.

Non-Fatal Suicidal Behavior:

1. Never scold a person who has attempted suicide.

   Usually people/elders in the family demean their act as cowardly, stupid, crazy, foolish , sinful (God will never forgive you), attention seeking and so on, but you should always keep this in mind suicidal behavior is “a desperate cry for help” . So do not scold, act shocked, argue about the value of life and make the person feel more guilty, sad and depressed, about causing suffering for themselves, family and friends, which may worsen the situation rather than helping him.

2. Avoid giving lecture/advice on value of life. Instead allow him to talk and express his emotions/feelings. This can be done only by active listening. Please avoid comparing them with anyone else.

3. Discuss about their behavior or feelings by asking :

   What circumstances/situations made him to choose that step?
   What made him to feel so helpless and hopeless?
   What made him to think that there was no way out of that situation?
   Explore about his recent life events and substance use
   Explore past history of suicidal attempts and family history of suicidal attempt
   Please avoid using words like “why?”

4. Ask for any plans of completing suicide or hurting himself in near future. There will be a high possibility of he may attempt again. Hence, ask for future plans of attempting again. Ask for any specific plan or ideas in his mind to commit suicide. Exploring suicidal ideas or thoughts does not increases suicidal behavior. In fact, many studies have proven beyond doubt that by exploring for suicidal plans or ideas, you are able to get an opportunity to intervene.

5. Reducing the availability of means/modes of committing suicide

6. Try to help him in all possible ways, knowing your limitations. Do not unnecessary delay the process of providing help. Communicate your concern and support for his recovery. Acknowledge your limitations in front of them and try to assure them that you will do your best to help them.

7. Do not challenge a person who had attempted.

8. Do not leave him alone at any cost. Make someone to stay with him all the time.

9. Do not give false reassurances.

10. If there are multiple threats and attempts, severe suicidal attempt, history of aggression and impulsivity, signs and symptoms of mental illness (like depression/psychosis/substance use) and

poor socializing behavior. Then discuss with family members about the risk and advice them to take help from mental health professionals.

11. These are emotionally charged situations. You may get stressed out easily, which may be detrimental in many ways to you and also to the person who had attempted suicide. Hence, do not handle these situations alone. Involve college authorities, survivor's family members and friends. Try to get help from all possible means.

12. Take help from mental health professionals to deal with such situations.

Dealing with the grief process

1. If a student has committed suicide:

Suicide committed by a student can have severe psychological impact on his friends and the staff of the college. It can even set an example for other students as a method to tackle their problems. Hence a protocol should be developed by the school authorities for dealing with such situations. School authorities should get adequate factual information about the event. Then information should be given to all the students by their class teacher. To avoid rumors, all students should get the same information. Don't describe the suicidal event in detail to the students. Do not glorify the suicidal act.

Allow students to discuss about their thoughts and feelings. Severely affected students (close friends) of the deceased should be allowed to ventilate and if required counseling services should be offered. It would be appropriate to inform their family members and help them to cope with the situation. This opportunity should be utilized later for discussing or brain storming sessions or seminars about suicide, help seeking behaviour, available services, problem solving techniques and depression.

2. If a student had attempted **(**Non-Fatal Suicidal Behavior) but survived?

- Treat him as a normal student,
- Encourage other students to interact with him,
- Help him in coping with his studies,
- If possible a teacher should be assigned to that student so that, he can discuss with the teacher about his thoughts, feelings and problems,
- To develop a contract with the student that he will not attempt,
- Communicate your concerns and support,
- Student should be clearly told that he can seek help without any barrier,
- If required referral to mental health professionals. If possible discuss with the student and their family members regarding, seeking help from mental health professionals. Initially, family members may refuse. Try to explain them in simple words about depression, impact of depression on academics and suicidal risk.

Prevention is better than cure:

1. Avoid humiliating/punishing students in front of other students,
2. Providing counseling services within the campus,
3. Establishing a student support network group through peer counselors,
4. Encouraging them to develop hobbies, sports, games and so forth,
5. Providing opportunity and encouraging socialization,
6. Involving family members in student's academics progress from the beginning,
7. Educating the family members about the student's strengths and weakness,
8. Preparing the students and family members before exams regarding the worst outcome in exams,
9. Teaching problem solving skills and improve interpersonal relationship skills.

Students can be educated through group discussions, brain storming sessions, seminars, debate, case-vignettes discussions, workshops, drama and discussions/talks/lecture by mental health professionals. Topics to be covered are reasons for attempting or committing suicide, depression, substance use, problem solving skills, available help/treatment/ counseling services, need for recreational activities and socialization. If possible involve family members and mental health professionals during these activities.

Aggression

Aggression in adolescents is relatively prevalent in all societies in various forms. Recently people are raising concerns about this issue because of its serious impact on the society, safety, economic and public health issue, across all levels of the community. Aggressive behavior in man is complex whereas in animals, it is usually considered as instinctive and helps the animal in survival of the species; Behavioral scientists believe that aggression is there in each of us, and can be modified by experience in both positive and negative ways. They have defined 'aggression as behavior aimed at causing harm or pain to others or self' Human aggression can be manifested towards self or others, can be direct or indirect, physical or emotional, active or passive, and verbal or non-verbal.

Aggression directed towards self can be seen in the form of suicide, deliberate self injury, taking high-risks like over-speed while driving a vehicle and substance use. Aggression directed towards others can be in the form of physical injury/harm (hitting), psychological pain (insulting), destruction of property and verbal abuse (shouting or spreading rumors about the victim). In simple words, malicious intent against someone, gains importance in the perpetrator's behavior. Considering the above definition, we usually see this type of aggression every minute/second in our life. Like simple temper tantrums, sibling rivalry, truancy, bullying/intimidation, ragging, passing comments on appearance or bad jokes, eve teasing, subordinates rebelling against authority figures, in family relation it is often used by husband displacing his anger on wife and children against their parents to achieve his/her goals or demands. The question that rises in such situations is when to intervene? When to seek professional help? Hence, to answer the above questions other important dimensions to be considered with regard to aggressive behavior are the antecedents, situations, frequency, duration, intensity of the aggression and deviation from the cultural and social norms.

Causes of human aggression: They are social, cultural, environmental, role modeling, psychological, and biological.

Social: financial problems, poverty, cheating, injustice, unequal distribution of resources, exposure to violence with in the community

Cultural: belief about gender, sexuality, role, religious beliefs, dressing, familial
Environmental: stress, broken family, family discord, academic pressure
Psychological: to gratify his/her needs, to show dominance/power over others (bullying), frustration, jealousy, greed, low self esteem, stress, retaliation against the authority figures.
Role modeling: from media, movies**,** T.V**.** serials, imitation of others behaviors
Biological: endocrine/hormonal abnormalities, brain injury, decreased serotonin, mental illness and genetics

All these factors may operate independently or in combinations resulting in aggression.

People at risk of having frequent aggressive behavior: Learn to identify and predict who are at risk of developing aggression can prevent serious consequences. Following are the risk factors, which are identified in various systematic studies;

Individual factors: poor problem solving skills, poor socializing skills, childhood trauma like sexual/physical abuse, and mental illness like depression, anxiety disorders, conduct disorders, oppositional defiant disorders, epilepsy & substance use and head injury.

*Family factors: b*roken family, family discord, violence within the family, substance use by the parents, poverty, improper parental discipline techniques, lack of parental monitoring.

Social factors: poor living conditions and social support, exposure to violence (media), victimization by peers (bullying), life events and stress.

MANAGEMENT OF AGGRESSION

Aggressive behaviors in human have different origins and aims, which are best controlled in different ways at different levels. Management can be planned at ***individual level***, ***family level*** and ***community level***.

1. INDIVIDUAL LEVEL:

During the aggressive behavior: First you should know how to defend yourself. If a person is physically violent, try to get help from others. If required as a last resort physical restraint may be used to avoid injuring oneself or to others.

After math of the aggression: Aftermath of the aggressive behavior, then the student/s involved should be called and counseled. During this process never give advice before listening to both perpetrator and victim. When you are clear about the incident and sure that both the parties calm and relaxed, explain them as you are explaining to adults, that violent behavior can affect in many ways. Like discipline action can be taken against him or it may lead to jail, which may reduces their chances of finding a job or friends. Make sure that you make eye contact, use firm voice but non-threatening, do not use harsh language and explain to them with genuine concern.

Behavioral methods: First and the foremost, we should analyze the aggressive behavior in terms of context, situation, frequency, intensity and the behavior itself in terms of

A. **a**ntecedent stimuli associated with aggression
B. **b**ehavioral and emotional response to the stimuli and
C. **c**onsequences of aggression

Once the analysis is completed, than you should give the feed back of the antecedents / situations which provoke anger, person behavioral response and consequence of his/her actions. Than plan for anger management techniques like:

- Moving away from that place / Time out,
- Avoiding arguments,
- Deep breathing techniques,
- Meditation,
- Relaxation techniques,
- Counting numbers or repeating God's name silently,
- Identifying and Managing emotions

  Managing own emotions - involves recognizing emotions in ourselves, being aware of how our emotions influence behavior and being able to respond to emotions appropriately. Intense emotions, like anger, rage and aggression can easily destroy rational thinking. Hence, everyone should learn how to control and modulate their emotions in constructive manner.

  Empathizing with others – A capacity to put one self into the psychological frame of reference of others, which helps to recognize or identify with the feelings and needs of others (in simple words understanding others' feelings and taking their perspective). Empathizing skills help us to understand and accept others, which will improves social interactions and relations.

  Replacing negative thoughts with positive – for example, if you get angry by mere sight of a particular person, than start thinking about his good behaviors /deeds/ actions. By doing this, you are replacing your negative thoughts about a person with positive thoughts.

- If anger is still not controlled, doing vigorous exercise, banging the pillow, playing outdoor games, listening to music may help.
- Finally if there is no improvement, than seek professional help. You may need tranquilizers.

<u>Reward and punishment should be used properly and adequately:</u>

Reinforcement patterns and punishment should be used properly. Differential reinforcement should be used (that is to encourage and reinforce good behavior, discourage and negatively reinforce the unwanted behavior). Another important thing you should remember is not to yield to temper tantrums. Once you yield to temper tantrums then the person learns how to get his/her way by throwing temper tantrums. Because by yielding for the demands you have reinforced temper tantrums by providing what the child wanted. If the person is behaving well/normally in all situations except at home, it shows that reward and punishment are used inappropriately in that family which have to be corrected.

Do's and don'ts:

Reward:

- Though material and money are attractive, they become expensive and we will be not be able to give them in the long run or when resources are limited. Therefore, verbal appreciations, kind words can be used liberally in front of others.
- Give the reward openly and in front of as many people as possible.
- Chose the right person, right behavior for the reward.
- Assessment should be objective, transparent and impartial.
- Give the reward to every one who behaves well or does the job well.
- Be consistent in your behavior.
- Give wide publicity for the reward. Find occasions to reward people.
- Don't delay/deny the reward.

Punishment:

- Use punishment as the last weapon to change human behavior.
- Instead deny his positive reinforcers when unwanted behavior occurs.
- Define type and severity of punishment before you use it.
- Do not punish any body openly and publicly. (in front of their sibs or agemates or juniors)
- Say to him/ her that you do not have any personal bias /grudge and you are punishing him/her for unwanted behavior or act of omission or commission.
- If you do not have power to punish but have responsibility of recommending it, do it and do not worry about the outcome.

Avoid physical punishments as much as possible and use it only as a last resort, because ***aggression will lead to aggression only***. Hence, be a role model by remaining calm, showing patience, unconditional support towards non-violence and forgiving nature. This will help the students in imbibing good qualities from you.

Provide counseling to the individual for occasional aggressions.

Identify signs and symptoms of mental illness and refer .

