ARTS THERAPIES AND THE MENTAL HEALTH OF CHILDREN AND YOUNG PEOPLE

Contemporary Research, Theory, and Practice, Volume 2

EDITED BY UWE HERRMANN, MARGARET HILLS DE ZÁRATE, HEATHER M. HUNTER, AND SALVO PITRUZZELLA

ICRA
INTERNATIONAL CENTRE FOR RESEARCH IN ARTS THERAPIES

ECArTE
EUROPEAN CONSORTIUM FOR ARTS THERAPIES EDUCATION

International Research in the Arts Therapies

Chapter 7

Arts therapies and psychoeducation for adolescents in India

Project Reflect

Preetha Ramasubramanian and Anshuma Kshetrapal

Introduction

While training in the UK, both authors experienced a fixed and reliable context. The various guidelines and ethics compliance documents were support systems that they could refer to when needed. However, returning to India, they found that there was no licensure board for Arts Therapists and no culturally relevant ethics documents that could guide them. There was also a lack of supervision, follow-up to check the effectiveness of training of primary care workers in mental health, funding, and resources. These factors posed a challenge to integrating classical mental health services with health care in any setting (Mahajan et al., 2019).

During a conference presentation in 2016, both authors found themselves discussing similar experiences and ethical dilemmas. Their struggle to maintain their ethical position brought them together despite their cultural differences, as Anshuma is from North India and Preetha from South India. They both felt unsupported systemically and over several meetings, they realised that they had taken similar routes to adapt to their cultural contexts and constraints. Thus began a journey of peer supervision and discussions around developing an ecosystem through endeavours best suited to develop the field of Arts Therapies in India. Project Reflect was the first of such endeavours. Since both authors worked in systems that produced common issues, they identified the necessity for a psychoeducational project adaptable to any system.

Adolescents' mental health in India

India is home to the largest number of adolescents in the world, comprising about a fifth of its population. According to the National Mental Health Survey of India, the prevalence of psychiatric disorders amongst adolescents is around 7.3% (Murthy, 2007). However, mental health difficulties remain one of the most neglected issues among adolescents in India, resulting in

DOI: 10.4324/9781003265610-8

increasing mortality and morbidity due to mental disorders at an alarming rate (Sivagurunathan et al., 2015).

Alongside the common issues rampant during this period of change, Indian adolescents face an abject lack of access to and availability of health care services. This situation extends to a lack of accurate information, proper guidance, and skills, as well as insufficient healthcare delivery systems and services, all of which are major barriers to adolescent mental health (Sivagurunathan et al., 2015).

According to World Health Organisation's (WHO) guidelines, one of the core principles of the Child and Adolescent Mental Health policy in India should be that the environment within and outside their residence and school be 'friendly' for optimum development (Hossain and Purohit, 2019) which, we suggest, includes taking an intersectional and psychosocial approach to mental health. However, given the country's vast diversity, this is challenging. Therefore, mental health workers aiming to practice with this population must be well-versed in the nuances of adolescent issues related to culture, family structures, financial background, language, and caste systems.

Another layer of difficulty in approaching this work is the social attitude formed due to the lack of information and infrastructure around mental health. In 2018, a study yielded a few important insights about the lack of mental health literacy in adolescent girls in India. It stated that in being unable to identify and label the problems as psychological or psychiatric conditions, sources of help for mental health problems become 'friends and parents, which begets inadequate knowledge about mental health services and treatments' (Saraf et al., 2018. p. 437). Adding to this is an allocentric culture that encourages adolescents to keep their issues to themselves or share them only with family members, further perpetuating stigma and impeding access to adequate mental health resources. As a result, there is an acute lack of awareness of mental health problems in Indian adolescents, and individuals with difficulties constantly express fear, shame, and sadness (Gaiha et al., 2020). This systematic review paper highlights the need for integrating mental health education into mainstream education by building awareness and sensitising youth through culturally appropriate methods.

Drawing on personal experience, we are aware of the efforts made by family members to keep their kin with mental health issues quiet. While these practices seem to be changing very slowly, the lack of psychoeducation has meant shame and malaise remain rampant. Through the National Health Mission in 2014, the government of India introduced school-based short programmes to improve adolescents' overall health. However, its inadequacy is manifested when addressing the mental health epidemic in the adolescent population (Hossain and Purohit, 2019).

