Mental health of young people: Exploring the relationship between alienation from school, resilience, coping and spiritual health.

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The traditional definition of health as having physical, mental and social components will be extended by the delineation of the concept of spiritual health, a notion that unifies research based on the concepts of resilience, coping and alienation from school. These latter concepts involve both the individual and their environment. They are currently being used as indicators to unravel the complex area of measuring mental health of school students. Their combination into the one concept of spiritual health, might be more useful as an explanatory concept of mental health of young people, than the traditional interpretation of mental health which is more closely aligned to mental illness.

Research has identified a direct relationship between young people’s mental health and academic achievement. Utilising the concept of spiritual health may provide the opportunity to draw together separate areas of research in designing and evaluating comprehensive approaches to mental health promotion in secondary schools.


Introduction

Worldwide mental health and in particular depression have been identified as important determinants of the overall health status of a population (Murray and Lopez 1998). Globally, it is predicted that depression will move from its current status as the fourth cause of disability and premature death, to become the second by the year 2020. In relation to young people, our own NHMRC has estimated that in any 6 month period 40% of young people are suffering long periods of sadness or depression (NHMRC, 1997). The report titled 'The Health of Young Australians', endorsed by Australian Health Ministers, identifies youth suicide, health damaging behaviours and the alienation of young people as the 'new' public health problems confronting Australia (Zubrick et al, 1997). The Western Australian Child Health Survey (Zubrick et al, 1997) found that 8% of students in their sample were encountering stress levels which they described as "more than they could take". It is not surprising then, that the health sector in Australia have mental health as a major area of activity.

In the health sector then, the agenda is set, planning, research and interventions are increasing. In the areas of early intervention and prevention, schools are seen as an ideal entry point. Whilst educational environments are the target, as with other health promotion interventions in schools, the starting point of much activity is a disease perspective, that is, a focus on risk factors, rather than a health promotion and an educational perspective. This is
problematic. There is evidence of the importance for the education sector of mental health. Poor mental health has been linked to low academic achievement; higher truancy rates; higher rates of school suspension and expulsion (Zubrick et al, 1997). Issues such as bullying and harassment; and problems with life transitions can be linked to educational achievement and school retention (Olweus 1992), which in turn can be related to health damaging behaviours such as drug use and suicide attempts and completions (Raphael 1993). Protective factors such as resilience, coping and connectedness have been linked to better educational outcomes (Blum & Rinehart 1997; Resnick 1997).

There is confusion and complexity in the cross over between health and education research. Much previous mental health intervention research has separated out a range of risk and protective factors. What is now needed is a clear sense of direction for preventive interventions for whole school populations, that acknowledges the interaction of these factors, as well as the environment within which they occur. That is, a sense of coherence and connection between these factors and the school environment needs to be conceptualised, in order not only to convey to school personnel how their efforts will contribute to improved mental health for young people, but also to develop appropriate research designs and evaluation tools. It is only in this way that effective interventions will be devised.

Many years of trial and error in the field of drug abuse prevention have already taught us this. In school settings health behaviour change of students will not be brought about and sustained by focussing on changing one or two individual risk factors (Perry et al 1996) but by addressing a combination of risk and protective factors, their interaction and the organisational change that influences the factors. The challenge for researchers is to identify what combination in what setting. For school personnel the challenge is to develop coherence and structure in their multifactoral intervention strategies aimed at encouraging young people to be optimistic about their personal and educational futures.

Current confusion and debates in the area of school mental health promotion, particularly in relation to preventive interventions in schools, exist around the following themes:

- ideological positions of health and education researchers;
- problems of language and the focus of research - selective, indicated or universal;
- lack of conceptualisation of "school mental health promotion" that can be used to design and implement strategies in school settings;
- research evidence from selective and indicated mental health research which is then proposed for universal implementation;
- lack of attention to the impact of context in shaping interventions in schools; and
- lack of inclusion and valuing of practitioner involvement in action research as a legitimate implementation strategy.

These themes will be explored in this paper with the intention of identifying commonalities and unifying ideas that might inform future "universal" preventive activities.