Medications: If aggression is frequent, difficult to control and with very high intensity leading to

- dangers to others,
- dangers to self (suicide),
- which is secondary to mental illness or brain injury,
- which is secondary to substance use, epilepsy.
- frequent breaking of rules and regulations

then consider referring to psychiatrist. There are various medications to decrease aggression.

2. FAMILY LEVEL:

- Educate about the proper parental discipline techniques, regular monitoring of the child's behavior, providing quality time with the child, and love to the child.
- Encourage family rituals
- Avoid comparing a child with other children. Encourage healthy competition.
- If there is family discord or marital discord between father and mother then family therapy should be advised.

3. COMMUNITY LEVEL:

1. Bullying and ragging should be dealt properly
2. Monitoring the media content: Many scientific studies have clearly documented that exposure to aggression or violence through media has been associated positively with violent behaviors.
3. Stress management.
4. Providing opportunities for healthy recreational activities.

Aggression in adolescent is a frequent problem for parents and college staff. The teachers should have general understanding of risk factors for aggression. Assessment should include evaluation of exactly how an adolescent is aggressive, frequency, intensity, the setting (home or school) in which it typically occurs and towards all or only specific adults can also shed light on possible reasons. Aggressive behaviors are best controlled in different ways at different levels, starting from individual to community level.

6. SPECIFIC PROBLEMS OF COLLEGE STUDENTS

As has been observed by the mental health professionals associated with college mental health services, 'late adolescent, college-going persons are highly vulnerable to the limitations in personal growth, imposed by emotional disturbances of varying severity. Further more, problems in a student population are unique in that many of the difficulties are related to developmental issues of gender, self-esteem, competition and cultural membership in a population in transition. These developmental issues lead to vague symptoms of anxiety and depression, rather than to clearly defined emotional disturbances one would expect in a general adult population.

As far as the Indian youth are concerned, they are very much under the domination of their parents and other elders of the family. All important decisions of life pertaining to education, occupation and marriage are seldom left to youth. In effect, the Indian youth generally remains prisoners of time and environment. This strange social situation unfolds a new environment which in turn creates stressful situation for the student youth, powerfully influencing their behaviour.

Srinivasan (1994) highlighted on the following nine situations influencing the college youth.

- Firstly, the student youth develops conflicts with adults who resist social changes and novelty. When parents were young, they inculcated in themselves a set of values and principles and created their own ideas and concepts of what was right and what was wrong. They tend to forcibly instill these values into their children. But sadly, in every walk of life there have been enormous changes. Their values are more suited to a time gone by. Today's youth tackle situations in a different way and this seems queer to their elders. Student youth by virtue of their education are always prone to fast cultural and social changes. Resistance to this end fosters stress in them and gives vent to student activism.

- The second factor that adds fuel to this fire is the inexperience of youth. The presumptuous views of life that youth hold is due to its being steeped in theoretical knowledge. What books convey is a mere fragment of life. Due to double difficulty of not knowing what life is and not being able to acquire some readymade experience, student youth tend to be vain in its view of life.

- Thirdly, young students function in an uncertainty. The growth of knowledge and changes in science and technology and their application to society often upset the planning of the youth. Hence, the youth of today undergoes greater stress than the youth of yesterday.

- Fourthly, the demographic situation is yet another factor which indirectly causes starain and stress in student youth. Fall in the living standards, unemployment / underemployment, decline in health and personal disintegration are the consequences of the increase in population. These find their reflection in the economic condition of youth and as a result youth have been placed in a social order in which avenues to affluence have been monopolized by a small elite.

- Fifthly, the gap between physical and intellectual maturation on the one hand and the social maturation on the other develop stressful conflicts in the youth.

- Sixthly, educational institution also create stressful situations to youth leading to student agitations. Prayog Mehta (1970) has conducted a study in this regard and has given a break up of the broad reasons for student agitation as perceived by the students as follows:

  "….. lack of good teachers and other educational facilities. Frequent changes in the pattern of education, tactless handling of student demonstrations by the administrations, administrative arrogance, corruption in administration, negligence and indifference of the Government towards student problems were mainly considered as reasons for student agitation….."

- Seventhly, alcohol and drug abuse is yet another problem unique to the present time. There has always been a traditional acceptance of alcohol and drug for pleasure and relaxation. The reasons why they are used can range from just a curiosity to an urge to escape from the frustration and problems of life. Alcohol and drug abuse are common among students in general and particularly among hostel students and who live alone.

- Eightly, biological development and emotional readiness of the youth for heterosexual relationship do not proceed at the same pace. The cheap literature, T.V. and films on sex, stimulate sexual impulses and anxiety and lead to dangerous and painful sexual experiment in youth. The older generation avoids talking about sex and sexual problems with the younger generation. The main source from which the Indian student youth comes to know about sex is the peers who are equally ignorant and confused about it.

- Ninthly, mass media exerts powerful influence on student youth in 'Construction of social reality' and unfolds stressful situations for the youth of today. The present age is dominated by the mass media particularly the Television.

According to Majumdar (1977) the unruliness and radicalism that characterize the behaviour of the students often look apparently illegitimate, unacademic and unacceptable. Students become turbulent and violent over such matters as travel concessions, postponement of examinations, attendance policy of the administration, minimum marks for pass, price of coffee and quality of food in the college canteen, statements made by teachers, disciplinary measures taken by administrators and trivial hostel matters. Whereas, the real reason for the student unrest ties in the frustration to which the students are consciously or unconsciously subjected. The back breaking social disparities are important among the factors that nurture student unrest.

Student youth in modern society is constantly subjected to the confusion of values all around them. There is great contradiction in what parents, teachers and leaders preach and what they themselves practise. In such confusing situation everybody suffers from a dilemma with regard to various values. The youth have distorted perception of the values of the adult society. The impact of social forces unique to youth's time, economic dependency, subordinate role in the society, denial of adult role in the society, adult's attempts to understand them in the light of their own experience, ambitions and aspirations, adults' distorted perceptions of the urges and aspirations of the youth create a social situation when the youth comes to occupy a marginal man students, - a stage of anxiety, (Sudarshan kumar 1978).

The characteristic symptoms of the marginal man are emotional instability and sensitivity. They tend to have unbalanced behaviour to either boisterousness or shyness exhibiting too much tension and frequent shift between extremes of contradictory behavior (Lewis; 1957).

Adjustment problems of the students are understood by administering standardized inventories of which Bell's Adjustment Inventory (Student form) is the most popular. It has 140 items covering 4 areas of adjustment, namely, Home, Health, social and emotional.

Students commonly encounter the following problems related to **home**

- Parents frequently criticizing
- Lack of real affection and love at home
- Unpleasant relationship with parent(s)
- Parents insisting on strict obedience
- Lack of money
- Parents objecting to the kind of friends / companions
- Irritability of father / mother
- Frequent family quarrels (relatives)
- Frequent quarrels with siblings
- Parents treating the youth still as a child
- Feeling that friends have had happier home life than the individual

In respect of health dimension, the college students face the following

- Problems related to eye sight / eye strain
- Difficulty getting sleep
- Frequently getting tired toward the end of the day (common cause is anemia)
- Loss of weight
- Injury and accidents
- Frequent absence because of illness

Among the problems experienced by students in respect of social adjustment, following are important:

- Shyness
- Self conscious in group of people
- Difficulty in starting conversation
- Difficulty in making friendly contacts with members of opposite sex
- Public speaking

Following are some of the important issues faced by the college students in respect of 'emotionality':

- Frequent day dreaming
- Frequent feeling of depression
- Feelings of loneliness
- Low marks in examination
- Envying the happiness that others seem to enjoy

- Inferiority feelings
- Feeling of self consciousness because of personal appearance
- Easily hurt
- Disturbed by criticism
- Ups and downs in moods without apparent cause
- Fear of being alone in the dark etc.

Srinivasan focused on the following ten problems commonly expressed by the college students in and around Coimbatore city:

1. Heavy work load
2. Ambiguity of goals
3. Uncertainty of some activities
4. Inadequate resources
5. Absence of authority to reward or punish students appropriately
6. Inability to understand the content of leadership tasks
7. Unreasonable demands from fellow students
8. Lack of commitment to many activities
9. Poor response of the management and the Government to their representation
10. Absence of long range perspectives in their activities.

As could be seen, the problems of the college students are inextricable interwined with macro and micro levels educational system, economic condition, political patterns as well as family problems, individual problems and inter actional issues. Counselling intervention would be definitely helpful in handling these problems to a great extent. It is worth remembering that counseling is not a panacea for all such problems. It could only focus on psychological and interpersonal problems faced by the college students. Alleviation of such problems would go a long way in improving the quality of life of the students, students-teacher interaction and standard of education in the college and university campuses.

REFERENCES:

1. Srinivasan (1994): An exploratory study of student leaders of the colleges in Coimbatore City Ph.D. Thesis submitted to Bharathiar University Coimbatore
2. Lewin K (1977). The Field theory approach to Adolescence. In: Seidman J.(Ed)
3. Majumdar T.(1977): Academic leadership and student unrest. A pilot study. Research project sponsored by ICSSR
4. Prayag Mehta (Ed) (1971): The Indian youth : Emerging problems and issues. Bombay Somaiya publications Pvt. Ltd.
5. Sudharshan Kumari 91978): Aspirations of Indian Youth. Varanasi. Chowshambha Orientalia.
6. Farnsworth. D.L.91978): College Mental Health Services. In. Comprehensive Text Book of Psychiatry p. 2716-2725

7.SUBSTANCE ABUSE IN STUDENTS

Accounts of use and abuse of psychoactive substances including alcohol, coca leaves, opium and cannabis are as old as civilization. In recent centuries and decades, advances in communication technology and medicine have led to the production and marketing of new drugs in many parts of the world and also new routes of administration of drugs.

Drug abuse is no more an individual problem but has assumed the proportion of a major social and public health problem.

The drug addiction committee in 1977 noted that most frequently abused drugs in India were alcohol, tobacco, opium and cannabis. The overall prevalence among the student population varied between 18.2% and 72%. In Bangalore, the prevalence of alcohol use varied between 23.5% for males and 5.3% for females, Heroin was used by 1% of males and 0.3% of females, Cannabis was used by 1.3% of males and 0.45% of female students. In a well conducted recent study in Karnataka, the prevalence of alcohol use (ever) among students was 41.2% and in general population was 33.7%. The prevalence of drug use (ever) was 11.9% among students and 7.5% in general population.

COMMONLY ABUSED DRUGS:

The substances of abuse are the following:

1. Narcotics: eg. Opium. Morphine. Heroin or brown sugar, pethidine, methadone
2. Stimulants: eg. amphitamines, cocaine, and crack
3. Hallucinogens: L.S.D., PCP, Marijuana, Ganja, Bhang, Hashish, Charas
4. Depressants: Alcohol, sedatives, hypnotics.
5. Nicotine
6. Caffeine
7. Volatile substances: gasoline, petrol
8. Others: Xerox ink, Iodex, poisonous mushrooms, nail polish remover

Drug addicts tend to keep experimenting with newer drugs as previous drugs become less effective. Many of the drug abusers could be using many drugs. The mode of use varies according to the drug of abuse. Ganja is smoked in beedies, cigarettes or chillums. Brown sugar is chased (smoke eminating from the substance kept on a silver foil and heated below is inhaled). Heroin is used intravenously. Bhang is usually mixed with tea or milk for drinking (Ramras). Tobacco is either smoked or chewed.

ALCOHOL:

Alcohol is by far the largest and the common substance of abuse. Alcoholism is a behavioural disorder. It is defined as a compulsion to drink alcohol causing harm to self or others.

Alcohol problems are associated with a history of school difficulty. High school dropouts and frequent truancy and delinquency have a particularly high association with alcoholishm.

