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INDIAN SOCIETY OF PROFESSIONAL SOCIAL WORK

It is my pleasure to offer my message to this 20th issue of the publication of the National Journal of Professional Social Work.

I would like to congratulate Prof. Rameela Shekhar and the Editorial Team. Seeing the fruition of the bold challenge taken up by her on 23rd February 2018 at the AGBM at Pondicherry, is indeed very gratifying. This completion is an achievement and fulfillment of a tough task undertaken. I consider it to be a wonderful gesture of commitment for professional development.

Editor's contribution to ISPSW - NJPSW will go on record and will be acknowledged during its forthcoming AGBM at Ranchi. I congratulate all those who have been involved in this accomplishment.

In this occasion, with immense pleasure, I would like to inform you that Wolters Kluwer (India) Pvt. Ltd, a renowned publication agency has agreed to publish our National Journal of Professional Social Work (NJPSW) as an online journal and is intending to bring two issues of a Volume in a year. It is a promise and opportunity for all the aspiring professionals. Support and guidance from this professional publication agency would enhance the visibility of our journal and society. Similarly the journal will be promoted among Social Workers across globe by indexing in reputed scientific sources such as SCOPUS and PubMed.

Social Work primarily deals with various social issues and aims to fight for social justice. The person-situation Gestalt and the six Methods of Social Work equip the professional to work fruitfully in any field. However, so far, Social Work Education in India was at the crossroads but since a year it is truly in a crisis for want of professional recognition and standing. I have the responsibility to respond to the current situation and provide leadership with regard to steps to be taken.

First and foremost, what we are witnessing now is the myth of considering merely two years of Postgraduate education in Social Work as profession with specialisation, which is not the practice in any other comparable professional education in our country. In India, we did not follow the four stages of a profession fully i.e. voluntary, occupation, career and profession, a sustained process we lost, astonishingly.

Western-oriented education, discounting the works of our reformers as mere social service, lack of indigenization and Indianization, urban-centric institutions and mushrooming of social work schools, limiting mainly to curative and remedial methods of practice than social action and social goal model, lack of competency-based classroom teaching and field work training, parallel and disconnected streams of social welfare sector of our country and schools of social work, lack of national policy for employment for qualified professionals and timely involvement in social legislation process, lack of distinct provision in state and central civil services, emergence of five-year plan based focus on specializations at PG level and lack of sustained national consensus on social issues and Social Work Education and the roadmap, lack of strong regional and national affiliating, accrediting bodies and associations are the impediments in the Indian Social Work Education system.

Secondly, from this perspective, we need to reflect and respect our history. We need to uncover the sands of time and rediscover the culture of service and social action which were embedded in Gopala Krishna Gokhale's initiative by starting the college of Servants of India Society, an academy at Pune in 1905 with secular aim and social justice. Here, the graduate men were recruited after a very rigorous selection for 5-year training with

1-year probation for nation-building of India in those complex times under British rule and various provincial governments. Similarly in Seva Sadan Society [1908], training was provided to women social workers on vocation basis addressing various socio-economic issues prevailing then. Also, the Social Service League was founded in 1911 to train social workers across the country. From this perspective, we have 115 years of Professional Social Work Education. With this background, TISS worked closely with provincial governments, helped in forming a number of social legislations, public welfare administration and training, forming government departments of welfare and starting schools of social work in India. The TISS Pre- Independence work led to the recognition of Social Work as a profession in India as well as the creation of the Indian Council of Social Work in 1947 [ICSW].

Down the line, we lost the process in consolidating these initial efforts into establishment of professional identity and standing. Here, I fully agree with Alexander's perspective in classification of Social Work Education in India in four phases i.e. one, from 1905 to 1936- Political Missionaries; two, from 1936 to 1947- Social Service Administration; three, from 1947 to 1990 - Specialization and four, from 1990 to Present phase of Social Development. Further, the UGC first Review Committee Report in 1965, Second Review Committee in 1980, Curriculum Development Centre (CDC-TISS) report in 1990, UGC Model Curriculum in 2001 and the National Assessment and Accreditation Council (NAAC) 2004 are the very notable initiatives. Apart from this, various crusaders like Ramachandran and Padmanabhan (1969), Ramachandran Barah and Vasudevan (1977), Nair (1983), Pathak (1983) and Ramachandran (1988) who carried out national and regional level quality assessment of professional social workers, mainly by using survey research design are very important to getting the missing links move forward.

In India or for that matter across the globe there is no dearth of social issues to be addressed by professional social workers. Multiple sectors need all three levels of interventions. Mostly, action oriented and social goal model may be the need of the hour for the social work practitioners, researchers, educators, trainers and policy makers. National Journal of Professional Social Work with its new initiatives may be facilitating the needed recognition.

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EDITORIAL

This is the 20th Volume of the National Journal of Professional Social Work. In addition to concepts such as social engineering with hygiene and its impact on family life, as well as the significance of technology in child development, which were taken up in the previous issue, we've moved on to a diverse plethora of issues such as multiculturalism in organisations, determinants of quality of life of HIV/AIDS infected widows and quality of work life in women teachers, needs of adolescent children of parents with mental illness, efficacy of life skills intervention among adolescents and a study of hopelessness in Valparai Hills, Tamilnadu. A not uncommon occurrence, but one that has not got the attention that it deserves such as the issues faced by troubled children in custody disputes and need for standard parenting procedures in such cases has been introduced and it surely adds to the overall value of this Volume.

This Volume, I'm happy to say, has been produced as per schedule. Every issue of a publication such as National Journal of Professional Social Work seeks to offer articles pertaining to research and practices in the field of Professional Social Work to empower readers with new insights into complex and many times uncharted waters in the realm of Social Work Practice.