**Ideological positions of health and education researchers**

Randomised controlled trials are the gold standard in health research (Hall 1994), (the equivalent in educational research would be an experimental research design). Where randomised controlled trials have not been used in school health interventions there have been difficulties in proving that positive outcomes were a result of the interventions. The remedy suggested was - more rigorous research designs (Baum 1995) but so far this strategy has not been perceived as successful. But are these appropriate research designs for school based research about complex health issues in particular settings, where the
intention is to bring about whole school change? It may be appropriate where particular risk factors are delineated for selective and indicated prevention efforts (Mrazek & Haggarty, 1994), but the data from these prevention efforts is not reflective of the lived experiences in school environments (it usually reflects special conditions established for the research). It is also not based on principles of good health promotion practice (Kickbusch 1989, Baum 1995), the principles of which, can be distilled to the need for the practice to be: contextual; participatory; multistrategic and dynamic (Ritchie & Rowling 1997).

More effective use of resources from a public health perspective indicates that "universal" school based approaches are likely to be more efficient and effective (Murray and Lopez, 1996). The "universal" approach for school communities should be on strengthening the protective factors such as resilience and connectedness to school by changing social organisations and structures rather than solely focussing on the risk factors. This provides for the reciprocal relationship between the individual and their environment, seeing the research as occurring in an open living system (Archer, Kelly & Bisch 1984), that is, delineating functional relationships in a social context. It recognises the interactive effect of change, rather than a unidirectional focus on change of individual risk factors. It allows this interplay to become part of the research agenda, thus utilising the principles of good health promotion practice for mental health promotion in schools, with staff actively shaping their interventions. This approach is currently being adopted by the Mind Matters National Mental Health in Schools project, that I am co-chair of and that Allyson will talk about the evaluation of and the approach that Sara’s team have adopted in the Gatehouse Project.

If the health sector is working in partnership with the education sector (as it should be), then intervention research needs to include and value evidence of interest to the education sector. The health sector needs to adopt research designs and research procedures that acknowledge good health promotion practice, and that move beyond a risk factor approach thereby addressing the complexities (Ritchie & Rowling 1997). That is, there needs to be a shift in conceptualisation of good school mental health promotion research.

Problems of language and the focus of research

Another difficulty in cross disciplinary research can arise because of difficulties of language. When you try to combine the two areas of research - health and education, the problems inherent in the use of particular language become evident. The need to give attention to the technical language we use has been highlighted in discussion about alienation (Finn, 1989). Often labels are ascribed to clusters of responses on questionnaires without a conceptual framework that delineates their relationships. For example Finn (1989) criticised the work of Hawkins, Doueck & Lishner (1988, cited in Finn 1989) who labelled as indicative of "social bonding" responses to items about school liking, expectations and aspirations.

Finn (1989) identifies a shift in models of alienation from school - from the individual focus of the "self esteem" model, where school failure is a starting point that culminates in the student rejecting or being rejected by the school; to a participation/identification model. In this model there is greater acknowledgment of the individual’s interaction with the environment, through "a psychological condition - identification with school" (Finn, 1989, p133); as well as the key role the organisational structure of the school can play in providing opportunities for engagement.

There are similarities and differences in the language and conceptualisations of alienation in health research. In health research alienation has been linked to damaging health behaviours (Nutbeam et al 1993). Evidence from a cross national study of health behaviour suggests that young people who have more positive school experience are far more likely to engage in health enhancing behaviours. The suggestions made to foster this experience
relate to structuring the environment rather than changing individuals to fit the environment, as Finn was suggesting when he advised that they needed to become more involved in extra curricular activities. That is, there is a difference in whether protective factors of connectedness to schools are the focus or the risk factor, alienation is the focus. This could be seen as merely a semantic difference, but a focus on the positive, in a school based intervention can be quite different to focussing on the negative. The latter orientation is more likely to target individual behaviour change. Whereas focussing on the more positive concept of 'identification with school' could result in concentrating on the provision of a well looked after school that creates a sense of pride, as has been recently identified by a Victorian study on resilience (Fuller, McGraw & Goodyear 1998).

In summary, when the word alienation is used then, some researchers would think of an alienated individual who does not fit the school; others would think of an environment that does not provide opportunities for contribution to school.

Additionally, the outcome of interest would be different. Health researchers would be wanting to link the alienation to health damaging behaviour. Education researchers would be interested in linking alienation to school retention. There is a common interest in alienation, but the health sector may need convincing that changing the organisational structural of schools and measuring those changes is a stepping stone to health enhancing behaviours. Education researchers are more ready to accept the connections, between school organisational change and outcomes.