Like other drug dependencies, alcohol is marked by a preoccupation with obtaining the drug in quantity sufficient to produce intoxication. Early on, the patient may deny this preoccupation or rationalize the need by assertions that he or she drinks no more than his or her friends. As problems from drinking become more serious, alcoholics may drink alone, sneak drinks, hide the bottle, and otherwise conceal the seriousness of their condition. This is accompanied by guilt and remorse, which produce more drinking, relieving the feelings. Non-availability of alcohol produces anxiety and depression. Often the patient succeeds in stopping drinking for several days or weeks, only to start again. Despair and hopelessness are inevitable. At this point they may be ready to acknowledge their alcoholism but feel powerless to stop drinking.

Problems related to alcohol abuse can be divided into psycho-social and medical.

Alcoholics have a high rate of marital separation and divorce. They often have job troubles, including frequent absenteeism and job loss. They have frequent accidents in the house, on the job and while driving automobiles.

Medical complications fall into three categories. (1) acute effects, (2) chronic effects and (3) withdrawal effects. Acute effects may be death due to respiratory depression, hemorrhage (gastrointestinal) and acute intoxication. The chronic effects are gastritis, gastic ulcer, diarrhoea, liver damage (cirrhosis), peripheral neuropathy, temporary blindness, Wernicke – Korsakoffs syndrome, anemia, thrombocytopaenia, cardiomyopathy, foetal alcohol syndrome.

The most common withdrawal symptom is tremulousness, which occurs a few hours after cessation of drinking. Transitory hallucinations and grandmal convulsions (fits) occur occasionally.

TREATMENT:

Treatment of alcoholism has two goals. (1) Sobriety and 2) amelioration of psychiatric conditions associated with alcoholism.

For several months after a heavy drinking bout, total abstinence is desirable. It is important for the patient to learn that he or she can cope with ordinary life problems without alcohol. For variety of procedures, both psychological and somatic, have been tried in the treatment of alcoholism. These are (1) Intensive psychotherapy (2) Aversive conditioning techniques. (3) Alcoholics Anonymous (group interactions with ex-alcoholics)

OPIOIDS:

This group of drugs includes morphine, heroin, pethidine, methodone etc. They are abused for euphoric effects. Dependence develops rapidly (within a few days) with regular usage especially when the drug is taken intravenously.

In addition to euphoria and analgesia, these drugs produce respiratory depression, constipation, reduced appetite, and low libido. Tolerance is developed rapidly, leading to increased dosage.

Withdrawal symptoms rarely threaten the life of one in reasonable health, though they cause great distress and so drive the person to seek further supplies. The withdrawal symptoms include intense craving for the drug, restlessness and insomnia, pain in muscles and joints, running nose and eyes, sweating, abdominal cramps, vomiting and diarrhoea, erection of hairs, dilated pupils; raised pulse rate and disturbance of temperature control. These features usually begin about six hours after the last dose, reach a peak after 36-48 hours, and then wane.

TREATMENT:

Heroin dependent people present in crisis to a doctor in three circumstances, First when their supplies have run out, they may seek drugs. The second form of crisis is drug overdose. This requires medical treatment. The third form of crisis is an acute complication of intravenous drug usage such as local infection, necrosis at the injection site, or infection of a distant organ – often the heart or liver.

During withdrawal, much personal contact is needed to reassure the patient. Opioids can be withdrawn rapidly while symptomatic treatment is given for the more unpleasant withdrawal effects.

Group therapy and community living are combined in an attempt to produce greater personal awareness, more concern for others and better social skills.

CANNABIS: Students take it with the belief that it increases their concentration. Some take it to feel 'high' or as a replacement to alcohol.

The effects of the drug vary with the dose, the person's expectations and mood and the social setting. Users sometimes describe themselves as 'high'. But, like alcohol, cannabis seems to exaggerate the pre-existing mood whether exhilaration or depression. Users report an increased enjoyment of aesthetic experiences and distortion of the perception of time and space. There may be reddening of eyes, dry mouth, increased heart beats, irritation of the respiratory tract and coughing. Cannabis use may precipitate exacerbations in the psychotic processes of some schizophrenic patients, Some marijuana users suffer (what are usually short lived) from acute anxiety states. Sometimes with accompanying paranoid thoughts. The anxiety may reach to the proportion of panic attacks. These reactions are self limiting and simple reassurance is the best method of treatment. Psychotherapy may be considered appropriate for the adolescent user of marijuana.

THE NATURE OF THE PROBLEM IN YOUNG PEOPLE

To some extent substance use is encouraged by supportive, attitudes conveyed in the popular media. Substance use is frequently glorified in movies, television show, books, records, and music videos. This provides youth with negative role models and communicates the message that smoking and drinking are acceptable and even desirable.

Prevention is important because of the following reasons (1) deleterious health, legal and pharmacological effects of substance abuse (2) role played by intravenous drug use in the transmission of Acquired immuno deficiency syndrome (AIDS), (3) Unfortunately the treatment of substance abuse problem has proven to be both difficult and expensive (4) Even the most effective treatment modalities typically produce only modest results, and treatment gains are most often lost due to high rates of

relapses. Therapists are confronted by a disorder that more often than not proves to be refractory to change by patients whose knowledge of drugs may be daunting to even the most experienced practitioner, and by a unhealthy environment that does its best to undermine any progress made by the patient through the ubiquity of drugs and a social network promoting drug use.

The evidence indicates that substance abuse results from the complete interaction of a number of different factors including knowledge, attitudinal, social, personality, pharmacological and developmental factors. Social factors are the most powerful influences promoting the initiation of tobacco, alcohol and drug abuse. These include the behaviour and attitudes of significant others such as parents, older siblings, and friends. They also include influences from the popular media portraying substance use as an important part of popularity, sophistication, success, sex appeal, and good times.

KNOWLEDGE AND ATTITUDINAL FACTORS:

Individuals who are unaware of the adverse consequences of tobacco, alcohol, and drug use, as well as those who have positive attitudes toward substance use are more likely to become substance users than those with either more knowledge or more negative attitudes toward substance use. In addition, individuals who believe that substance use is "normal' and that most people smoke, drink or use drugs are more likely to be substance users.

PERSONALITY FACTORS:

Substance users have been found to have lower self esteem, self confidence, self satisfaction, social confidence, assertiveness, personal control and self-efficacy than non users. Substance users have also been found to be more anxious, impulsive, rebellious, impatient to acquire adult status, and in need of more social approval than non users. Through experimentation with different substances highly anxious individuals may have found that alcohol or other depressants help them to feel anxious and they might use those substances as a way of regulating their feelings of anxiety.

PHARMACOLOGICAL FACTORS:

Virtually all these substances produce effects that are highly reinforcing and dependency producting. For tobacco, alcohol, and most illicit drugs, tolerance develops quickly, leading to increased frequency of use. Once a pattern of dependent use has been established, termination of use produces dysphoric feelings and physical withdrawal symptoms.

BEHAVIOURAL FACTORS;

Substance abuse appears to be part of a general syndrome or life style. Individuals who use one substance are more likely to use others. Individuals who smoke, drink, or use drugs tend to get lower grades in school, are not generally involved in adult sanctioned activities such as sports and artistic / creative activities and are most likely than non users to exhibit antisocial patterns of behaviour including aggressiveness, lying, stealing and cheating. Substance use has also been found to be related to premature sexual activity, truancy and delinquency.

INITIATION AND PROGRESS OF USE

For most individuals, experimentation with one or more psychoactive substances occurs during the adolescent years. Initial use of the "Gateway" substances – tobacco, alcohol and ganja typically takes place during the early adolescent years. First use and intermittent experimentation generally occur within the contact of social situations. In its initial stages, substance use is almost exclusively a social behaviour. After a relatively brief period experimentation, many individuals develop patterns psychological motivations for using drugs eventually yield to one driven increasingly by pharmacological factors.

Most individuals begin by using alcohol and tobacco, progressing later to the use of ganja / heroin. This developmental progression corresponds exactly to the prevalence of these substances in our society with alcohol being the most widely used, followed by tobacco, which is followed by ganja. For some individuals, this progression may eventuate in the use of depressants, stimulants, hallucinogens, pain killers and other drugs.

ADOLESCENCE AND SUBSTANCE ABUSE RISK:

Adolescence is frequently characterized as a period of great physical and psychological change. During adolescence, individuals typically experiment with a wide range of behaviours and life-style patterns. This occurs as part of the natural process of separating from parents, developing a sense of autonomy and independence, establishing a personal identity and acquiring the skills necessary for functioning effectively in an adult world. Many of the developmental changes that are necessary prerequisites for becoming healthy adults, increase an adolescent's risk of smoking drinking or using drugs. Adolescents who are impatient to assume adult roles and appear more grown-up may smoke, drink, or use drugs as a way of laying claim to adult status. Adolescents may also engage in substance use because it provides them with a means of establishing solidarity with a particular reference group rebuilding against parent authority, or establishing their own individual identity. During adolescence, the influence of parents is supplemented by that of the peer group.

PREVENTION STRATEGIES:

Supply reduction efforts are based on the fundamental assumption that substance use can be controlled by simply controlling the supply (i.e. availability). Demand reduction efforts, on the other hand are conceptualised as those that attempts to dissuade, discourage, or deter individuals from either using drugs or deserting to use drugs. Demand reduction includes prevention, education and treatment programmes.

TYPES OF PREVENTION:

Substance abuse prevention efforts can be divided into five general categories.

1. Information dissemination approaches, which may include the use of fear or moral appeals.
2. Effective education approaches – increasing self esteem, responsible decision making, interpersonal growth generally includes little or no information about drugs.
3. Alternatives – increasing self esteem, self reliance, providing variable alternatives to drug use, reducing boredom and sense of alienation.
4. Resistance skills: This can be done by increasing awareness of social influences to smoke, drink, or use drugs, developing skills for resisting substance use influences, increasing knowledge of immediate negative consequences, establishing non substance use norms.
5. Personal and social skills training: They are based on social learning theory and problem behaviour theory. Substance abuse is conceptualized as a socially learnt and functional behaviour, resulting from the interplay of social and personal factors. Substance use behaviour is learnt through modeling and reinforcement and is influenced by favourable attitudes and beliefs.

Personal and social skills training prevention approaches typically teach two or more of the following.

a) General problem solving and decision making skills
b) Right thinking for resisting interpersonal or media influences
c) Skills for increasing self control and self esteem
d) Adaptive coping strategies for relieving stress and anxiety through positive thinking and relaxation techniques.

8. CHANGING FAMILY AND ITS INFLUENCE ON ADOLESCENTS

Family is the primary and most important socializing agent for all individuals. It plays a very important role in the individual in terms of their personality development adjustment. The quality of parental care in the early years of a child plays a vital role in the mental health of a child. The basic needs of a child are to be met within the institution of family and this aids the individual's normal development. The family usually helps the child's development in two major ways, primarily, in terms of satisfaction of immediate instinctual needs and secondly by providing an atmosphere of affection and security. Based on these the child develops the physical, mental and social capacities to the full extent. The relationship with the mother at the early ages and later on with the father as the age increased plays an important role in the normal development of the child.

The Indian family systems are not only complex but have been undergoing a steady change in recent times. These changes are due to the changes in the larger system i.e. the society. The changes in the society are currently in a transitional phase. Yet the effects of it on the familial system cannot be ruled out.

One of the major factors in social development in any country is the economic development. This has been the basic factor in the organization of society and family. Any change in the economy would have its impact not only on the society but also on the family. In the past, during the pre-modern era, agriculture formed the basic occupation of a large number of house-holds. The economic activity was confined within the family. This could be visualized the terms of the village as a social unit, wherein occupation was ascribed in terms of the varna system or the caste system a tag which every family carried on its own.