The management of mental health in a fast paced and dynamic society that is greatly impacted by technology and its impacts on lifestyles is an issue that is gaining traction in the plans of policy makers. Yet we are aware that much more needs to be done to bring about even a modicum of improvement in the society around us. Such studies serve to highlight the strong empirical foundations needed for policy making and publications like this one will hopefully serve their purpose.

I thank Dr. Jotheeswaran A Thiyagarajan, Technical Officer (Epidemiologist), Department of Ageing and Life Course, WHO, Geneva; Dr. Rashmi Gangamma, Assoc. Professor, 601 E. Genesee Street, Peck Hall, Dept of Marriage and Family Therapy, Syracuse, New York – 13202; Dr. N. Janardhana, Additional Professor, Department of Psychiatric Social Work, NIMHANS, Bengaluru; Dr. Lakshmana G, Assistant Professor, Dept. of Social Work, School of Social and Behavioral Sciences, Central University of Karnataka, Kalaburgi; Dr. Manisha Kiran, Head, Dept of PSW, RINPAS, Kanke, Ranchi; Prof. P. Ilango, Dean, Faculty of Arts, Bharthidasan University, Tiruchirappalli; Dr. Sonia Pereira Deuri, Prof. & Head, Dept of PSW, Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, Tezpur;

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I am very confident that the articles offered in this Volume will add to the body of work in the field of Social Work and contribute to a better understanding of the role of social scientists in policy making.

Here's wishing all readers a fruitful time.

Dr. Rameela Shekhar
Editor

PERCEPTIONS OF INDIAN EMPLOYEES ON EXPERIENCING MULTICULTURALISM IN ORGANIZATIONS

[1] Alisha Rachel Kurian, [2] P.M. Mathew

ABSTRACT

The 21st century organizations serve a broad range of clientele with diverse needs and interests and have a workforce hailing from multicultural backgrounds. To hold a competitive advantage over their clients they need to identify strategies to manage their culturally diverse workforce by helping them attain their fullest potential.

This study mainly throws light on the best practices followed by organizations to attract, retain and manage their culturally diverse workforce and how these multicultural employees deal with conflicts and rejection at the workplace.

Thematic analysis of perceptions of ten Indian employees who are exposed to cultural diversity at their organizations have been deployed to arrive at these findings. An organization's excellent work environment which has strong diversity programs, helpful and knowledgeable colleagues, appreciation and recognition from the management for notable performances, flexibility and freedom to approach any employee for help, flat organizational hierarchy, open door policy and giving opportunities to people of all colors are practices highly valued by the employees.

Remaining self-confident and motivating oneself by updating various competencies and accepting that there could be other, better ideas than one's own can help employees to deal with rejection at the workplace.

Key words: Multiculturalism, Organizations, Conflicts, Management

INTRODUCTION

Multiple organizations now function without many barriers in countries other than their home countries. Through the aid of information technology, globalization helps to interact and combine people, organizations, and governments of various nations with one another in order to utilize international trade and investments (DeLancey, 2013). The increasing diversity of the workforce can be an asset or a liability, depending on how it is dealt with.

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Rather than counting only on market research and surveys, a diverse workforce provides good cognizance as to the motivations and concerns of a wide variety of customers. Today's organizations genuinely require leaders, teams and staff who can simultaneously promote the values and requirements of an organization while adjusting to the cultures touching the organization. This skill requires more than just cultural sensitivity and awareness, and it is where cultural intelligence becomes the most essential intelligence for the 21st century (Livermore & Dyne, 2015). Attracting the best employees during times of economic uncertainty is a hard task for organizations and job seekers. When unemployment rates are rising, some companies can more easily choose from a large number of potentially qualified job seekers. The Great Recession provided diversity-canny companies a momentous opportunity to recruit multicultural talent before other companies could recruit them. After all, top talent with diverse background brings about a broader perspective and better connection to emerging markets (Henderson & Herring, 2015).

A paradoxical view of diversity suggests that greater the diversity, higher the group conflict and better the business performance. This may occur as diverse groups are more liable to have conflict but such conflict forces them to go beyond easy solutions that occur when like-minded people come together. Diversity leads to debating of diverse ideas, better creativity, and higher level solutions to problems. Homogeneity, may lead to greater group cohesion but also less adaptability and innovation. Thus, diversity, in spite of the possibility of more conflict and process loss, is associated with creativity and greater value (Henderson & Herring, 2015). Implementing diversity in the workplace is difficult. This is primarily due to the fact that human beings prefer to work in homogeneous groups. Secondly, human beings, and the organizations they are a part of, have a tendency to avoid and resist change. HR managers should possess skills in leadership, organizational development, change management, psychology, communication, measurement, and assessment. These skills will be useful to the success of any business initiative. In order to profit from diversity, the people in those organizations must change the way in which they interact. Hence changing human processes requires and defines HR's role in diversity management (Kreitz, 2007). Organizations are influenced by national culture and the parent corporate's culture. Managers need to understand how to successfully work with citizens of other countries. Culture plays a significant role in styles of communication and negotiation. It also determines what motivates employees. Different incentives motivate employees from different cultures. Leadership style is also influenced by culture. In the Global market, teamwork is a key factor of the new workplace and team members from different cultures have diverse perspectives and values. Cross cultural management is about managing differences and similarities when working with a culturally diverse workforce. It also helps us to know how to examine the impact of culture on performance apart from understanding what to do while working in a particular company (Madhavan, 2016). In this study, qualitative research approach is used to gain perspectives of Indian-origin employees working in various

organizations across the globe where multiculturalism is experienced. The primary objective of this research is to answer the questions such as: How do multicultural employees tackle conflicts and rejection at their workplace? What are some of the best initiatives taken by corporates to manage the diverse workforce?