Another need for intervention has emerged following the 'Right to Education (RTE) Act' (2009), which states that 'every child has a right to full-time elementary education of satisfactory and equitable quality in a formal

school' This web site is referenced fully in the reference list. An abbreviated reference, for example: (Department of School and Literacy, 2009) might be more appropriate here within the text. This means that children from lower economic backgrounds are attending private schools. Nevertheless, the RTE Act does not provide due process for integrating them. Introducing such diversity without a supportive structure has left room for inequity. The resulting inequality vis-a-vis identity politics in classrooms has increased peer bullying (Malik and Mehta, 2016). The disparity between the rich and the poor has always played a huge role in inequalities in education in India, with most opportunities cushioned in the urban cities. On the other hand, children from rural areas and socially disadvantaged groups such as Scheduled Castes (SC), Scheduled Tribes, and Other Backward Classes (OBC) do not receive an equal number of opportunities in the educational system to succeed or realise their abilities, despite numerous governmental programmes aimed at reducing the gap between various socioeconomic categories (Bana, 2019).

The most current and prevalent mental health work in schools targets 'problematic' children. Therefore, counselling in schools is also viewed as a punitive rather than supportive measure. The lack of information also permeates the referral system and the counselling space, which is used to 'discipline' students. In contrast, the systemic issues that emerge in the classroom are not given enough attention unless they disrupt the class order. However, we believe the issue lies in inadequate measures for resolving underlying, fundamental, and pervasive issues. As Langs (1998) affirms, the framework within which the therapeutic context is set informs the practice itself as 'all the conditions of the context affect the status and operations of all the elements and the entities within the confines of the framework' (p. 3, 2019). This describes how the working alliance of the client – therapist dyad is affected by the cultural and political context, timeline, education systems, and what is considered acceptable social behaviour impacting both the client and the therapist.

The ensuing anonymised case vignettes exemplifies the many incidents that led the authors to develop Project Reflect.

CASE VIGNETTE 1 Psychoeducation and Morality

Anshuma: How are you feeling?

Chandan: I don't know. How does a person usually know how they are feeling?

Anshuma: Sometimes, our body can reveal how we are feeling. But sometimes it doesn't because we aren't feeling safe.

Chandan: Safe? What does that mean?

Chandan ran away from home when he was 14 years old. Growing up in a community of sex workers, he did not have the privilege of being child-like for very long. Finally, fed up with experiences of being beaten, bullied, and feeling that neither home or school was a safe environment, Chandan decided to risk venturing out into the world himself. 'How much more unsafe can it be out there?' he asked the friend who helped him plan his escape. However, within two weeks, he returned.

When the school nurse examined him, he had several unexplained scratches and bruises. He could not recount many parts of his experience. Unable to give the authorities any details of where he had been or what had happened, Chandan would only cry inconsolably anytime someone asked him where he had been. To date, no one knows these details.

Unfortunately, this case was not unusual. Chandran's school was part of a government initiative lòcated on the outskirts of Delhi, in north India. It was specifically set up for the children of migrant workers, sex workers, and other poverty-stricken individuals and families who had built a slum community in this area. At first, the government tried to give them housing elsewhere, but they refused to move because they remained tied to their work, which was only possible at the fringes of urban society. While the government gave them aid and support systems such as schools, electricity, and healthcare options, the community remained rife with violence, drug-related issues, and crime. The authorities either looked the other way or blamed them for 'choosing' this life. A study on home-based sex workers and their children in India has shown them to be a 'highly vulnerable' population due to their poverty and exposure to high-risk sex and sexual violence. Safe spaces or care services from the public sector also remain inaccessible due to the illegality of their work in India (Hennink and Cunningham, 2011).