During this phase, the family was the unit of production. The structural characteristics of these families was that of a joint family system with large number of individuals bound together upto the third generation level. The management of the house-hold was in the hands of the head of the house-hold who usually happened to be the senior most male member of the family. These patriarchial families were bound together by kinship and economic ties. The roles and tasks of every member was defined and supported by the cultural values of the time. Men took lead in dominant economic and social roles which were purely external. They were placed in higher levels in the family and the society. Young men were usually married to girls who were younger and lesser or not educated. Subsequent to the marriage, the girl used to be uprooted from the family of origin and brought to the place of her husband.

The women took care of the internal issues within the home in terms of upbringing the children and other house-hold activities. Their participation in economic generation activities were marginal and relegated to the second place. The roles and tasks played by the individuals had its effect on the educational attainment between men and women. By virtue of a better educational attainment, exposure to a larger community was usually credited to men than women.

The independence in functioning was also altered due to the above fact. Men had higher autonomy compared to women. Among men too the senior most member enjoyed a very high degree of independence followed by younger male members to a lesser degree. When it came to the women they exercised the least amount of autonomy.

All the family members usually used to live within the same infrastructure or within the same geographical area depending upon the distribution of properties among the male members. Thus, sons who lived along with the parents or closer to them were regarded more important than the daughters who get into their family of procreation subsequent to marriage. Due to this there was an increased preference for the male child compared to that of a girl child. Even division of properties were carried out among the male members of the house-hold than to the daughters in the family.

The attitude towards women in general and daughter-in-laws particularly were nurtured partly due to the above mentioned facts. They were most of the time expected to take care of the children, care for the aged in-laws in the family, carry out the domestic chores within the house-hold and help in the agricultural activities in the fields. Due to her minor role and lack of contact with outside world, the women's position in the house-hold carried the least degree of autonomy.

Intra familial problems were settled within the family by the head of the house-hold, who was the senior most male member in the family. These problems never became a major societal or public issue. The jointedness within the family was kept to the highest possible extent by heeding to the utterances of the head of the house-hold. The head of the house-hold also enjoyed a major power enterprise over other members in the house-hold disputes within the family at the best went to the local caste or community or religious councils. Hence, no major public forums were present to redress inter or intra familial disputes.

In the recent times, the Indian family has undergone a series of transitions. The transitions in the family system is basically a by-product of the changes at the social level. These constant and gradual changes have been the result of the influence of various 'zations' namely modernization, westernization, industrialization, liberalization, sanskritization. Industrialization and modernization emerging in a major way at the societal level resulted in migration. Young able bodies men migrated out of the traditional agrarian communities to the urban industrialized area along with their small families. Men with their minimal educational attainment and exposure were able to be absorbed into the factories. The women in the mean time were relegated the house-hold duties and child rearing alone. They lost the minimal economic generating activities in the farms. The family no longer was the arena of economic activity but revolved around the adult members working outside the home. This resulted in smaller nuclear families with few children.

This broke the traditional joint family to nuclear family. Younger men enjoyed more autonomy in these house-holds compared to the joint family head of the household in agrarian communities. The autonomy was a product of elevation of their status as the sole bread winner of the family. The women were dependent on the men as they were less qualified and not accustomed to move in the outside world. New opportunities went to men in the non-agricultural sector. Women lost even the secondary economic role they enjoyed in the family farming. Thus, husband became the sole bread-winner and women full time home makers.

Subsequent to this period came in the transition to an industrial society. This resulted in women increasing their educational attainment and competing for jobs suitable to them. The social policies of the Government also enabled the women to a greater extent towards attaining independence. Few of the educated women joined the labour force in small numbers which later on increased and resulted in competing with men in almost all the areas. Both men and women started working outside the home. The gender role identification in economic and domestic chores started diffusing. Both men and women

were engaged in economic careers and qualifications; parenting and domestic chores were shared between husband and wife; patriarchial system diminished and members of family became individualized and autonomous. This led to the situation of relationship within family to be more on psychological and emotional sphere than on economic dependence alone in the developed urban areas. Individuals started becoming units within the family and intra-familial disputes became public issues and are aired out in public institutions like, family court.

The current transition thus resulted in women performing dual role of bread winners and home makers. Neglect of child and aged is seen every where. The sanctity of marriage being questioned led to the spiraling rate of divorce. This resulted in an increased incidence of single parent families.

Further, there is a reluctance to accept responsibility of rearing children. The families are more towards material culture which has brought in major changes in value systems. Economic strife has become the main focus resulting in personal autonomy and individual freedom.

Inspite of various changes occurring in the family, Erna Hoch a Psychiatrist identifies two positive characteristics of Indian families in comparison to the western families. The western families can be represented as a more or less conglomeration of fairly well delimited individuals who all carry out their transactions with the outside world on their own merits and within their own spheres of interest. In traditional Indian families, a strong family boundary is seen within which the individual members hardly develop any ego boundaries. Transactions with the outside world are carried on by the family as a whole. Thus, in Indian families one could observe a sense of togetherness which is quite primary. They point to a oneness which is primary "root organization" of the community in comparison to the west wherein a super imposed "roof organization" is observed.

To conclude one needs to view family in transition as a bio-psycho-social unit. Wherein, the changes at family level needs to be recognized at multiple levels. Every system is characterized and influenced by the configuration and status of the system of which each is a part……Every system is constantly in flux and influencing the other system over time, each domain serves as a constant for the other and all functions in relation to one another (Engel, 1980) We have to understand the problems of youth in the context of changing family system.

9. CAUSES AND MANAGEMENT OF ACADEMIC PROBLEMS

There are many causes of poor learning and poor memory.

1. Poor development of brain and low IQ.
2. Ill health like anemia, repeated infections of the sinuses, ear, tooth, skin, throat, lungs etc.
3. Poor motivation.
4. Specific learning deficits like some have decreased ability to learn science, maths, language, or they are poor in reading and writing (Dyslexia)
5. Poor attention and concentration because of

    (i) internal disturbances like worries, tension, emotional problems, sexual feelings, guilt, financial difficulties, family & friends problems

    (ii) external disturbances like noise, TV, Radio, games and other entertainment, uncomfortable environment

6. Severe competitions, pressure and criticisms from others
7. Severe low esteem and lack of self confidence
8. Wrong teaching methods: Monotonous lecturing, no audio-visual aids, no practical demonstrations, negative attitude of teachers, irregularities in the campus and examination, discrimination etc.
9. Wrong study habits like continuous reading without understanding or break, memorizing, no review, no recall, no practice to write answers in stipulated time, not studying all the chapters, irregular in eating and sleeping, reading till late in the nights. etc.
10. No or inadequate recreation and relaxation.
11. Mental disorders like depression , anxiety, obsessive compulsive disorder, adjustment disorders, schizophrenia, alcohol abuse.
12. Last hour hurried learning for the examination.

Many times in spite of capacity and skills, students are seen having a wide variety of problems related to learning, remembering, writing and securing good marks in the examination.

They need systematic orientation towards

a) How to tackle a text book?
b) Effective study habits
c) How to deal with examinations?
d) Reasons for failure in the examination

Such orientation will help them to understand their potentials and limitations and to enrich their potentials and to effectively cope with limitations. If such orientation programmes are held in groups, the effectiveness is high.

a) HOW TO TACKLE A TEXT BOOK?

One strategy that has proved very successful and can be adapted to most kinds of reading is often known as SQ3R.

This stands for the initials letters of the five steps in studying a book (or chapter or article).

Survey
Question
Read
Recall
Review

According to this formula, give the following instructions to the student"

1. Get the general outline of what you have to study by carrying out a preliminary survey of the text.
2. Ask your self, questions that you expect to have answered by the time you have finished reading the text.
3. Read the text and understand it
4. Try to recall the main points. Write them on paper.
5. Go back and review the text to check how well you have picked out the main points. Put a time limit and write answers to the questions.

These points need to be discussed in the group so that the counselor can clear their doubts about these techniques. Moreover, the students could bring out the innovative techniques related to the steps.

b. EFFECTIVE STUDY HABITS

There are certain 'Do's and 'Don'ts' in the study Habits. By following 'do's, one will have good memory and understanding.

SOME DO'S:

- Making a time table for studying for each day and strictly follow it
- Studying in the same place every time. Let there be no attractions or distractions like TV, film magazines or frequent visitors.
- Getting written work on time
- Trying to contribute to class discussion
- Trying to analyse one's work to see where one is weak.
- Glancing through a chapter, making a preliminary survey before reading it in detail
- Using dictionary to understand the meaning of difficult words. Read and understand what you read.
- Writing notes in skeleton form or short summary
- Keeping all notes for one topic together
- Consciously using ideas one learns in one course to help in some other course.

SOME DONTS:

- Frequently skipping tables and graphs when they occur while reading
- Usually trying to memorize something all in one sitting without understanding
- Continuous reading without a break.
- Sitting up late in the night studying
- Being irregular in food intake, sleeping / waking up time.

When such things are discussed, the group members will add to the list of 'do's and 'don'ts' from their observations and experiences. The members could learn from each others' success stories as well as failures related to examinations.

C. HOW TO DEAL WITH EXAMINATION?

I. Examination success demands planned preparation

- Apply effective study techniques over a period of time
- Start now, don't procrastinate
- Make a time table for revision and rehearsals to write (Mock exams)
- Form a revision group (3 class mates and 3 times a week)
- Practice doing what the examination requires of you

a) Emphasis on recall

b) Reorganize your ideas by

i) discussing with others
ii) revising all notes on the topic at once
iii) revising related topics together
iv) criticizing own notes
v) rewriting notes

c. Tackle old examination papers

i) write outline plans for answers
ii) write complete model answers in stipulated time
iii) take mock examination
iv) don't try to outguess the examiner

On the day before the examination:

i) Do not learn new things
ii) Revise as much as possible or relax completely
iii) Gather examination equipments
iv) Go to bed early and get a normal night's sleep

II. Technique on the day of the Examination:

- Don't discuss prospects with other students
- Read right through the examination paper
- Budget your time
- Plan your answers
- Keep sense of priorities
- Write legibly
- Check all answers till time is up.
- If there are difficult questions, don't panic. Answer them at the end.

Though, these things look simple and trivial, they go a long way in making students successful in the examination significantly.

d) Reasons for failure in the examination:

a) Irregular attendance
b) Not attentive in the class
c) Not having a stable study pattern
d) Not having a proper plan for preparing for examination
e) Excess examination fear and worrying about the performance and results.
f) Health problems and emotional problems
g) Bad handwriting
h) Low self confidence by comparing with other good students.

Such difficulties need to be identified and corrected immediately. Otherwise, student does not know why he / she has failed repeatedly in the examination or why he scored less marks.

Explain the following abilities in which students have difficulties and allow them to give examples of difficulties in each area:

1. Listening
2. Reading
3.Thinking
4.Writing
5.Talking
6.Remembering
7.Mathematical calculations

IV. Let them bring out useful suggestion and practical steps to overcome the same.
If these issues are discussed by the members of the group, the students will gain insight into the mechanisms of effective study and good examination performance.

10. COUNSELLING

COUNSELLING PROCESS

Counselling is a helping process which by way of talking and discussing, helps the client to find solutions and feel comfortable. It starts with the first contact of the client with the counseller or counseling agencies. It may get completed in one session or in many sessions (though there may not be an upper limit, it is desirable to limit the sessions to 5 to 6 to be cost effective), counseling is done in three stages.

I stage : The client comes to contact with the counselor. They develop trust and rapport with each other. The client is helped to talk about his perceived problems and his emotional reactions. He is encouraged to have an emotional ventilation or even an abreaction. He is assured help to find solution to his problems.

II stage: understanding the problems: The factors which appear to be the cause, aggravate or become hurdles in finding solutions for the problems are identified and understood. Realistic and scientific explanations for the growth and worsening of the problems are identified. All the faces of the problems are visualized and understood.