METHOD

The main Objective of the study is to identify the best practices followed by organizations to attract, retain and manage their culturally diverse workforce. This qualitative study has a sample consisting of 10 participants who were spread across the globe. Those respondents located in India were interviewed in person and others were interviewed through telephonic interviews using video calls. The researcher used convenient sampling as it helped to find a small pool of apt participants easily. The interview guide consisted of questions that are related to the respondent's motivations, aspirations, conflict management practices and the like. The data was analyzed by breaking it into themes. The software for qualitative research analysis called ATLAS.TI was utilized for the same and various codes were identified through open coding.

RESULTS

Table 1 - Socio Demographic details of the Respondents

Respondents	Gender	Country where the respondent works	Parent country of the respondent's organization	Years of experience in the current organization
R1	Male	India	India	12
R2	Male	India	U.S.A	0.6
R3	Female	India	India	1.4
R4	Male	U.S.A	U.S.A	10
R5	Male	India	Singapore	4
R6	Female	India	China	1.5
R7	Male	France	France	1
R8	Male	India	U.S.A	2
R9	Male	Canada	Canada	0.4
R10	Female	UAE	UAE	2

It is identified from the respondents that diversity and inclusion both attract them to the organization and motivate them to remain in them. They firmly value their organization's excellent work environment which has strong diversity programs and their helpful colleagues or coworkers who are knowledgeable. Other factors that

attracted them to the company were the diverse opportunities available for them in the company, remuneration, job location, friends who work in the same organization, facilities, and the corporate image. The factors that motivate them to remain in the organization were great learning opportunities available in an organization, career growth, flexibility at work, unparalleled employee-friendly work culture, reforms done by the organization for the betterment of services, good work-life balance, mobility within the organization to move to different teams based on the employee's interests, job profile, remuneration and the proximity of the work location. Merit-based unbiased recruitment and merit-based promotion system are given very high importance by most of the employees.

The various practices within their organization that, they value and cherish are: appreciation and recognition from the management for notable performances, flexibility and freedom that the organization offers to approach any employee for help, flat hierarchy in the organizational structure and open door policy. The organization's practice of giving opportunity to people of all color, the freedom to work at any time of the day as he or she likes (as long as the tasks or milestones are met within the prescribed time), the fact that the company seriously takes into account employee engagement and the performance appraisal system where the employees set goals (with their superiors) and have the freedom to change these goals themselves also are valued by the employees.

The respondents also appreciate it when their organizations encourage their ideas, be it small or big (provided they have clarity regarding it). Certain organizations have online platforms which empower the employees to voice their ideas or suggestions. By being self-confident they motivate themselves during situations in which their ideas or performances are neglected by their organization. In such situations they also work on their strengths by updating various competencies and accepting that the other person's idea may be better than theirs. They also analyze why it was undervalued and how to better it so that they can deliver it successfully next time.

Quoting a Respondent: *"In the case of my friend who was in a start-up company, there were just 15 people and they had to do lots of work with no breaks. So there were 15 screens in front of which they sat from morning till evening with no conversation other than a formal greeting. Post 6 months, 6 people left or got fired. There was no cooperation, no team work, no communication and employees had no knowledge about each other's work. So it is important to give opportunities for employees to interact."* Recreational and team bonding activities are really important as they increase cohesion between employees. In the absence of such activities there would be neither cooperation nor team work and communication and employees may not have knowledge about each other's work. So it is vital to give

opportunities for employees to interact like providing a common place for employees to get together during breaks within the organization. Various recreational activities like events, talk shows, summer camps, picnics, get-togethers on holidays, games, CSR, team lunches or dinners that are organized by their respective organizations or specifically by the department's recreational committee help to network across the organization. Training sessions conducted by the HR department help to connect with other employees. Collaborative workspaces also help them to bond with other employees as they utilize these common spaces in their organizations during their breaks or even team meetings to talk to other employees and connect with them.

Differences of opinion are common in every organization. People may have diverse viewpoints due to the fact that each individual is unique. Quoting a participant on how he deals with conflicts at the workplace: *"It all depends on how you express . Don't target or put a person down, but address it in a cordial fashion by not making the other person feel hurt or attacked. A debate on the differences of opinion is required. People might be interested to hear other people. So let the debate be open to ideas. But don't put up a defensive debate. Open discussion using theories they know is the right kind of discussion required. When it is a homogeneous team, differences experienced could be rare. Mostly it would be the same opinions. In heterogeneous teams, everyone knows different ideas will be there, so there will be more open-mindedness. In such a team you need a leader to oversee the disagreements and facilitate an environment to carry out open discussions. In order to help foster mutual understanding and be in sync with each other, the best thing to do is have merit-based recruitment. This improves the morale of the employees and leads to positive emotions while they interact with each other."* When conflicts arise in the workplace, respondents may talk it out. One can even put down all the points for and against the opinion and debate it. But in such a case the right expression of disagreement matters. It must be dealt with in a cordial fashion by not making the other person feel hurt or attacked and by being open to ideas and not putting up a defensive debate. It is also necessary to listen to another's point of view and adopt a strategy of consensus-building during discussions, team meetings and negotiations if the conflict is based on professional decisions. If that does not help then matters can be escalated to the superiors and if needed the dispute council or the HR department could step in to resolve them. If the conflicts are on ethics then it has to be reported to the ethics committee and the whistle blower policy can also be considered. Organizations that have strong HR policies and diversity programs, take any discrimination among employees seriously. Such programs focus on training people on inclusiveness like interactive seminars on LGBT communities, and in dealing with handicapped/challenged employees and celebrating LGBT month. Organizations may have various practices that ensure that the identity of the employee is not judged and the performance is given due importance. Unbiased recruiting based on merits, unbiased performance reviews and project assignments and annual employee surveys where the employees can voice their feedback on the organization are examples of

such practices. Management-level initiatives need to be taken to ensure that the minority feels respected and included as it boosts confidence in one's own diversity when one sees colleagues from different cultures trying to embrace others as their own. Another way to manage cultural diversity in organizations is by training the workforce specifically on the concept as well as offering training on different languages to avoid culture shocks while handling clients from different locations due to their varying tolerance for quality, sensitivity to the privacy of their data and various rules or conditions to be kept in mind.