Children like Chandran were sent to school at the insistence of the social workers, albeit irregularly. For most parents, the school was considered valuable only as a place to safely remove the child from the home environment for the day. Conversely, schooling was seen by the authorities as an opportunity to teach the children the morals and values that their parents had not. The value systems of these two spaces were vastly different, and the children were expected to negotiate the gap. Instead, it led to confusion and feelings of alienation from both spaces. Violence and strife were the norms at home, while the school propounded sermons and prayer verses insisting on peace and non-violence written in big red letters all over the walls. Morning and evening prayers aside, the children also had to attend compulsory moral science classes and received frequent reprimands and detentions for their problematic behaviour.

At this time, Chandan was in class 8. As the son of one of the sex workers from the slum community, he was considered to be at the bottom of the social hierarchy and would often get bullied. He did not have access to his own space at home since his one-room 'kaccha' home (temporary structure) was also his mother's workspace, and he would often spend entire days and

portions of the night out with other children or in the homes of neighbours. At school, he was quiet. In his few interactions with Anshuma, in her role as a part-time school counsellor and Drama and Movement Therapist, he would only state that both the home and the school made him feel like he was 'Nalayak' (not good enough).

Running away was a common occurrence amongst the school's students. However, Chandan's injuries, which included broken ribs, a concussion and suspected sexual assault, alarmed the school authorities. They decided to investigate the events, and Anshuma was also consulted to understand the necessary next steps as part of the measures undertaken. She proposed individual work and trauma-informed intervention for Chandan to establish a dynamic process that could include legal options, for example, alternative housing, if and when required. Alongside this individual intervention, she suggested a group process space where the students could express their feelings about the event. She also asked the school leadership, staff, and administrators to consider meeting the students to understand how to support them further. However, this latter proposal was deemed 'unnecessary'. The individual sessions were given the go-ahead, but instead of a group process space, a collection of students (including Chandan) considered to be 'difficult' or 'most likely at risk for being runways' were gathered, and Anshuma was asked to 'fix the problem'.

She understood that what was being called 'difficult' or even 'delinquent', was perhaps just confusion expressing itself through violence or escape. Given the lack of an enabling environment for age-appropriate social or emotional skill-building, the students were punished for 'acting out' because the overworked staff could not find time or space or had the skills to offer psychoeducational input. No one could focus on the larger, underlying issues in this volatile environment. Anshuma had to navigate the ethical dilemma of complying with the school authorities yet remaining true to the ethics of process-oriented, client-centred arts therapies.

CASE VIGNETTE 2 *Psychoeducation and Privilege*

'I haven't read the Harry Potter books Abi, why don't you come out of the toilet and explain it?' Preetha said. Abi came out of the school toilet holding a blade in her hand, as she had self-harmed, again. She had been in therapy with Preetha for three years and had co-created safety measures, but it did not help her this time due to the intensity of her experience.

Initially, Abi arrived as a 'self-referral', saying she wanted to talk about her dynamics with her friends and use the space for self-exploration, as she struggled with extreme anxiety and recurrent panic attacks. She came from

an affluent family who were always forthcoming when discussing Abi's struggles. Abi proactively engaged in therapy and was open to using creative arts therapies and exploring aspects of the body and gentle movement to regulate her emotions. She would bring in interesting metaphors, and her self-awareness and general outlook on mental health were quite expansive.

After Abi was coaxed out and given the necessary medical attention, the task was to talk to the class who had witnessed the entire incident. In this private school, they had a holistic vision of supporting children's overall well-being. The conjunction of management, staff, parents, and the children were quite strong, so they could always communicate and refer the child for mental health support. Though the school's major population falls into the upper-middle-class category, with the Right To Education (RTE) Act (2009, the school had a required percentage of students categorised under full scholarship from the lower-income group. Access to mental health support was for everyone.

As the predominant feelings of the class who had witnessed the incident were sadness, anger, confusion, guilt, helplessness, and fear, a whole class psychological intervention was designed to help the class process what they had witnessed, address mental health, focus on self-harm, and process these feelings using the arts. Since the probability of self-harm increases when children hear or witness others' self-harm (Fisher et al., 2012), it became crucial to check in on a few students individually and bring it back to the entire class to reflect on relevant mental health issues and topics. Using Arts Therapies helped create aesthetic distance in exploring safety, boundaries, empathy, and mental health.