III stage: After knowing the measures taken by the individual to solve the problems and the results of the same, he is helped to I) work out both short term and long term solutions. ii) or to reduce the severity of the problems, iii) or how to cope up with the problems, if solution is not possible. The individual is helped to find out people, agencies and institutions who may help him in this regard. Referrals are made and follow-ups are done by the counselor. Thus the main goal of counseling is, the individual is encouraged to keep trying to improve his conditions using the available resources and feel comfortable in this on going struggle.

I STAGE

The student may come to the counselor on his own or may be referred by a teacher/friend. The first contact of the person is very important. He comes with full expectation that the counselor would solve all the problems in shortest time possible. Sometimes, he may expect a miraculous positive result immediately. He attributes lot of magical powers to the counselor. He may expect him to be kind, helpful and efficient person. He may have lot of anxieties, and shyness to expose himself to the counselor. He may have his own doubts whether he would be accepted and helped by the counselor. He may not be very sure whether the counselor would understand his problems and make a good effort to help him. Thus he may have severe discomfort, when he is in front of the counselor. Therefore, what is appropriate and the timely need is:

MAKE THE PERSON TO FEEL COMFORTABLE :

Invite him to sit and relax: Say ‘Please come in, Be seated. You might be tired. Was there difficulty in finding me? Relax, you can have a cup of water’ This general approach, makes the person to relax and feel comfortable. Once he is settled in the chair, see that you do not do anything to give a feeling that you are very busy or you are uncomfortable by his arrival. If there are other people in the

room, introduce them to the client or send them out. Give privacy. Introduce yourself and then ask him to introduce himself and what he wants from you.

"Now, my name is……. I am a counselor. May I know your name, your background and why you have come to me, what can I do for you?" Note down what the person says. He may give his name and background but hesitate to say why he has come or what he wants from you. You address him by name and say, "Nagendra, I am pleased to see you here, Many people come here to find solutions to their problems. What is bothering you. Feel free to talk about it,. I assure you that I won't discuss the issue with anybody. If you find it difficult to talk, here is pencil and paper, write down your problem".

If there is an accompanying person, like a friend ask who he is and how close he is to the client. Find out whether the individual wants to talk to you in private. Whether the accompanying person should leave the room. Then request that person to sit outside. Give preference to the individual.

If the student is willing to talk, the interview has begun. It is an interaction between two people, one person is giving and another person is collecting information. Both persons should know what to communicate and how to communicate. Otherwise there would be enormous wastage of time and efforts. The clients may not be clear regarding what and how to communicate. They may get mixed up or their emotional state may not allow them to communicate properly. Therefore it is your task to help him to communicate his problem in such a way that you understand the problem in the right perspective. Use a format to collect the information by asking appropriate questions and probes. When he is talking, do not interrupt him unless, he is going totally out of the way. Keep listening, encourage him by your nods, gestures, repeat certain statements to assure him that you are listening with interest. Observe his facial expressions, body movement when he is talking, look at the variations he makes in sounds. That may give clues regarding his stress. For example, when you ask a girl, why she has come to the counseling centre, the way she says that she has lot of problems at home and cries, (use the proforma given in the appendix-8). You will get a clue whether she is happy or unhappy with parents. When a person, describes his study problems, you may get clues whether he likes the course or not.

Some Do's and Don'ts while conducting interview :

1. **Maintain eye to eye contact** : While talking to the person, keep eye to eye contact. Don't look at something else. Don't write while you are interviewing.

2. **Interrupt only when necessary :** Allow the person to talk. Don't interrupt because by doing so, the person may lose the track pf his thinking. When you feel that the person is giving unnecessary details or gone away from the topic, interrupt and ask him to be precise:

3. **Ask always open ended questions :** Do not ask questions which elicit yes or no answer. For example "Do you get angry if your needs are not fulfilled ?" instead of that "How do you feel when your needs are not fulfilled ?. "Are your parents good to you ? instead of that, "can you describe your parents or what do you feel by your parents ?"

4. **Do not be in a hurry :** You should give sufficient time for the client to express his problems. If you are in a hurry, the person may not know how to communicate or he may think that you are not really interested to help him. If you have short time, tell him to talk about one aspect of the problem only and give time at a later date.

5. **Do not pass judgements :** You should not pass remarks on the person's behaviour. You should be neutral, E,g, :

   S : I often go late to the class

   C : It is bad. One should be punctual, (wrong)

   C : Are there reasons to go late to the class ? Have you tried to be punctual ? (right)

   S : I drink (alcohol). Often I get intoxicated and quarrel with my friends.

   C : It is not good (wrong)

   C : Drinking a lot may lead to lot of problems. You have already experienced it. (Right)

6. **Do not threaten** : If the person is not co-operative, if he gives wrong/ false answers, do not scold/threaten him.

   Don't say : "You are not telling the truth. You are hiding certain things. You must be ashamed of it. I will not help you. You can go. Don't waste up time".

   Say : "It would become difficult for me to help you as you are not giving all the information. If you co-operate with me. I would be very happy to help you"

   Don"t say : "You did not keep the appointment. You have come late. I hate people who come late".

   Say : It would save your and my precious time, if you had come in time. Don't worry. Please try to come in time. I would appreciate it very much".

7. **Don't be- little :** Don't make him "small", by your comments

   Don't say : "you are a fool to give up the course".

   Say : "Probably it was not a wise decision to quit the course. Anyway, you have done it. Let us see what best you can do now.

8. **Be reassuring and supportive** :

   Say "I agree that you have severe problems. You feel helpless. There is no point in worrying. Have courage. You will find some way to solve the problem. You will be better. I will do my best to help you

9. **Clarify :** when you interview the person and the family members, there may be discrepancies in their versions. They may report totally opposite things. Do not think that one of them has deliberately told you lie. Do not question / doubt their integrity. Probably their perceptions are different or one of them maybe using a neurotic defense mechanism like denial or projection or suppression. Bring the difference to their notice and ask them to recall their memory and clarify the issue, if they don't, get information from another person of the family.

10. **Give time:** When you find the person hesitating to give information or says that he does not have the information, do not keep pressing him to give it. Tell him 'probably you can't recall the information, probably you are not ready to give the information. Do not worry. You may want to tell it later'.

11. **Prepare**: When you try to probe areas like sex, you have to prepare him to talk about it freely with you. Say "In our culture people hesitate and feel shy to talk about sex. If you have any problem in this area, do not feel shy to talk to me. When you want, you talk about it. Sex is an important need of any person. As we talk about other needs.We can talk about our sexual needs also". See that there is sufficient privacy when you are discussing these issues. If you are a male and you are talking to a girl, it is desirable to have another female counselor along with you and allow her to probe this area. Similarly, if you are female, have a male-colleague to interview the boy.

12. **Recording**: Once the interview is over, after the student has left your room, record what you got. If you cannot remember some facts, clarify and record later.

Getting maximum – relevant information, in a short time as possible, without causing any distress to the persons is 'Good interviewing' and it is an art. By practice one can master it. Please give a try.

II AND III STAGE OF COUNSELLING:

When you start collecting information about the student, you have already started the helping process. The person may talk about one problem. For example, a student may talk about his fears about the examination. He may say that he becomes sleepy when he opens the book. He may say that he is unable to study and wants your help. Similarly, a girl may talk about her parents who ill-treat her and do not take care of her needs. She is upset about it and wants you tom set right the situation. Whatever may be the presenting the problems you have to probe other areas and identify problems which may be affecting the well-being of the person.

1. **Interpersonal relationships in the family** : Encourage the person to describe the interpersonal relationships between him and others and relationships between all the family members. Similarly you have to ask other family members to describe the same. Perception of each one may differ. But the common findings will help you to understand whether there is harmony in the family or not. You will understand the quantity and quality of love, affection, hostility, hatred, discipline and punishment, the life style of the individual and family. The individual has to depend on the family for both material and emotional support. In many cases you will find gaps between the individual and the family. You have to help to bridge these gaps as part of counseling process. The family has to become more accommodative and the individual has to give 'more' to the family. You have to arrange more occasions for the family members to come together and interact with each other.

2. **College :** Ask details regarding the experience in the college, with classmates, teachers, academic and non-academic activities, let him talk about his assets and liabilities in this area.

3. **Financial area :** Money has become very important in our life that it has its tentacles in almost all the areas of our life. Irrespective of the class one belongs to each one of us may have financial constraints. The individual may have problems in money matters. Let him talk about them.

4. **Sexual area :** Explore the attitude, beliefs and practices of the student : Ask about his views, about maleness, masturbation, semen loss, his perception of sexual potency and any pre-marital sexual experience, In the beginning ask a general question: Some people may have problems in the sexual area. They hesitate to talk about it. Do you have any problem ? Feel free to talk about it either now are later'. The person may choose his own time to talk about any sexual problems, if it is bothering him.

6. **Self-image :** Ask him to describe himself, what type of person he is. What are his attitudes, values and how he rates himself compared to others. Let him talk about both positive and negative aspects of his personality, his achievements and failures.

METHODS OF COUNSELLING

Many counseling techniques are used to help a person who is in distress. In one case you may predominantly use one technique, in another you may use more than one and in any combinations. You have to plan these combinations depending on the individual, family and the problem.

1. **VENTILIATION** : Many people try to suppress their emotions. Many try to forget the cause / situation as they are unpleasant but they may not succeed in it. Whether one tries to suppress or forget these issues or not, if he is allowed to talk about them freely and repeatedly, he feels a sense of relief. He says 'Oh, now my chest is lighter. I feel better. This is called ventilation. Along with talk about the stress, he may bring out the bottled up and hidden emotions like sadness and anger. Do you remember the proverb 'joy shared is doubled; sorrow shared is halved'.

   That is why in any culture, relatives and friends visit the victims of disaster, sick persons, bereaved and allow them to talk about the loss and bring out the emotions. Therefore, with empathy,

if you encourage the person to talk, good ventilation occurs. Allow the person to cry, express anger or fear. Don't stop him.

If ventilation occurs suddenly and more dramatically, the person may burst out sobbing or crying, use obscene, dirty words, bang the table, show extreme fear. It is called abreaction. Do not get upset by it. Don't try to stop it. Either you keep quiet or encourage him by saying 'I know, it might have caused you lot of distress. I can understand how you would have felt at that time'.

You can also encourage him to express his unpleasant experience through creative activities like writing, painting, music etc. Many writers have produced their best work in times of emotional crisis and distress.

2. Explanation : The process quite often gets a relief when he understands that his 'symptoms' or 'unusual behaviour' are the result of unconscious defence mechanisms.

3. Reassurance : The person with emotional problems, has a poor self image, feels helpless and remains pessimistic. He is not sure about what he would do or what he would not do. He has no self confidence. Uncertainty haunts him all the time. He takes some decisions but not sure whether he would improve or not. Therefore he needs re-assurance, approval and encouragement from the counselor. Find out positive things, the correct and right decisions he has taken earlier and try to increase his confidence. Reassure him that with the help of counseling, with the support of his family and friends, he would get rid off the problems. If he is worried that he might have some physical illness or worried about the 'outcome' of his bodily symptoms, reassure him that he is not sick and he should stop worrying about his health.

4. Diversion by physical & mental activities : The person in distress, gets pre-occupied with other his problems or symptoms. He worries about the past as well as future, you have to divert his attention by prescribing him physical and / mental activities which are interesting and beneficial to him.
E.g : Reading and writing, physical exercises, games, swimming, decorating the house, embroidery, making dolls, painting, religious activities, gardening, crossword puzzles, any other creative activities.

5. Recreation : Recreation helps to break the monotony and boredom. It also helps to relax from fatigue. It brings pleasant feelings, it helps in socialization, it brings people together, it helps to forget worries, and even physical pains. Free and open conversation with friends and family members, listen to music, visual entertainments (T.V., Cinema, Drama, Dance), playing with children, indoor or outside games, visiting friends and relatives, picnics, parties, eating variety of foods along with friends and relatives can be suggested.