SUGGESTIONS

For projects of long duration, organizations need to deliberately put in efforts to mix people up during work. Even though a culturally diverse workforce that has been hired based on merit would definitely take time to adjust, quality will be enhanced due to more opinions leading to better decisions and also better problem-solving. In case of homogenous teams which may also be hired based on merit, the interactions would be easy due to similar background and there could be better efficiency especially for short duration projects but there may occur stages of stunted ideas or idea stagnation and the right spark may be missing. A culturally diverse workforce can solve such situations. If guidelines which outline the organization's policy towards diversity and non-discrimination are implemented and sensitivity training is conducted to make employees more self-aware, it will play a vital role in helping employees understand their own cultural biases and prejudices.

CONCLUSION

Implementing fine cultural diversity programs is crucial for organizations to attract and retain best talents that have a diverse set of skills. It is important to understand the employees' take or perceptions on what attracts and motivates them to remain in the organizations, what they consider as remarkable practices by the organizations that make them feel valued, how they network with other employees, how they handle conflicts and rejection in workplace. This will help the organizations to draw out insightful awareness about the same and build efficacious initiatives to manage cultural diversity in their organizations. Undoubtedly, effective maintenance of a culturally diverse workforce is indispensable for 21st century organizations.

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QUALITY OF WORK LIFE IN WOMEN TEACHERS WORKING IN RURAL AREAS OF TIRUCHIRAPPALLI DISTRICT, TAMILNADU

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ABSTRACT

Teachers who are the ultimate change agents of society ensure that they are not facing any major hurdles in performing their duties.

Objectives of the study are to assess the level of Work and Social Adjustment (WSAS), Quality of Work life (QWL) and its correlates with background characteristics of the women teachers working in higher secondary schools in rural areas.

There were 508 women teachers working in rural higher secondary schools of Tiruchirappalli district. Of these, 243 were selected as the sample using simple random sampling technique. The data was collected using the Work and Social Adjustment Scale (WSAS) developed by Mundt et al., and Quality of Work Life Scale (QWL) developed by Sirgy et al., and the reliability values for the scales were Alpha 0.805 and 0.859 respectively.

Findings indicate that nearly two third (65%) of the respondents scored low level of WSAS and little higher than half (55%) of the respondents scored high level of QWL score. The research hypothesis was true in the context of age, marital status, type of school and management, teaching experience, size and type of family and ownership of house. Further it is found that age and WSAS were negatively correlated with QWL whereas it is positively correlated with size of family.

Findings indicate the need for providing counselling in order to reduce work and social adjustment, so that quality of work life will be enhanced.

Key words: Women Teachers, Rural areas, Work and Social Adjustment, Quality of Work Life.

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INTRODUCTION

"Education is the manifestation of the perfection already in man" said Swami Vivekananda. Education, in a broad sense is knowledge passed down from one generation to another guided by certain aims and objectives. It is the formal process of educating the people to acquire knowledge, skills, customs, and values among other qualities. In recent years, there has been a tremendous increase in the importance of higher education in India. However, the same amount of attention is not been given to schooling and especially to the problems and challenges faced by school teachers. Women teachers in higher secondary schools in rural areas have a bigger challenge of guiding students to succeed in life. A majority of Indians still reside in rural areas and as a result, women teachers in rural areas have a task of ensuring that the potential of students from rural areas is realized. The job of a teacher, in a higher secondary school, is a very complex and mentally taxing one. As a result of this, there is also a possibility of their Quality of Work Life (QWL) being affected. This pattern of thought resulted in the birth of a few questions in the mind of the researcher: What is the socio-economic profile of the women teachers working in higher secondary schools in Tiruchirappalli district, Tamil Nadu? What is their level of quality of work life?

REVIEW OF LITERATURE

Various studies have been conducted on the work and social adjustment and quality of work life of women teachers. A study by Toulabi et al.,(2013) showed that happiness has a significant effect on all the other components of QWL sparing promotional opportunity. Ilgan et al., (2015) reported that there exists a moderate level of relationship between quality of school work life and psychological well-being. Hamidi and Mohamadi (2012) proved that there doesn't exists a QWL relationship between the theoretical and technical high school teachers. Baleghizadeh and Gordani (2012) reported that a medium level of QWL and a medium-to-low level of motivation exists among the high school teachers. Singh and Singh (2015), in their study, concluded that QWL is a determinant factor that enhances job satisfaction, commitment, engagement, performance, organisational commitment and so on. A study by Sharplin (2008) indicated that in determining the QWL in rural schools, the quality of organisation and the workplace plays a significant role. Mehta and Mehta (2015) reported that QWL was found to be a factor for good job satisfaction. Swathi and Reddy (2015) found that there was difference in stress and QWL based on experience of the teachers. Bhavani and Jegadeeshwaran (2014) reported that job satisfaction has a positive impact on the QWL of women teachers. Gondi (2015) found that the female teachers have significantly higher adjustment scores compared to male teachers of secondary schools. Bhat and Beri (2016) conducted an analytical study to evaluate the disparity among social adjustment and job performance of college teachers on the basis of gender. The study revealed that there is a positive significant relationship between social adjustment and job performance. Varalakshmi and Reddy (2017) reported that there was a statistically significant

influence of age and teaching experience on the adjustment of primary school teachers. From the review of earlier literature, it is safe to opine that a majority of the studies have been conducted with a small sample size. Moreover, there is no combined study on Work and Social Adjustment and QWL of women teachers working in rural areas in recent days. Further, there were only few background characteristic features that were used as independent variables to measure QWL of women teachers. In order to fulfill this research gap, the researcher has proposed to design an in-depth study to explore various psycho-social aspects of women teachers with larger sample size.