The school's administration realised the need to compile a safety document focusing on self-harm. Though the Rashtriya Kishor Swasthya Karyakram (National Adolescent Health Programme) in 2014 under the Ministry of Health and Family Welfare had launched a programme ensuring holistic development of the adolescent population, the specifics of safety when addressing issues of mental health and self-harm had been overlooked. However, without much reference material and limited access to supervision, Preetha had to negotiate with the school, parents, peers, and students to make a culturally relevant self-harm protocol document. This solitary endeavour made it even more crucial for her to proactively seek collaborations from like-minded professionals in the field in India.

Though both authors worked in different economic, geographical, cultural systems, they realised the need for customisable psychoeducational projects. Project Reflect was the first of such endeavours.

The mental health of adolescents in India and the birth of Project Reflect

Many schools and institutions in India that did not earlier implement culturally relevant practices and ethical guidelines now give time and space to

trained Mental Health First-Aid Professionals to develop interventions and best practices. However, we have observed that the norm in educational institutions for adolescents in India is that the authorities cannot specify a function for MHPs. As a result, these professionals sometimes become part of the disciplinary system or are used as substitute teachers due to the paucity of opportunity and lack of role clarity.

According to the Mental Health Atlas report by WHO (2017), there are 1.93 mental health workers for every 10,0000 of the general population of India, a situation which puts a tremendous strain on the Indian healthcare system, which in turn is unable to address the prevention of mental health issues (Singh, 2020). In addition, the scarcity of MHPs and the lack of a supportive infrastructure means these professionals have had to create community-based mental health programmes with a psychosocial approach. The reality is that there is inequality of access which means that while an urban Indian may have access to the 1.93 mental health workers, an individual from a rural part of the country does not. Barriers to implementation were identified as travel distance to receive care, limited knowledge about mental health, high level of stigma related to mental health issues, and poor mobile network signals and connectivity in the villages. Furthermore, a lack of familiarity with and access to mobile phones, especially among women, constitutes an obstacle to accessing health-related messages as part of the intervention (Tewari et al., 2021).

A research study in South Africa reveals a similar paucity of public sector mental health resources. It shows that participants of a psychoeducational mental health and well-being programme unanimously agreed to the importance of such a programme in their schools. Staff and school counsellors felt that the programme supported the behavioural and mental health issues of children whose families do not have the means to help their children with such services (Coetzee et al., 2021). Similarly, classroom-based psychoeducational programmes have contributed towards psychosocial and emotional development (Fazel et al., 2009). As arts therapies are non-threatening, have a playful approach, and normalise emotional expression, they enhance resilience, coping, self-esteem, and social behaviours that improve emotional and behaviour problems (Beauregard, 2014; Quinlan et al., 2016). One important feature of Project Reflect is that all children are positively engaged to promote inclusivity instead of addressing only children labelled ‘difficult’.

Considering this, Project Reflect was started primarily as a classroom-based psychoeducational programme. Nevertheless, individual work or small group therapy formats felt more culturally relevant as we worked on the ground. We also realised how important it was to involve all the stakeholders in the adolescents’ development (parents, teachers, students, and other staff). Therefore, alongside forming a research-based programme for the students, we also work with parents and teachers so that the programme can see long-term success. Studies show that school counselling programmes

need evidence-based practices and policies, which can be achieved with more training and competence-building initiatives for school counsellors and teachers, which would in turn, improve their services (Vaishnavi and Kumar, 2018).

Given India's diversity of cultural paradigms, each context required a different approach. Therefore, the project had to be versatile, personal, and accessible. The choice of arts was for their expressive possibilities and also because Arts Therapies share a commitment to using physical and emotional expression as a therapeutic technique, harnessing creative energy for healing of the mind body and spirit, and belief in the power of creative imagination to navigate through difficult problems and conflicts (McNiff, 2004).

Project Reflect was conceived to bring the therapeutic and reflective aspects of the arts into classrooms through a programme designed to engage emotional intelligence and encourage empathy, inclusivity, and sensitivity in young minds. The aim was to develop a culture of emotional well-being within schools by engaging with all the stakeholders, to understand the needs to be addressed and devise a psychoeducational programme that could be delivered in the classroom. The result was an approach based on the principles of the arts therapies (Art Therapy, Dance Therapy, Drama Therapy, and Music Therapy) which combines these modalities with psychological and psychotherapeutic principles. The programme was then designed in progressive segments carefully adapted to the needs of the environment.