6. Improve the problem solving skills: Quite often, you will find persons, who think in a stereotyped manner; they think of one common solutions for their problems, if it does not work, they stop thinking or they cannot think of other alternatives. They struggle to run in the same track in vain. As part of increasing their coping skills, ask them to think all the other possible solutions and work out merits and demerits of each solution.

7. Encourage healthy defence mechanisms : Sublimation, altruism and humor are said to be healthy defence mechanisms. Ask and encourage the person to.

i) have alternative goals in life
ii) try to achieve some successes in the area of their interest
iii) do some constructive work which will help others or society
iv) join a social service agency and take part actively in the activities
v) use humor in difficult situations and keep smiling
vi) give money and materials for good work done by others. Get involved in such work

8. Suggestion : If the person has exhausted a few methods to solve the problems if he is not capable of planning strategies to face difficult situations, you have to give him alternatives and help him to plan as well as carry out new strategies. Instead of your forcing a decision on him or forcing a particular strategy on him You have to explain the benefits as well as drawbacks of different methods and make him to choose one, so that he is a made to take up the responsibility.

When you give suggestions, take extra care to see that they are realistic, practicable and acceptable to the individual and his family. You should not suggest to forget a religious oath taken by the person, if he is God-fearing person.

9. Reinforcement :When the person follows some suggestions taken during counseling enquire whether there is some benefit / improvement in his conditions. Recognise and reward even slightest improvement seen. Many times expecting a big change or substantial improvement, the person fails to recognize a small change / benefit. He may report 'No improvement' and become pessimistic. Highlight the change that has occurred. Bring to his notice his improvement of even one symptom and say. "You are on the right path. Next week or next month you will experience substantial improvement". Keep his hopes alive but be careful not to give false hopes.

9. Get support from significant others : Persons who suffer from emotional problems, most of the time feel lonely, unheard by others and helpless. During counseling get the parents, classmates, friends, siblings and get their support to the person. They can interact with him, empathise with him and get involved in his solving problems. They can take over your role. Otherwise the person will depend on you and you have to keep seeing him for a long time.

10. Change of attitudes and life style : The person is encouraged to live and function meaningfully. Help him to review his faulty and negative attitudes and life styles and bring other sudden or gradual changes. Simple life styles, low expectations, enjoying small little benefits and spending more time with intimate friends are desirable.

CODE OF CONDUCT FOR THE COUNSELORS :

If you want to be an effective and good counselor, if your efforts have to give results, you have to faithfully follow the following code of conduct.

1. **Accept the person :** Irrespective of age, sex, caste, class, education, family and social background. You have to accept the person as he is , without putting any condition. Respect him as an individual. Do not look down upon him or belittle him. You are not a special and better person. Treat him as a friend. Do not have an attitude of you as a 'giver' or he as a 'poor reciever'

1. **Confidentiality :** Whatever you discover during counseling process will have to be treated with strict confidence. You should not divulge any part of the information, without his permission to any other person, even to the principal or the college administrators. You promise strict confidentially and keep it up. Request your authorities not to ask for the confidential issues of the student.

2. **Be a good listener :** Have time and patience when the person is communicating his distress to you. Listen to him with good attention. Don't look at the watch, door, your registers. Keep eye to eye contact , observe his facial expressions and body language which give more information than his verbal responses.

3. **Empathy :** It is the ability to understand other persons emotions and other's reactions to a given issue by putting yourself in their 'shoes'. This is much more than sympathy or showing kindness.

4. **Sincerity:** You have to have a genuine and sincere desire to do your best to help the person and make him comfortable. Please convey your sincerity to the person so that a good rapport develops between you and the person.

5. **Patience** : Quite often the person may say things and behave is such a way or demand or even question / doubt your abilities which may upset you. You may become angry with him. Please control yourself. Have patience. You sit back, close your eyes for few seconds or drink some water. The emotional reaction in you passes off. Think, what made you to lose your temper. Try to be neutral.

6. **Non-Judgemental :** The person may report many things which you may think and feel are wrong and against moral, social norms. The person or his parent ,may ask you to pass judgement (right or wrong, good or bad } on the person's activities, actions and reactions. Do not accept the role of a judge. Do not use your 'yard stick' to analyse the behaviour. Tell him / them clearly that it is not your job to judge him. You are helping to find out where and when things went wrong and how to correct them.

7. **Resourcefulness :** You have to be knowledgeable and have good contacts of people who work in different fields. You have to collect necessary information to guide the person. You have to be resourceful. Please have a list of experts, institutions, in the field of health, law, banking and service, training centers, etc. You can refer the person to these agencies when the need arises.

8. **Knowing one's limitations :** You will not be able to understand the problems of all people who come to you. You may not know the solution for the problems. Do not boast about your self that you will solve the problem. Know your limitations and accept them. Do what you can and stop at the point where and when you have to refer the person to the appropriate expert / agency.

9. **Self-disclosure :** Do not share your problems with the client. For e.g., when you find a student who is very dis-obedient, demands money and not doing well in the college, you may feel like talking about the same problems you are facing with your son. Restrain your self from doing so. But you can share general experience like waiting for bus, minor accidents, strange experience etc.

10. **No favours :** Do not get some work done or get help from the client during the period of counseling. Do not ask for any favours. Do not have any monetary transactions with the person. These things will harm the relationship between you as a counselor and the person as a client. Do counseling as a service to the mankind. It will keep your morale high and command respect from everybody.

11. **Special precautions :** When you interact with young persons of opposite sex: if you are a male, when you have to interview / counsel a young female, it is safer to have another female person along with you. If you are a young female, when you counsel adult male persons, it is safer for you to have another person along with you. A volunteer is not legally protected. So your actions, relationships should be within normal social constraints.

12. **Positive and Negative Transference :** While you are counseling a person, consciously or unconsciously you may start liking or disliking that person. He may resemble your sibling or your child and you may show love or hatred towards him. Similarly the person you are counseling may develop similar feelings towards you. You have to be vigilant and identify these positive or negative emotions (which are called as 'Transferences'} and get rid of them. You must maintain 'Neutral relationship with the person. You should not get emotionally involved with the person.

13. **Recording :** Make it a habit to write down the summary of the sessions. Record the suggestions given by you and the tasks assigned to the person. Do this after the session and not during the session. Follow them up in the next session. With such documentation, you can review the progress made. You can correct the person if he misinterprets your suggestions . You will be able to remind him of his tasks. It will help you to correct your mistakes also.

14. **Preparation for termination :** Prepare the person for closing the counseling sessions. Tell the person in advance, when you are going to close the counseling process so that he can mentally prepare himself to continue his efforts to improve himself without your presence. Tell him to contact you in case he needs your help later or at any time in future.

11. WORKING WITH GROUPS: GROUP COUNSELLING:

'Group' could be defined as "a collection of individuals who have a relationship with one another, who are interdependent and may have common features or problems" Three or more persons are referred to as group.

As far as the students that could be taken up for the discussion in the group are concerned, Joe and Harry have given the following model. It is popularly called, "Joeharry Window":

	Know to self	Unknown to self
Known to others	I "open"	II "Blind"
Unknown to others	III "Hidden"	IV "Unknown, unconscious"

In the first quadrant, the individual as well as other group members know about the problem. They could easily discuss the issues in the group.

The second quadrant, the individual does not know about the problem where as other group members know about it. For example, the individual acts in an impulsive, manner in the group interaction. Unless the group members bring it for discussions, it could not be known to the concerned individual.

The third quadrant refers to certain secrets only known to the individual and the group is ignorant about it .Certain personal life events, failures or guilt feelings of the individual are examples a for 'hidden part', unless the individual shares with other members, it could not be discussed.

The fourth quadrant, neither the individual is aware of it nor the group members know about it. It is" unconscious" Unless the counselor is well trained in psychodynamics, such issues cannot be understood or discussed in the group. The college teacher counselor will not be able to discuss these issues in the group.

SPECIFIC ADVANTAGES OF GROUP METHODS :

1. It offers scope for learning effective social skills
2. It provides support to new / positive / healthy behaviour
3. A wide variety of experiences are shared and positive changes are facilitated
4. The individuals experience feeling of emotional closeness and caring.
5. Students psychosocial problems are dealt more economically compared to individual counselling.

6. Various studies have proved the effectiveness of group methods in dealing with the psychological and interpersonal difficulties of the clients in general and the adolescents in particular.

HOW COUNSELLING IN GROUP SITUATION IS HELPFUL ?

The participation in group, the communication that takes place in the group, guidance provided by the counselor and sharing of experience by the members of the group are effective in many ways. Some of the potentials of such group situations are as follows:

1. Seeing the progress of others in the group, a group member becomes, hopeful about receiving similar help and making progress

2. When a group member sees that others in the group share similar feelings or have similar problems, his anxiety is decreased.

3. Information on problem solving is shared among the group members.

4. The opportunity to support and to help others; Mutual supporting and helping occurs. This gives the helping individual increased self-esteem. It also encourages a preoccupied individual to become less self-discussed and to divert his attention.

5. The interaction that takes place in the group gives insight about individual's attitudes and behaviours.

6. The counselor or group leader or any group member who has already mastered a particular psychosocial skill or problem solving skill becomes a valuable role model.

7. The group offers opportunities for relating to other people on 'here-and-now' basis.

Considering such beneficial effects of group counseling, the teacher-counselor could follow some effective techniques as given below-

a) Provide a safe, comfortable atmosphere. Generally when people feel secure, they are able to participate more easily to self-disclosure.

b) As a general rule, focus on the 'here and now ' while some discussion of past events can be helpful. A client's obsession with them may be his or her way of avoiding current problems in living.

c) Use the communicational / international patterns of the group members as learning and self awareness development opportunities.

d) protect individual members from verbal abuse or from scapegoating.

e) Whenever appropriate, point out any change a group member has made for the better. Positive reinforcement provides ego-support and encourage future growth.

f) Handle sensitive matters or secrets revealed by the members in a manner that protects the self esteem of the individual but that also sets limits on the behaviour in order to protect the other group members.

g) Develop the ability to intuitively recognize when a group a member or a new member is 'fragile'. Chances are that the member is indeed in a precarious mental emotional state and should be approached in a gentle, supportive and non-threatening manner.

h) Use silence effectively, to encourage self responsibility within the group. Silence should not be allowed to continue when it is non-productive or when it becomes too threatening to the group members.

i) Laughter and a moderate amount of joking can act as a safety value and at times can contribute to group cohesiveness.

j) Role playing and role reversals can some time be useful. Short, modified, versions, they may help a member develop insight into the ways he or she relates to others.

k) Some techniques to promote group interaction:

i) Reflecting or rewarding comments of individual group members

ii) Asking for a group reaction to one member's statement.

iii)Pointing out any shared feelings within the group

iv) Summarising at various points within the session and at the end.

By experience, one will become not only competent in applying these principles and techniques but also become innovative in handling the problems of the students in group setting. Such group situations could also be used for promotive as well as preventive aspects in addition to an inteventive strategies in psychosocial problem situations in college campuses.

Group counselling helps to prevent many problems and also to cope with any type of problems we encounter in course of our life.

12. CODE OF ETHICS FOR COUNSELLORS

As ethic is a standard of behaviour or a belief valued by an individual or group, it describes what ought to be, rather than what is a goal to which one aspires. These standards are learned through socialization, growth and experience. As such, they are not static, but evolve to reflect social change.

Groups such a professionals, can build a code of ethics. Such a code guides the profession in serving and protecting consumers. It also provides a frame work for decision making the members of the profession. It aims to certain impulsive and unethical behaviour. It is also educative, with the goal of raising members ethical consciousness.