METHOD

Objectives: To assess the level of Work and Social Adjustment of the women teachers, To assess the Quality of Work Life and its correlates with background characteristics of the women teachers working in higher secondary schools located in rural areas.

Ethical Considerations: Permission was attained from the school authorities to collect the data and consent was obtained. It is assured to the teachers that data collected will be kept confidential and used only for research purpose. The questionnaires were distributed to the respondents and the purpose of the study was explained to them. The respondents were given the option not to participate or to withdraw from the data collection at any time for any reason.

Inclusion and Exclusion Criteria: The specific objective was to study the women teachers. Therefore, the male teachers were excluded from the study. Teachers from unaided schools in rural areas were not included in the study.

Method and Participants: The schools located in the rural areas of Tiruchirappalli district have been chosen purposively. There were 508 women teachers (305 in 66 government schools and 203 in52 government aided private schools) located in rural areas of Tiruchirappalli district. Of these, 243 women teachers were selected (161 from 42 Government schools and 82 from 17 government aided private schools) as sample for the present study using Yamane's formula (1967) of sample determination. As per this formula, the researcher was supposed to select 223 respondents as per the size of the universe. However, it is well known that, there is a possibility of the questionnaire either being incomplete or not returned. Hence, as a precaution, the researcher decided to add an additional 20 respondents above the expected sample size. However, none of the respondents failed to return their completed questionnaires. Thus all 243 respondents have been treated as a sample for the present study and were included for the analysis. The individual respondents were selected by adopting the simple random sampling technique using Tippet number table.

Research Design: A simple descriptive research design was used when data was collected by using a survey methodology in order to describe the characteristics of the women teachers working in the selected schools. Since, one of the objectives of the study was to describe the background characteristics, work and social adjustment and quality of work life of women teachers working in higher secondary schools located in rural areas, the researcher has adopted a descriptive design. Further, a correlational design has been used since the primary objective of this study was to establish the correlation between socio-demographic variables, work and social adjustment and quality of work life. The present research is also cross sectional in nature since data was collected at only one point in time to assess the socio-demographic background, work and social adjustment and quality of work life of the respondents at the point of data collection. This study has thus used a descriptive design based on survey methodology adopting questionnaire method. In the present research, age, salary, training programme attended, teaching experience, family members and work and social adjustment scale were used as the independent variable while QWL was used as the dependent variable.

Tools of Data collection: Work and Social Adjustment Scale (Mundt et al., 2002) and Quality of Work Life Scale (Sirgy et al., 2001, Tasdemir-Afsar, 2011) was used.
The Work and Social Adjustment Scale contains 5 statements. The responses are nine possible alternatives on a Likert type scale with a scoring pattern of '0' (Not at all) to '8' (Very Severely).It is noted that lower the scores better is the Work and Social Adjustment and vice versa. Further, the Cronbach's Alpha values for the WSAS scale is 0.805. The Quality of Work Life Scale contains 16 items. It is a 7-point scale ranging from "strongly disagree" (value of 1) to "strongly agree" (value of 7). A higher score indicates better Quality of Work Life. The reliability value of QWL scale is alpha 0.859. The data was collected through questionnaires from the respondents. The process of collecting the data took almost five months as the teachers were very busy with academics, examination, and special coaching activities for the higher secondary school students. The data was collected during the period August 2015 to December 2015.

Data Analysis: In order to analyze the data, the researcher used, SPSS AMOS-24 (IBM Corp, 2016). Besides percentage analysis / frequency distribution, the researcher also used mean and standard deviation for analysis of the data. In order to examine the differences in the mean scores of quality of work life of the respondents according to the selected demographic and socio-economic characteristics of the respondents, the test of significance, that is, t test and one-way analysis of variance (ANOVA) were employed. So as to find out if there exists correlation between the selected demographic and socio-economic variables and the scores of quality of work life, Pearson Zero-order Correlation Coefficients were calculated.

RESULTS

Background Characteristics of the Respondents:

The findings show that the respondents in the lower middle age group (36-45 years) constitute the single largest majority (39.1%). The average age of the respondents was 41.98 years with a minimum of 23 years and maximum of 58 years. A majority (85.2%) of the respondents were married. More than half (58.0%) of the respondents belonged to Backward Community. A little more than half (53.1%) of the respondents were found to be living in medium sized families with 4-5 members and the average size of the family was found to be 4.6, with a minimum of 2 members and maximum of 12 members in a family. A majority (61%) of the respondents belong to nuclear family. The respondents living in rural and urban areas are 50.2% and 49.8% respectively. About 58.4% of the respondents possess a master's degree in arts/commerce and the remaining (27.6%) possess a master's degree in education. It is evident that almost all the respondents have a postgraduate degree in their respective subjects. Almost two third (63%) of the respondents have studied up to postgraduation in urban localities through English medium (77.8%) only. A majority (73.3%) of the respondents have a permanent position. Their average salary was found to be Rs. 45,000 with a minimum of Rs.20,000 and maximum of Rs. 74,000 per month. Their average family income was Rs. 62,700 with a minimum of Rs.20,000 and a maximum of Rs. 2,50,000 per month. The average years of teaching experience of the respondents was 12.92 years with a minimum of one year to a maximum of 24 years. The average number of training programmes/orientation/refresher courses attended by the respondents was 12.92. A majority (77.4%) of the respondent are working in co-educational schools. A little more than two third (66.3%) of the schools in the study area are government schools. Finally, it is reported that a little more than two third (67.5%) of the respondents live in their own houses.

Level of WSAS and QWL of the Respondents:

In order to measure the level of work and social adjustment score and quality of work life score, the results have been classified into 'low' and 'high' categories based on the mean scores of two these two subject dimensions The findings indicate that nearly two third (65%) of the respondents scored 'low' level of work and social adjustment score while a little more than half (55%) of the respondents scored 'high' on QWL score.