The other major problematic area of language is the term mental health itself. In my current research and development work in schools, the term mental health has proven to be a stumbling block. Many people see mental health as synonymous with mental illness. This can be an initial problem for preventive interventions. The NSW Health Department has defined mental health as:

"the capacity of individuals within groups and the environment to interact with one another in ways that promote subjective well-being, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice" (NSW Department of Health 1997, p5).

There are a number of key words here that need to shape preventive interventions: individuals; groups; environment; mental abilities; individual and collective goals. There are also words that denote action and values: interact; promote; subjective well being; optimal development; achievement. We are not looking at a one dimensional unidirectional concept, but rather a concept that is multifactoral and dynamic. Interventions need to reflect this, but as already has been suggested such approaches present many problems for researchers.

The concept of spiritual health has the potential to help to develop a framework for elucidating characteristics of mental health and to provide a unifying idea for other aspects of health. Spiritual health has been represented diagrammatically by a circle surrounding the traditional health triangle. That is, it is a unifying factor that can influence social, physical and emotional health. It may also be a dimension that can help draw together the various aspects of mental health.

Yet the future widespread acceptance of the concept of spiritual health is encumbered by its association with religiosity. Religiosity has been identified as a protective factor for adolescents in American research (Blum & Rinehart 1997; Resnick 1997), although this has not been found in recent Australian research (Fuller, McGraw & Goodyear 1998). However,
the construction of spiritual health may be enlightening, for it heightens our awareness of the existence of something more than the physical self. The importance of highlighting this, is that there is a fear that Australian adolescents are growing up with a sense of "spiritual disorientation" (Elkins et al. 1988 p7). This is being manifest in suicide statistics and drug use (Eckersley 1993), two of the risk behaviours that researchers in mental health are interested in. Eckersley argues that we need to provide for young people "a sense of belonging and purpose, and so a sense of meaning and self worth, and a moral framework to guide ... conduct" (Eckersley 1993, S16). His solution is to go back to a world that is commnal and spiritual "by revealing the extent of our inter-relationship and interdependence with the world around us" (Eckersley ibid S18).

There are elements in the following definition of spiritual health that echo the definition on mental health:

The spiritual dimension of health provides meaning and purpose in life; it acts as a unifying force within an individual, integrating the other dimensions of health; it is the product of connectedness to self to others and a greater reality. Balance and harmony of these three areas of connectedness create optimal spiritual health and the conditions to achieve one’s full potential in life (Gehrig 1998, p46).

The elements in this definition of spiritual health are not new. They have been emphasised, using different language, as important in people’s lives and have been used as the focus for mental health interventions. For example resilience has been defined as: "the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances" (NSW Department of Health 1997, p5). Similarly the research literature on social support emphasises the importance of connectedness to others (Cohen & Syme 1985). The more recent concept of "social capital" defined as "the processes between people that establish network, norms and social trust and facilitate co-ordination and co-operation for mutual benefit" (Cox 1995, p15) emphasise the role of the individual in society. Resilience, social support and social capital are amongst the many concepts that relate to how people cope with life.

Fully conceptualising mental health and spiritual health will allow us to move from the negative to the positive, that is from mental illness to mental health, a more appropriate conceptualisation for school population based orientations - a focus on changing individuals and environments to enhance well being rather than focussing on weakening risk factors.

My work with Catholic and Independent schools particularly in the Mind Matters project suggests that they readily see mental health as their underlying ethos, that is, they see mental health in a spiritual health framework. It will be interesting to see if that linkage means that they can more easily take up mental health issues. Whether they can also implement good health promotion principles of being: contextual, participatory, multistrategic and dynamic, will also be interesting to assess.

In conclusion, mental health promotion in schools will be advanced if we:

• can adopt research designs and evaluation tools that reflect cross disciplinary perspectives;
• develop our conceptualisation of what universal school mental health promotion is;
• utilise good health promotion practice principles involving being: contextual; participatory; multistrategic and dynamic in school setting implementation; and
• recognise that different approaches that those adopted for "selective" or "indicated" interventions will be needed for "universal" implementation of preventive interventions in school settings.
References