The teacher counselors should follow these ethical guidelines as they extend counselling services to students. Knowing one's own values and implementing them within the framework of the code can increase both the quality of the care one gives and the satisfaction the teacher counselor receives from his / her practice. It also gives him moral strength, support and protection.

Ethical guidelines : Please take the following oath:

1. I regard, as my important obligation, the development of students, which includes, action for improving psychosocial conditions.

2. I will not discriminate because of caste, colour, religion, age, sex or ancestry and in my job capacity will work to prevent and eliminate, such discrimination is rendering counselling services.

3. I shall give precedence to counselling responsibility over my personal interests. I will not use the client or his / her strength and weakness for my benefit

4. I hold myself responsible for the quality and extent of the services I perform.

5. I respect the privacy of the people I serve. I keep their information in strict confidence.

6. I shall use in a responsible manner information gained in counselling relationships.

6. I shall treat with respect the findings, views and actions of colleagues and use appropriate channels to express judgement on these matters.

8. I shall practise counselling within the recognised knowledge and competence

9. I shall recognise my responsibility to add my ideas and findings to the body of counselling knowledge of practice

10. I shall support the principle that professional practice requires professional education.

13. COUNSELLING SERVICES: SOME ORGANIZATIONAL ISSUES

Counseling refers to the process of enabling a person to explore his / her resources and make him / her to use the same to become a self directed and changed person. This results in the acualization of his / her potentials, which includes transcendence of his / her inherent and acquired capanbilities too (Romate and Bhogle, 2000). Counseling does not have a rigid pattern. It is highly flexible in the sense that it is malleable according to the needs of the counselee as much as with the perception of the problems by the respective counselor.

College counselors have greater responsibility in the area of guidance and counseling. They must become more aware of the threatening problems in their campuses. Now HIV / AIDS are threatening of the whole country and it is our responsibility to help our students not to become victims of such a dangerous virus. It is high time the counselors understood the need for updating counseling techniques for getting specialized or oriented in the new approaches in counseling, so that they can help the students become better citizens of tomorrow and remain healthy.

How do you arrange the counseling room?

A counselor should take much care to arrange the room though counseling can occur almost anywhere. The room should not be too small to make the client feel uncomfortable. There should be soft lighting and ensure that the light coming from the window should not fall on the face of the counselee directly. The wall should be painted with quiet colours and a comfortable chair should be provided. There should not be anything on the table except necessary things. Also there shouldn't be anything, which can distract or arouse emotions in the clients. It is always advisable to avoid a table between counselor and client. The table may be kept on the right or left side of the counselor conveniently. There is no research-based evidence in our country to help us decide the distance between counselor and counselee. So it can be decided on the basis of the gender difference and the nature of relationship, etc. A distance of 30-40 inches has been found to be the range of comfort between counselors and clients of both genders. It will be more comforting to the client if his / her chair is set at a 90 degree angle from the counsellor's so that the client can look either at the counselor or straight ahead.

How do you make clients understand the confidentiality of the counseling?

The counselor has to convince the client in the initial stage about how he can maintain confidentiality of clients' records. The confidentiality may be broken only in situations where the counselor needs to prevent another person from danger or to protect the client from any serious problem. It is often seen that in public gathering some counselors discuss clients' problems openly in such a way that the listeners can guess and identify the client. It should be strictly discouraged.

How do you ensure privacy for the counselee in your counseling center?

Counselling is a confidential process hence the counselor has to ensure adequate privacy for the client. First, as soon as a client enters your room you close the door; put a notice outside the door "Do not disturb" and make sure that nobody is standing or sitting near the door that can hear your conversation. It is always better if the telephone is turned off because the telephone calls would disturb both of them.

The counselor should check that people couldn't see the client from outside through the windows. So he has to make seating arrangement in such away that the counselee is not seen.

What are the precautions to be taken by the counselor while interacting with his clients?

Firstly, the counselor should be objective in his views and be aware of his personal bias ad prejudices. Secondly, he must keep in mind the 'halo error' – i.e., the tendency to be influenced by one's first impression of an individual or by an exceptional trait.

Do you think that counseling is an 'advice' process?

No. counseling is a process through which the counselors support clients in taking responsibility for their behaviour, decisions, and finally enable them to achieve autonomy.

How long can a counseling session be?

There cannot be any specific answer to this question. The duration depends on the nature of goals and outcomes, etc. Usually a session will be for 30 to 45 minutes for a client. The number of sessions usually may range from 5 to 10 spread over one or two sessions per week. Now the 'Brief counselling' and 'time limited' counseling techniques have become more popular. If the counselor wants to shorten the duration of his counseling session he can make use of the techniques mentioned above.

How does a counselor recognize that the client is not co-operating or showing resistance?

A counselor can easily recognize if the client talks only minimally and remains silent most of the time. Sometimes the responses of the client also indicate resistance, for e.g. preoccupation with past / future issues continuously, small talk, intellectual talk, symptom preoccupation, etc. The client also manipulates the way of communicating the information to the counselor by false promising (e.g. will do everything): limit setting (e.g. can't do more than this) last-minute disclosure, second-guessing, forgetting, externalization, thought censor, etc. It can also happen that the client violates some basic rules of counseling by poor appointment keeping, refusal, asking personal favour etc. These indications should prompt in the counselor to modify his approach style to effectively overcome the influence of these problems.

Is it advisable to keep relationship with clients outside the center?

It is not advisable to keep any personnel relationship with clients outside, when the counseling process is going on.

How do you respond to the 'crying' of clients during counseling?

Crying is common and may occur during some of the sessions. It must be taken as a normal behaviour and healthy way of letting out one's emotions. However do not disturb the counselee by showing false and exaggerated assurances or asking him/her to control. If the counselor gets affected by the clients' cry or influenced by such as act of the client it is suggested that the counselor should undergo a professional training.

Can a counselor offer refreshments to counselee?

It is not advisable to offer refreshments to the clients during counseling process. It maybe given either before or after the session. But if a client asks for water it should be made available.

Who can be a better or successful counselor or what are his / her qualities?

There are no standard criteria to find it out. However, Okun (1982) notes that "it is hard to separate the helper" personality characteristics from his /her levels and styles or functioning, as both are interrelated. He lists five important characteristics that she believes helpers on any level should possess: **self-awareness, honesty, congruence, ability to communicate, and knowledge**. Guy (1987) identified some of the character traits such as: ability to listen, comfort with conversation, introspection, capacity for self-denial, tolerance of intimacy, comfort with and ability to see the tragic / comic quality of life events.

Can some self-help books play the role of counselors

We find innumerable self-help books in shops for solving varieties of problems and developing skills. Some good books can foster the well-being of the readers and some books may mislead. Before reading such books I would suggest that one must find out the professional qualifications of the author and whether the techniques have been scientifically tested and proved effective. They must also check whether the books make exaggerated claims, or truly express the limitations of techniques, whether the techniques be periodically tested and experimented, etc. It is the readers who have to take the appropriate decisions before buying such books.

How effective is 'Telephone counseling'?

Telephone counseling is an emergency counseling method, and is necessitated by the distance. It calls for special skills and training, as it is to be supplemented by "face-to-face counseling" later. I have found Telephone 'Counseling' to be highly effective in most of the cases in providing immediate relief and guidance. Most of the time, it is a mode of guidance, and not a full-fledged counseling. We are working towards creating a full fledged website counseling package. It will be referred to as "website" counseling.

What aspect of counseling determines the value of counseling?

Is it its result or something else? Counseling should not be assessed by quantified result or instant change. The result is a by-product of counseling. More than these aspects, the "process" in counseling is very important. If the counselor focuses his energy and attention on the process, the outcome will be in the expected and positive way. It implies that the counselors should not struggle for "result" throughout the session. It is a spontaneous occurrence. Doubts and questions are endless. You are always welcome to write to us for further clarification also to use the telephone counseling approach .

REFERENCES

- Okun, B.F. (1982). Effective helping (2nd. Ed.). Montery, CA: brooks / Cole.
- Guy. J.D. (1987). The personal life of the psychotherapist.NY: Wiley.
- Romate, J.(1989) Development of psychological well-being: eastern and western approaches. Unpublished Doctoral Dissertation, Bangalore University, Bangalore.
- Romate, J. (2000). The school counsellor's role in changing scenario. In course book in practical psychology- Training and orientation; A two- day workshop for teacher tutors in practical psychology conducted by Psychotronics Bangalore from 26 & 27 Jan, 2000.
- Romate, J & Sudha Bhogle(2000) A need for training and Professinalizing Counseling psychology in India. A paper presented at the National Seminar on psychology 2000 conference on psychology in the 21st century- strategies for professionalization, Kerala University, Kerala from 7-10 March, 2000.

ACTIVITIES AND RESPONSIBILITIES OF TEACHER - COUNSELLORS

The teacher after undergoing training in students counseling may undertake the following activities which may help in establishing student counselling services in his / her college.

1. **Sensitize the principal, management and other teachers :** The teacher should talk to the principal regarding establishing student counselling services. Through the principal he should explain to the management and other teachers about the counselling and seek their support and cooperation. In this regard, a sensitization programme of one to three hours duration may be organized in the college. A mental health expert may be invited to give a talk and motivate everybody to take active part in organizing student counselling services.

2. **Identify a room or place as 'Students Guidence Centre :** A room or a place with basic facilities to interview the students and offer counselling services should be identified. This place should be easily approachable and have the required privacy, educational materials on health in general and metal health in particular.

3. **Organise talk, dialogue for students on psychological problems, mental health and need for counselling**

   The teacher should organize talks, dialogues, discussion for students in group of 100 to 200 so that different issues are discussed to increase the awareness of students about their psychological problems and their emotions. Mental health experts, doctors, educationalists and other concerned persons may be invited to carry on this activity.

4. **Organise group discussions on the following topics for the students in the class or in small groups at periodic intervals.**

   a. Good study habits.
   b. How to improve communication , learning and memory,
   c. How to prepare and face examinations.
   d. How to improve self-esteem.

e. Common health problems and how to prevent them.
f. Healthy life style.
g. Sexuality
h. How to manage negative emotions like anxiety, depression, anger.
i. How to say "No" to tobacco, alcohol and other drugs.
j. Healthy relaxation and recreation.
k. How to improve inter-personal relationship.

5. **Popular literature on health, mental health :** The teacher with the help of colleagues and students may collect all the popular literature published in news papers and periodicals on various aspects of health and mental health. They should be made available for reading. Book and video-materials on these subjects should be bought and kept in the college library or in student guidance centre for students use.

5. **Individual counselling services :** The students having psychological problems should be encouraged to come for individual counselling. All the teachers and students should be involved in this process. The required confidentiality and ethical norms should be adhered to.

6. **Debate and essay competitions :** Debate and essay competitions on health topics and students problems may be organized in each college,

7. **Parents' involvement :** Parents should be encouraged and motivated to come to the college so that they are aware of students problems and help in solving them.

8. **Record keeping and documentation :** The teacher should do record keeping of the various activities done, document it for sharing his her experiences with others.

10. **Start college counselors forum in your place, invite all the trained teacher counselors to meet once a month. In such meetings present the students problems and discuss about their management. Discuss the difficulties faced. There can be a topic discussion on health and for mental health issues. Experts may be invited to give lectures or answer questions. This forum acts like self supporting, and self learning group.**

APPENDIX

1. Form to be filled by the Teacher trainee on the first day.
2. General Health Questionnaire designed by Prof. DAVID P. GOLDBERG. This questionnaire will identify a teacher trainee who has emotional disturbance.
3. Pretraining assessment of the trainee regarding his approach to students' common problems. It is administered in the I session.
4. Post training assessment of the trainee. The responses my reflect the knowledge and change in the approach of the teacher at the end of the training programme. This has to be administered in the last session.
5. Time – table of the programme.
6. Assessment sheet which should be given to the trainees. The feed back can be discussed every day or twice a week.
7. The proforma to be used to collect information about the student client.
8. Simple record to be maintained by the teacher.
9. Model of the register to be maintained by the Teacher counselor.