QWL across the Background Characteristics of the Respondents:

In this part, using one-way ANOVA test, the QWL was measured across the background characteristics of the respondents viz., age, marital status, type of school, type of management, social standing, educational qualification, professional qualification, medium of study, nature of appointment, monthly salary, years of experience, number of training programmes, size and type of family and ownership of house.

Table 1: Mean Scores of QWL of the Respondents across their age group, marital status, type of school, type of management, caste, educational qualification and medium of study.

S.No	Variable		N	Mean	S.D	Df	F	Sig.
1.	Age Group	Young(Up to 35)	59	97.08	9.540	2	10.490	0.000
		Lower Middle (36-45)	95	93.01	12.366	240		$p<0.001$
		Upper Middle (46&>)	89	87.62	14.482			
		Total	243	92.02	13.086			
2.	Marital Sta-tus	Unmarried	24	96.62	12.802	2	2.476	0.086
		Married	207	91.25	13.107	240		$p<0.10$
		Widow/Divorce	12	96.17	11.464			
		Total	243	92.02	13.086			
3.	Type of School	Boys	9	85.78	10.035	2	6.256	0.002
		Girls	46	97.70	14.756	240		$p<0.01$
		Co-Educational	188	90.94	12.406			
		Total	243	92.02	13.086			
4.	Type of Management	Government	138	90.55	13.634	1		0.044
		Private	105	93.96	12.120		4.104	
		Total	243	92.02	13.086	241		$p<0.05$
5.	Caste	OC	21	95.62	13.231			
		BC	141	91.75	13.014			
		MBC	48	91.94	10.883	3	0.610	.609
		SC/ST	33	91.03	16.149	239		$p>0.05$
		Total	243	92.02	13.086			
6.	Educational qualification	Arts M.A./ MCom.	142	92.53	13.332	1	0.710	0.478
		Science M.Sc./ MCA	101	91.32	12.763	241		$p>0.05$
		Total	243	92.02	13.086			
7.	Medium of study at P.G level	Tamil(mother tongue)	54	93.87	13.038	1	1.176	0.241
		English	189	91.50	13.086	241		$p>0.05$
		Total	243	92.02	13.086			

Age and QWL: Panel 1 of Table 1 highlights that the mean score of the QWL was higher among the young age group (97.08), when compared with lower middle age group (93.01), and the upper middle age group, (87.62). Further, the finding reveals that as the age of the respondent increases, the QWL decreases. This is possibly due to the fact that young people are physically fit and have better QWL than those belonging to other age groups.

Marital status and QWL: Panel 2 of Table 1 reveals that the mean score of the QWL was higher among the unmarried respondents (96.62) than the widowed and divorced respondents (96.17) and married respondents (91.25).

Type of School and QWL: Panel 3 of Table 1 shows that the mean score of the QWL is higher among the respondents working in the girls' higher secondary schools (97.70) than the respondents working in co-educational schools (90.94) and boys' higher secondary schools (85.78) and P value is **< 0.01**

Type of School Management and QWL: Panel 4 of Table 1 describes that the mean score of QWL is higher among the respondents working in private higher secondary schools (93.96) when compared with the teachers working in government higher secondary schools (90.55). Here the P value is **< 0.05**

Social standing and QWL: Panel 5 of Table 1 reveals that the mean score of QWL is higher among Other category (95.62) when compared with Backward Caste (91.75), Most Backward Caste (91.94) and Scheduled Caste/Scheduled Tribe(91.03) categories.

Educational Qualification and QWL: Panel 6 of Table 1 highlights that the mean score of QWL is higher among the respondents who have Masters in arts or commerce (92.53) than the respondents having a master degree in science subjects (91.32).

Medium of study at P.G. level and QWL: Panel 7 of Table 1 shows that the mean score of QWL is higher among the respondents who have opted for Tamil as their medium of study at their postgraduate level (93.87) than the teachers who have opted for English as their medium of study at their postgraduate level (91.50).

Table 2: Mean Scores of QWL of the respondents across their salary, years of experience, size of family, type of family and ownership of house

S.No	Variable		N	Mean	S.D	Df	F	Sig.
1	Salary	Rs. 20000 or less	42	94.50	10.325		0.681	0.564
		Rs. 20001 to 40000	87	91.99	12.782	3		p>0.05
		Rs. 40001 to 60000	96	91.05	14.393	239		
		60000&>	18	91.61	13.258			
		Total	243	92.02	13.086			
2	Years of Experience	0-10 Years	117	94.13	11.705			
		11-20 Years	82	89.29	14.700	3	2.603	0.053
		21-30 Years	28	90.04	13.150			
		31 Years and Above	16	94.12	11.730	239		p<0.10
		Total	243	92.02	13.086			
3	Size of family	Small (1-3 members)	73	91.22	13.843			
		Medium (4-5 members)	129	91.07	12.086	2	2.885	0.058
		Big Family (6&>)	41	96.46	14.119	240		p<0.10
		Total	243	92.02	13.086			
4	Type of family	Nuclear Family	148	89.50	13.370	1	-3.860	0.000
		Joint Family	95	95.96	11.646	241		p<0.001
		Total	243	92.02	13.086			
5	Ownership of house	Owned	164	93.32	12.778	1	5.002	.026
		Rented	79	89.34	13.390	241		p<0.05
		Total	243	92.02	13.086			

Monthly salary and QWL: Panel 1 of Table 2 explains that the mean score of QWL is higher among the respondents who earn Rs.20,000 and below (94.50) when compared with the respondents earning Rs.20001 to 40,000 (91.99), followed by the respondents earning Rs.40001 to 60,000/- (91.05) and Rs.60.000/- and above (91.61).

Years of experience and QWL: Panel 2 of Table 2 highlights that the mean score of QWL is higher among the respondents having ten years or less experience (94.13) when compared with the respondents having thirty-one years and above (94.12) followed by twenty-one to thirty years (90.04) and eleven to twenty years (89.29) of teaching experience.