Theoretical underpinnings of Project Reflect

Although our respective education as Creative Arts Therapists differed, we shared ethical positions and the theoretical framework through which we understood the adolescents' problems. We both work from a psychodynamic lens, viewing mental health difficulties from a developmental, attachment-based, and trauma-informed approach. Being culturally sensitive and rooted in experience, we based Project Reflect on flexible theoretical paradigms that allowed movement and agency according to the particular needs of the setting. Thus, it constitutes a customisable programme that works within the system rather than outside of it. However, this does not mean that all the system's stakeholders are on board, and the workshops and training programmes aim to instil a way of thinking about mental health rather than prescribing it.

We found Maslow's (1987) hierarchy of human needs relevant to our work. Maslow conceived of human needs as a pyramid, ranging from 'physiological' at the base, ascending through 'safety', 'belonging and love', 'social needs', and 'esteem', to 'self-actualisation' and 'transcendence' (Crandall et al., 2020). In order to arrive at the next stage, the preceding one should have been satisfied. By organising our plans around the client's needs, we placed value on the urgency of intervention during the needs analysis. For

instance, we included Mental Health First Aid (2017) as a part of our training so that students in distress could first be attended to, while the self-exploratory sessions came afterwards. Of course, not all students or schools opt for higher-order needs, so we specifically address other issues such as bullying. While doing so, we pay special attention to why the issue arose in this specific situation and the needs of this cultural context.

Thus, while psychoeducation is a model that encompasses some didactic elements, it also requires the practitioner to hold space for emotional and psychological aspects that get challenged or arise during the process. The structure that we proposed had a strong base in the arts therapies, including Chace's approach of structuring sessions in Dance Movement Psychotherapy (cited in Sandel, 1993); additionally, being observant of the body and movement using Laban movement analysis (North, 1990) was helpful to understand non-verbal cues. We also drew upon trauma-informed expressive arts therapy (Field, 2016) in response to a presented need. Furthermore, an integrated psychodynamic and humanistic framework, alongside Erik Erikson's psychosocial stages of development (1968), informed our facilitation of group work that addressed issues young people faced in schools and other environments.

Yalom's principles of group therapy (2008) have informed how we facilitate interpersonal learning within the group to make it even more context-specific and less dependent on the facilitator. For example, in Yalom's therapeutic principles, interpersonal learning amongst group members is a key therapeutic factor, as is the 'recapitulation of the family unit', which addresses interpersonal conflict and reflects familial and attachment-related conflict (Bowlby, 1984). In addition, giving space for individual work and allowing the students to engage in more personalised models of therapeutic drama, such as psychodrama (Moreno and Fox, 1987) and Developmental Transformations (Johnson, 2009), felt important and enabled empathy and insight, which sparked important psychoeducation topics as well as more contextually relevant group work.

Whilst the holding environment (Winnicott, 1953) allows expression, dialectical discussions, and processing through verbal and arts-based modalities, the overarching Project Reflect framework serves as a container for our trained counsellors and teachers (Bion, 2013). As their engagement with the students is continuous, we support them with tools that they can build upon and sustain as arts-based support for the students. When all of this goes hand in hand with psychoeducation around emotional regulation, adapting to physical changes in adolescence and to psychosexual developments, and dealing with anxiety, the student receives a well-rounded and holistic experience of personalised mental health care.