APPENDIX – 1

COLLEGE TEACHERS TRAINING PROGRAMME IN STUDENTS COUNSELLING.

Name: Sri/. Smt. ----------Date----------

Designation---------- Years of service ----------

Department ----------

College: ----------

Pin: ----------

Phone No. ----------

Residential Address with phone No.

---------- Pin: ----------

Signature

APPENDIX 2

Name…….

GENERAL HEALTH QUESTIONNAIRE

Please read this carefully:

We should like to know if you have had any medical complaints and how your health has been in general, over the past few weeks. Please answer all the questions on the following pages simply by underlining answer which you think most nearly applies to you. Remember that we want to know about present and the recent complaints, not those that you had in the past.
It is important that you try to answer all the questions.
Thank you very much for your co-operation.

Have you recently:		Score 0	0	1	1
A1	Been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
A2	Been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual
A3	Been feeling run down and out of sorts?	-"-	-"-	-"-	-"-
A4	Felt that you are ill?	-"-	-"-	-"-	-"-
A5	Been getting any pains in your head?	-"-	-"-	-"-	-"-
A6	Been getting a feeling of tightness or pressure in your head?	-"-	-"-	-"-	-"-
A7	Been having or cold spells?	-"-	-"-	-"-	-"-
B1	Lost much sleep over worry?	-"-	-"-	-"-	-"-
B2	Have difficulty in staying asleep once you are off?	-"-	-"-	-"-	-"-
B3	Felt constantly under strain?	-"-	-"-	-"-	-"-
B4	Been getting edgy and bad-tempered?	-"-	-"-	-"-	-"-
B 5	Been getting scared or panicky for no good reason?	-"-	-"-	-"-	-"-
B6	Found everything getting on top of you?	-"-	-"-	-"-	-"-
B7	Been feeling nervous and strung up all the time?	-"-	-"-	-"-	-"-

C1	Been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
C2	Been taking longer over the things you do?	Quicker than usual	-"-	Longer than usual	Much longer less well
C3	Felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
C4	Been satisfied with the way you've carried out your task?	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied
C5	Felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less capable
C6	Felt capable of making decisions about things?	-"-	-"-	-"-	Much less than usual
C7	Been able to enjoy your normal day-to-day activities?	-"-	-"-	-"-	-"-
D1	Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
D2	Felt that life is entirely hopeless?	-"-	-"-	-"-	-"-
D3	Felt that life is not worth living?	-"-	-"-	-"-	-"-
D4	Thought of possibility that you might make away with yourself?	Definitely not	I don't think so	Has crossed my mind	Definitely have
D5	Found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
D6	Found yourself wishing you were dead and away from it all?	-"-	-"-	-"-	-"-
D7	Found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely has

SCORE TOTAL

APPENDIX – 3

Date: ……

Name ……College……..

Teachers Training Programme in students counseling: PRE-TRAINING ASSESSMENT

Dear Teacher

Write briefly how you have managed / you would like to manage the following problems which are commonly seen in students

1. A student with severe feelings of inferiority

2. A student with fear of examination

3. A student who has failed in the examination

4. A student who is very depressed because of family problems

5. A young man who is worried about his habit of masturbation or about semen loss.

6. A student who is exhibiting 'bad behaviour' like disobeying, misbehaving with classmates.

APPENDIX – 4

Teachers Training In Students Counselling:
Post Training Assessment

Date: ……..

Name …… College ……

1. A student who has started taking alcohol

2. A student who is staying in the hostel has become ‘Home-sick’.

3. A student who has lost his parent recently.

4. A student who has made an attempt to commit suicide

5. A student who thinks that he / she is in love with a person and who is preoccupied with the idea of marrying that person

6. A student who has become the victim of ragging

Appendix 5

TRAINING IN STUDENTS COUNSELLING FOR COLLEGE TEACHERS

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Time Table

Day	F.N. 9.30 to 1.00 pm with coffee break	A.N. 2 to 5 p.m. with coffee break
I day	Reporting Pre-training assessment. Distribution of teaching and reading materials. Self-introduction objectives of the training programme. Discussion of Time-table and norms of the training.-	Group Discussions. 1. Academic problems 2. Problems of boys-girls students. 3. Problems of Rural and urban students 4. Problems of hostilities and who live away from parents.
II day	Understanding human behaviour Bio-psycho-social aspects of adolescence. Adolescent sexuality	Emotional and other mental health problems of adolescents. Discussion on GHQ.
III day	Intelligence, Learning, Memory. Management of academic problems including exam fear.	Prevention and management of substance use/abuse, suicide, aggression and anti-social behaviours.
IV day	Principles and techniques of counseling. Interviewing skills	Role play or Demonstration of live 'cases'
V day	Life skills education	Principles & Techniques of stress management: relaxation exercises
VI day	Ethical and legal issues of counseling. Qualities of a good counsellor. Documentation, record keeping and reporting.	Post training assessment Feed back and discussion Organising counselling services in the college Valedictory function

Appendix-6

SIX DAYS TRAINING COURSE IN STUDENTS COUNSELING FOR COLLEGE TEACHERS OF DEPARTMENT OF COLLEGIATE EDUCATION ASSESSMENT AND FEED BACK

Name of the Teacher:

Sl.No.	Topic	Time allotted	Presentation	Usefulness
1		A= Adequate B= More C= Less	A=Very Good B= Good C= Average D= Not satisfactory	A= Useful B= Average C= Not useful and may be deleted
2	Factors disorders and mental health problems			
3	Emotional disorders and mental health problems			
4	Aggression suicide, substance abuse			
5	Learning and memory exam			
6	Counseling			
7	Role play			
8	Life skills			
9	Stress management and positive mental health			
10	Ethical issues / documentation organizing counseling services			

Comments regarding:

1. Venue of training programme:
2. Food
3. Resource Persons
4. Training Course
5. Reading Materials

Any other suggestion

Signature

APPENDIX – 7

No……..Date…….……College……..Confidential

STUDENT COUNSELLING SERVICES

Part A: Basic information about the student (to be filled by student)

Name:…….Age:……..……..years

Sex: Male / Female. Living with parents / guardians / Hostel / Other

Address:……

Course……..Class……
What is the Problem?

a) related t studies,	b) classmates / friends,	c) teachers	d) family
e) finance,	f) self,	g) health	I) _____

When & How it started?
Problem: increasing / decreasing / same / fluctuating.
Total duration of the problem?
What are the causative factors / Who are causing the problem?
What the student has done to solve the problem?
To what extent problems are causing distress in the following areas. Please make a tick, mark in the appropriate column.

Area	Mild distress	Moderate	Severe distress
1 Studies 2 Examinations 3 Relationship with classmates 4 Relationship with teachers 5 Relationship with family 6 Health 7 Financial 8 Sexual 9 Future 10 Any other Specify			

What type of help expected from the counselors?
Details of the family and college life:

1. Father : Alive / dead

Living with the family / stays most of the time away

Age …….Yrs…….Education…….

He is strict / fearful / helpful / kind

He cares / does not care for family

Alcohol: No / uses occasionally / use excessively

2. Mother : Alive / dead

Age ……Yrs…….Education……...

Housewife / Working lady……...

She is caring / not caring …….

Relationship with mother and father: Good / not satisfactory
Father and mother living separately / divorced / and how long?

3. No. of brothers : Elder……Younger …….

Sisters : Elder……Younger……..

Relationship with brothers / sisters / Good: Not Satisfactory

4. Who are the other family members staying with the family for last one year?

……

5. If the student is living with guardians / hostel / room details:

Stay: Comfortable / not comfortable

6. Financial condition of the family:
Good / Not Satisfactory / Serious problems.

7.Details about the course / college life

a) Course is student's choice,
parent's choice,
others's choice

b) Interest in the course: Present / absent
c) Any specific difficulties / problems in studies / exam
d) Relationship with classmates: Good /Not satisfactory / strained
e) Relationship with teachers: Good / Not satisfactory / Strained:
f) Any specific administrative problems in the college
Details:

g) Any difficulty to continue the course?

8. Health problems: a) Any major illness? Details

b) any treatment being taken now? Details.

c) In the last one month any moderate / severe problem in the following areas:

i) Sleep: Difficulty to get sleep / disturbed sleep / normal
ii) Appetite: Absent / less / normal
iii) Energy to carry on daily activities: Absent / less / normal

9. Do you have any worry / difficulties in the following areas of Sexuality

a) Masturbation
b) Semen-loss during sleep / urination (for boys)
c) White discharge
d) Menstrual cycle / flow
e) Any other problem in Sex? Details

10. Habits / hobbies: Do you have interest and spend time in the following activities.

a) Sports or other physical activities : Daily / occasionally / No
b) Fine arts like music / dance / painting /drama : Daily / occasionally / No
c) Literature: Reading / Writing : Daily / occasionally / No
d) Yoga / Meditation / Breathing Exercises : Daily / occasionally / No
e) Smoking : Daily / occasionally / No
f) Alcohol / Drugs / Both : Daily / occasionally / No

11. Can you describe what type of person you are (Encircle the features)
Shy, Sensitive, Active, Enthusiastic, Outgoing; Fun Loving, Serious, Hardworking, Short tempered, Easily get provoked to quarrel / Fight, Easy-going, Punctual, Disciplined, High moral values Rebel, Fearful, Rigid and unable to change, Optimistic, Pessimistic, Inability to trust others.

12. By putting a dot, please tell where do you stand in the Superiority- Inferiority Scale. Superiority_____Inferiority. If you place towards inferiority side, why do you think you are inferior?

13. This section is to be filled by the Counsellor:
    1. Who referred the student
    2. Why he was referred (problems)
    3. What is expected from counselor
    4. Is there an informant? Who? What is his / her version of the problem?
    5. Any other information available like Anti Social / Anti moral behaviours Details.

After interviewing him, what are your impressions,

- He is having understandable problems or
  His problems are vague. Need clarification
- He is having problems in the following areas. Mention severity by using plus marks.
  +++ Severe, need urgent attention
  ++ Moderately severe
  + Mild

1. Self image
2. Studies / course
3. Examination / related
4. Classmates / Collegemates
5. Teachers
6. Family
7. Finance
8. Health: Physical
   Mental
   Sexual
9. Habits
10. Other (Specify)

ACTION TO BE TAKEN:

1. Refer the student to: _____
2. Call and involve the family members
3. Call and involve the friends
4. Involve the teachers
5. Accepted for Counselling
6. No action required.

Remarks:

APPENDIX – 8

STUDENTS COUNSELLING CENTRE: CASE SHEET

No……COLLEGE……..DATE……..

NAME OF THE STUDENT……

AGE……Yrs. Sex M/F Course of class…….

Living with Parents / relatives / hostel / alone / friends

Social Class : Low / Middle / Upper

Education of Father…….Mother……

Referred by Teacher / Principal / Self / Others

Problem:

1. Difficulties in Studies
2. Exam Fear / Failure
3. Inferiority Feelings
4. Sadness
5. Excess Fear / anxiety
6. Anger / Irritability
7. Worries about feature / career
8. Disturbed relationship with parents
9. Disturbed relationship with Teachers
10. Disciplinary problems in college
11. Disturbed peer group relationship
12. Problems with boy / girl friend
13. Sexual problems
14. Financial problems
15. Tobacco / Alcohol use
16. Health problems
17. Suicidal thought / attempt
18. Others

Description:

Teacher's Impression: _____
Action Taken: Refer / Counselling Signature

APPENDIX – 9

REGISTER

Students Counseling Programme: College……

Register and Reporting Form: Counsellor's Name:……..

No.	Name of the student	Age	Sex	Class	Main Problem/Problem area	Date of Regn.	No. of Sessions	If referred to whom