Family size and QWL: Panel 3 of Table 2 reveals that the mean score of the QWL is higher among the respondents who belong to big size family (96.46) than with medium

(91.07) and small (91.22) size families.
One possible reason behind this finding could be the fact that those who have more number of family members in their home might have better personal and emotional support at home, which in turn might be aiding them in focusing and enjoying their work life as teacher.

Type of family and QWL: Panel 4 of Table 2 reveals that the mean score of the QWL is higher among those respondents belonging to joint family system (95.96) than the nuclear type family (89.50). As mentioned in the previous section regarding size of family, those with a big size family have better personal and emotional support, which in turn helps them focus on having a better QWL.

Ownership of House and QWL: Panel 5 of Table 2 reveals that the mean score of QWL is higher among the respondents living in their own houses (93.32) when compared with the respondents living in rented houses (89.34).
Based on the ANOVA results, the research hypothesis with regard to QWL is statistically significant in age group ($p<0.001$), type of school ($p<0.01$), type of management ($p<0.05$), type of family ($p<0.001$) and ownership of house ($p<0.05$).

Zero- Order Correlation between QWL, WSAS and its Background Characteristics of the Respondents:

Table 3: Correlation matrix between the Respondents' Background Characteristics and WSAS and QWL score.

Variables	Age	Salary	No. of Training	Teaching Experience	Family Members	WSAS Score	QWL Score
Age	1						
Salary	**.485	1					
Training Attended	.120	*.129	1				
Teaching Experience	**.422	**.320	**.310	1			
Family Members	**-.253	**-.198	.039	*-.126	1		
WSAS Score	**-.299	**-.182	-.088	**-.187	.109	1	
QWL Score	**-.278	-.117	-.080	-.110	**.184	*-.129	1
**. p < 0.01 * p < 0.05							

The results of the zero-order correlation (Table 3) shows that as age, salary and teaching

experience of the respondents increases, work and social adjustment score decreases (lower the score better the adjustment). Further, it is observed that as age and work and social adjustment score increases, QWL score decreases, whereas, as the number of family members increases, the QWL score also increases.

IMPLICATIONS OF THE STUDY

Steps must be taken to improve the teachers' mental health, difficulties to function in terms of work, home management, social leisure, private leisure and personal or family relationships should be dealt through personal and family counseling.

The women teachers who work in higher secondary schools in rural areas can be given residence and quarters with all infrastructure facilities. They must also be motivated to stay in the quarters themselves, so that they can involve with students in an effective manner.

Teachers should be motivated and encouraged by getting additional incentives and promotions, so that they can know their capabilities and improve their teaching skills.

Teachers may also be encouraged to attend the training programmes/orientation programmes/refresher courses. Hence, the government should take necessary steps and encourage the teachers who work in rural areas to attend the training programmes.

Teachers who work in a temporary basis should be made permanent, this can enhance heir motivation.

Steps must be taken by the school authorities to fulfill health and safety needs, economic and domestic needs, social needs, need for recognition, need for self-actualisation, need for knowledge and aesthetic needs through training programmes, additional incentives, recognitions/awards and rewards.

CONCLUSION

It is concluded that the level of QWL of the respondents is found to be low among the young age group, married, SC/ST category and those women teachers who are working in boys' schools. It is suggested to improve the QWL of the respondents and steps must be taken to provide counseling. As the teachers have a high mean score in QWL for the dimensions in health, economics, family and social needs, they can find a way to improve their self-esteem, self- actualisation, knowledge and appreciation.

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NEEDS OF ADOLESCENT CHILDREN OF PARENTS WITH MENTAL ILLNESS: ADOLESCENT AND PROFESSIONAL PERSPECTIVES

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ABSTRACT

Children of parents with mental illness (COPMI) are not routinely included in psychoeducational and supportive family interventions in India. Furthermore, a combination of genetic and psychosocial vulnerabilities puts them at increased risk to develop mental health issues and other adverse outcomes. This study aimed to understand adolescent COPMI's mental health needs.

In-depth interviews were conducted with 28 adolescent COPMI and six mental health professionals (MHPs). The data was audio-recorded, transcribed and analysed using thematic analysis.

Common themes that emerged across the adolescent and MHP interviews were *parent-focussed needs* to support parenting needs of the ill parent; *adolescent-focussed needs* to help adolescents understand and cope with the illness, be supported, be able to detach themselves from the illness and have developmentally appropriate experiences; *and family-focussed needs* such as strengthening family communication and relationships. An additional theme from the MHP interviews was *system-focussed needs* to overcome challenges within mental health systems in providing interventions to this population.

The findings provide culturally-relevant insights into the needs of adolescent COPMI, provide the basis for developing mental health interventions and carrying out further research with them.

Key words: Children of parents with mental illness; Adolescence; Mental Health needs

INTRODUCTION

Studies from around the world have reported that between 12 - 45% of mental health service users are parents (Maybery & Reupert, 2018). To date, no large-scale survey in

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India has estimated how many persons with mental illness have children. Some small-scale studies provide an approximate picture, reporting that 49% of persons with Schizophrenia (Thara & Tirupati, 1997) and 66% of women in-patients with mental illness (Chandra, Carey, Carey, Shalinianant, & Thomas, 2003) had children, making it reasonable to assume that in India, like in other countries, many persons with mental illness have children. However, the issues of children of parents with mental illness (COPMI) remain largely invisible in mental health settings. They are not routinely included in family interventions focussed on psychoeducation and support and therefore, are often left to manage their experiences on their own.