Erikson (1978) stressed that spontaneous, improvised play begins in the body. This experimental aspect of play transformed into symbolic acts helps develop relationships and social impulses (Piaget, 1998). Bringing play into

the classrooms through the therapeutic impact of art forms, we also needed this model to be adaptable. Therefore, we decided that the ethos of Project Reflect will be strongly based on a need-based, flexible programme that school counsellors and class teachers on the ground could deliver. The framework would accommodate the 'here and now' of issues faced whilst providing a loose structure that could allow mental health education to be available in response to students' needs. The loose structure was also mindfully introduced to enhance the facilitator's innate ability to be creative and spontaneous and adapt to situations that might develop during the session. One such situation arose when a co-ed school reached out, saying there was a clear lack of engagement of their class 11 students (age 16) during class time. On observation and from in-depth discussions with the teachers, it was evident that the students were struggling with transitioning to college, anxiety around academic performance, and interpersonal challenges with their peers, which impacted their performance in learning and classroom presence. According to Erikson's developmental stage theory (1968), this is the stage referred to as 'identity versus role confusion' and an emphasis on adolescents forming their own identities as a result of their peer relationships (Rageliene, 2016).

Considering this, we planned whole class interventions addressing themes around mental health, transitions, performance pressure, emotional regulation, and interpersonal dynamics. We also addressed themes emerging from these topics, such as the upcoming end of school life, separations from friends, and worries about new beginnings. Again, we played the role of consultants. Arts Therapies approaches played a huge role in helping design sessions that the school counsellor and class teacher co-facilitated for the students in class. We noticed that though class interventions were planned, it was largely through the playfulness of the arts that children found it easier to engage, as processing their worries through the arts allowed them to verbalise their concerns rather than enact them in destructive behaviours and actions. As imitative behaviours play a vital role in group therapy formats (Yalom, 2008), the class started to model new acceptable behaviours from their peers and facilitators. Through supervision, we brought to the fore their challenging relational issues that helped the whole class move from old dysfunctional patterns to more empathetic and supportive ones.

Constant supervision with the on-ground staff and building a dynamic plan helped both the teacher and the counsellor to put certain strategies in place for emotional regulation. Though Project Reflect started as a short-term intervention programme, in some schools, it gradually became part of an expanding class curriculum. The project intended to embed mental health care's core values into the school system. However, once the school counsellors and teachers built this rapport and method of connecting with their students, they continued to evolve beyond our 'intervention' into a deep and resonant state of empathy. This evolution is apparent because even beyond

the project, they continue to build tools such as feeling wheels, games, and nuanced and complex expressive arts activities that allow their expression and engagement to continue. As a result, we are now only consulted if they face a step requiring supervision.

When the pandemic hit in March 2020, India had a full lockdown, with all schools closing and reopening as online schools. This measure impacted unprivileged children, as they could not afford electronic devices or internet use. When onsite teaching slowly resumed after a year, the learning gap between underprivileged children benefiting from the Right to Education Act (2009) and more affluent children became even more prominent. The pandemic highlighted adolescent mental health, as quarantine made meeting friends and attending school impossible. As a result, there has been a surge in children's symptoms of stress, anxiety, and depression due to excessive worry, feelings of helplessness, loneliness, and a sense of collective unhappiness (Gore et al., 2021). The governments of different Indian states recognised this and suggested that schools deliver short psychoeducational programmes. This situation made Project Reflect more accessible for adolescents who otherwise disengage with mental health topics, as we support school counsellors in designing courses relevant to this particular group.

Adapting to the context and building a secure frame for creative arts therapies

In a country and a context that felt 'unsupportive', Project Reflect provided an itinerant service and laid the building blocks of a support system. Navigating complex systems of culture and systemic issues was a humbling process, and it became clear that this project, or any other endeavour, needed to be collaborative. Also, the country's sheer diversity and vast geography required all interventions to be adaptive and independent of specific staff. A spirit of collaboration, cooperation, and collective passion for seeing the field grow led us to establish The Arts Therapists Co-Lab (TATC), which supports arts-based, psychoeducational, and therapeutically oriented mental health ventures in India. So far, we have collaborated with established institutions and offered master classes to MHPs, teachers, artists, and others working with clinical and subclinical populations.

Privileges and opportunities

In our quest for mental well-being in children and adolescents in India, we have found ourselves amid systemic, seismic changes and have become part of the change. Nevertheless, we must pause to reflect and recognise our privilege to affect that change and have a voice. We are aware of our positions as educated, upper-caste, English-speaking, upper-middle-class women

who could use our identities to express our minds. This reminder is important so that we do not perpetuate any discrimination but rather acknowledge our favourable position.

On returning to India as qualified practitioners, neither of us had envisioned that setting up our practice meant having to engage with establishing the field of work in the country. Most of us who have traversed the same path found no employment waiting upon our return, the very lack of available positions also constituted an opportunity. The scope of uncharted work in India meant that Project Reflect could access and collaborate across the country and its cultures to reach children and adolescents. The work ahead is both daunting and exciting as the field of Arts Therapies in India is in its adolescence. In conclusion, we hope to have initiated and piloted the beginnings of what could then grow into a field of practice that supports and sustains children and adolescents from all strata of Indian society. Project Reflect will stay committed to ethical client care, which the children and adolescents in India deserve.

References

Bana, A. (2019). *Socially Disadvantaged Groups and Poverty in India.* [Online] Law Corner. Available at: https://lawcorner.in/socially-disadvantaged-groups-and-poverty-in-india/

Beauregard, C. (2014). Effects of classroom-based creative expression programmes on children's well-being. *The Arts in Psychotherapy*, 41(3), pp. 269–277.

Bion, W. R. (2013). Attacks on linking. *The Psychoanalytic Quarterly*, 82(2), pp. 285–300.

Bowlby, J. (1984). *Attachment and loss* (2nd ed). Harmondsworth: Penguin.

Coetzee, B. J., Gericke, H., Human, S., Stallard, P., and Loades, M. (2021). What should a universal school-based psychoeducational programme support psychological well-being amongst children and young people in South Africa focus on, and how should it be delivered? A multi-stakeholder perspective. *School Mental Health*, 14, pp. 189–200. 10.1007/s12310-021-09465-3

Crandall, A. A., Powell, E. A., Bradford, G. C., Magnusson, B. M., Hanson, C. L., Barnes, M. D., Novilla, M. L. B., and Bean, R. A. (2020). Maslow's hierarchy of needs as a framework for understanding adolescent depressive symptoms over time. *Journal of Child and Family Studies*, 29(2), pp. 273–281.

Department of School and Literacy, The Right of Children to Free and Compulsory Education (RTE) Act. (2009). Available at: https://mhrd.gov.in/rte

Erikson, E. H. (1968). *Identity, youth, and crisis*. New York: W. W. Norton.

Erikson, E. H. (1978). *Toys and reasons: Stages in the ritualization of experience*. London: Boyars.

Fazel, M., Doll, H., and Stein, A. (2009). A school-based mental health intervention for refugee children: An exploratory study. *Clinical Child Psychology and Psychiatry*, 14(2), pp. 297–309.

Field, M. (2016). Empowering students in the trauma-informed classroom through expressive arts therapy. *Education*, 22(2), pp. 55–71.

Fisher, H. L., Moffitt, T. E., Houts, R. M., Belsky, D. W., Arseneault, L., and Caspi, A. (2012). Bullying victimisation and risk of self harm in early adolescence: Longitudinal cohort study. *BMJ*, 344(Apr 26 2), pp. e2683–e2683.

Gaiha, S. M., Taylor Salisbury, T., Koschorke, M., Raman, U., and Petticrew, M. (2020). Stigma associated with mental health problems among young people in India: A systematic review of magnitude, manifestations and recommendations. *BMC Psychiatry*, 20(1), pp. 538–538.

Gore, M., Swain, A., and Saraf, A. (2021). Has the COVID 19 pandemic exacerbated Indias mental health issues: A narrative review. *Annals of Medical and Health Sciences Research*, 11, pp. 114–118.

Hennink, M. M., and Cunningham, S. A. (2011). Health of home-based sex workers and their children in rural Andhra pradesh, India. *Asian Population Studies*, 7(2), pp. 157–173.

Hossain, M., and Purohit, N. (2019). Improving child and adolescent mental health in India: Status, services, policies, and way forward. *Indian Journal of Psychiatry*, 61(4), pp. 415–419.

Johnson, D. R. (2009). Developmental transformations: Towards the body as presence. *Current Approaches in Drama Therapy*, 2, pp. 65–88.

Langs, R. (1998). *Ground rules in psychotherapy and counselling*. Routledge.

Mahajan, P., Rajendran, P., Sunderamurthy, B., Keshavan, S., and Bazroy, J. (2019). Analyzing Indian mental health systems: Reflecting, learning, and working towards a better future. *Journal of Current Research in Scientific Medicine*, 5(1), p. 4.

Malik, A., and Mehta, M. (2016). Bullying among adolescents in an Indian school. *Psychological Studies*, 61(3), pp. 220–232.

Maslow, A. H. (1987). *Motivation and personality* (3rd ed). New York: Harper & Row.

McNiff, S. (2004). *Art heals: How creativity cures the soul*. Boston: Shambhala.

MHFA, Mental Health First Aid India (2017), (Online: Training Courses), Available at: https://www.mhfaindia.com/

Moreno, J. L., and Fox, J. (1987). *The essential Moreno: Writings on psychodrama, group method and sponteneity*. New York: Springer Publishing Company.

North, M. (1990). From personality assessment to dance education and therapy. *The Educational Forum*, 54(1), pp. 65–70.

Piaget, J. (1998). *Language and thought of the child: Selected works* (Vol. 5, 4th ed.). Taylor & Francis Group, Routledge.

Quinlan, R., Schweitzer, R. D., Khawaja, N., and Griffin, J. (2016). Evaluation of a school-based creative arts therapy program for adolescents from refugee backgrounds. *The Arts in Psychotherapy*, 47, pp. 72–78.

Rageliene, T. (2016). Links of adolescents identity development and relationship with peers: A systematic literature review. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, 25(2), pp. 97–105.

Sandel, S. L. (1993). Imagery in dance movement therapy groups: A developmental approach. In Marian Chace, Susan L. Sandel, and Sharon Chaiklin (Eds), *Foundation of Dance/Movement Therapy: The Life and Work of Marian Chace*. Amer Dance Therapy Association; First Edition, pp. 112–119.

www.nhp.gov.in. (2014). *Rashtriya Kishor Swasthya Karyakram (RKSK)/National Health Portal Of India*. [Online] Available at: https://www.nhp.gov.in/rashtriya-kishor-swasthya-karyakram-rksk_pg.

Saraf, G., Chandra, P. S., Desai, G., and Rao, G. N. (2018). What adolescent girls know about mental health: Findings from a mental health literacy survey from an urban slum setting in India. *Indian Journal of Psychological Medicine*, 40(5), pp. 433–439.

Singh, U. A. (2020). *Disentangling India's Mental Health Distress: Does India Have the Resources to Control the Impending Mental Health Crisis?* [Online] Research Matters. Available at: https://researchmatters.in/news/disentangling-india%E2%80%99s-mental-health-distress-does-india-have-resources-control-impending-mental

Sivagurunathan, C., Umadevi, R., Rama, R., and Gopalakrishnan, S. (2015). Adolescent health: Present status and its related programmes in India. Are we in the right direction? *Journal of Clinical and Diagnostic Research*, 9(3), pp. LE01–LE06.

Srinivasa Murthy, R. (2007). Mental health programme in the 11th five year plan. *Indian Journal of Medical Research*, 125(6), pp. 707–711.

Tewari, A., Kallakuri, S., Devarapalli, S., Peiris, D., Patel, A., and Maulik, P. K. (2021). SMART mental health project: Process evaluation to understand the barriers and facilitators for implementation of multifaceted intervention in rural India. *International Journal Mental Health Systems*, 15(1), p. 15. 10.1186/s13033-021-00438-2. PMID: 33557902; PMCID: PMC7871593.

Vaishnavi, J., and Kumar, A. (2018). Parental involvement in school counseling services: Challenges and experience of counselor. *Psychological Studies*, 63(4), pp. 359–364.

WHO. (2017). Mental health ATLAS 2017 member state profile. Available at: https://www.who.int/mental_health/evidence/atlas/profiles-2017/IND.pdf?ua=1

Winnicott, D. W. (1953). Transitional objects and transitional phenomena; a study of the first not-me possession. *The International Journal of Psychoanalysis*, 34, pp. 89–97.

Yalom, I. D., and Leszcz, M. (2008). *Theory and practice of group psychotherapy, fifth edition* (5th ed). New York: Basic Books.