Additionally, COPMI are at increased risks of developing psychiatric disorders (Hosman, Van Doesum, & Van Santvoort, 2009) as well as other adverse psychosocial outcomes (Hans, Auerbach, Asarnow, Styr, & Marcus, 2000; Johnstone et al., 2000) due to a combination of genetic and prenatal influences, parent-child interactions, family processes and conditions, and other social influences (Garmezy & Streitman, 1974; Hosman et al., 2009; Van Loon, Van De Ven, Van Doesum, Hosman, & Witteman, 2015). A few Indian studies carried out with COPMI have found that they use maladaptive coping strategies (George, Shaiju, & Sharma, 2012) and have higher levels of internalising and externalising behavioural problems (Bhat & Srinivasan, 2006; Malhotra, Kumar, & Verma, 2015).

Other Indian studies with adult COPMI have reported that many have adverse experiences in childhood such as unstable families and discontinued education (Manjula & Raguram, 2009). Though resilient, they report burden and a lack of support (Herbert, Manjula, & Philip, 2013). Spouses of persons with mental illness have reported that children are negatively affected by the parental illness (Pashapu, Hamza, Chandra, & Marimuthu, 2014) and have described challenges in supporting their children and talking about parental mental illness (Ballal & Navaneetham, 2018).

Studies from other countries on the needs of COPMI have most commonly reported the need for information and support. Additionally, COPMI have reported issues around care giving responsibilities, communication problems, coping with the illness and dealing with crisis situations (Fudge & Mason, 2004; Maybery, Ling, Szakacs, &Reupert, 2005). Issues have also been reported around the hospitalisation of the parent, raising the need for a family focus and for 'family-friendly spaces' in psychiatric settings (O'Brien, Anand, Brady, & Gillies, 2011) and children have reported that it is helpful to receive information and support from mental health professionals (Drost, Van Der Krieke, Sytema & Schippers, 2016). Children have also stressed the need for support from other agencies such as schools (Fudge & Mason, 2004; Grové, Reupert, &Maybery, 2016).

Mental health professionals have also similarly reported the need for COPMI to be recognised and included within mental health services. Additionally, they have discussed particular challenges faced by professionals including children's preferences for informal support rather than formal support, families' ambivalence or lack of readiness in discussing issues relating to parental mental illness, and lack of clear guidelines within mental health systems about the responsibility of professionals towards these children (Reupert &Maybery, 2010;O'Brien, Brady, Anand & Gillies, 2011; Afzelius, Plantin, & Ostman, 2015, Power et al., 2015; Grove, Riebschleger, Bosch, Cavanaugh & Van Der Ende, 2017).

There is a dearth of culturally-relevant literature discussing the needs of COPMI and supportive or preventive mental health interventions for them. Therefore, this study aimed to investigate the needs of adolescent COPMI, from the perspective of the adolescents themselves and that of mental health professionals, so as to generate deeper insights about this population and facilitate the development of appropriate mental health services for them.

METHOD

Study Setting and Participants

This paper is based on the findings from a larger Doctoral research study of the experiences and needs of adolescents who have a parent with severe mental illness. The study was conducted in a tertiary mental health-care hospital in urban Bengaluru and was approved by the Ethics Committee of the Institute. Parents with Schizophrenia or Psychosis NOS as per the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10), who had children between the ages 15-19 years, were identified from the in-patient and out-patient settings. Twenty eight of their adolescent children were recruited through purposive sampling.

Additionally, six mental health professionals (MHP's) were also recruited from the same setting; they had various academic backgrounds and specialisations and had an interest in or experience of working with families and children affected by parental mental illness.

Procedures for Data Collection

Parental consent and adolescent assent (or consent, if the adolescent was over 18 years) was obtained prior to the adolescents' participation in the study. Socio-demographic information and family characteristics were collected via an information sheet. Details of the parent's mental illness were collected from their hospital records. Semi-structured, in-depth interviews were conducted with the adolescents, based on an interview guide

that focussed on eliciting their experiences in various domains of their lives. Their stated and implied needs were elicited through questions such as what had helped them to manage their experiences, what they thought would further help them, what expectations they had from the mental health care setting, and what advice they would give to other adolescents in a similar situation.

Mental health professionals were also recruited after Informed Consent. Brief socio-demographic data and details about their training and experience in mental health were collected. Semi-structured, in-depth interviews were conducted with them, focussing on four broad topics: experiences of adolescent COPMI, their mental health needs, possible mental health interventions for them and the challenges in providing these interventions. All interviews were audio-recorded and later transcribed.

Data Analysis

The segments of the adolescents' interviews that referred to their needs as well as the data collected from the mental health professionals were coded separately using thematic analysis (Braun & Clarke, 2006) and with the aid of ATLAS.ti software (Version 8). The researcher began by familiarizing herself with the data by re-reading the transcripts and noting down initial ideas and codes. Following this, the transcripts were coded with initial codes. Once all the transcripts were coded, the researcher looked at the list of codes, looking for potential themes and combining codes to form overarching themes. All the transcripts and the coded extracts were then re-read and coded to ensure that the extracts matched the themes. The themes were further defined, refined and reworded during the process of writing of the final analysis.

RESULTS

The findings from the analysis of the adolescent data and the MHP data are presented in two sub-sections and discussed together in the discussion section of the paper. Segments from the participants' transcripts have been provided to illustrate the results. All participants are identified by their participant IDs: A01, A02, etc for adolescents and MHP01, MHP02 etc for mental health professionals. Unless otherwise specified, all references to a parent (father or mother) in the quotations refer to the parent with mental illness. The researcher's comments and descriptors are placed within square brackets '[ ]'. Where certain portions of the text are omitted, they have been indicated by '[...]'.

Adolescents' Perspectives

Profile of adolescent participants: The adolescents were 13 boys and 15 girls. They came from 19 families and 18 of the adolescents were sibling pairs. Their education ranged

from Class 5 to graduation; 23 of them were still studying, three had dropped out of school and two were working full-time. Twenty of the adolescents were living with the ill parent and eight of them were living away, but all had regular contact with the parent. Twenty four of them had a mother and four of them had a father with mental illness. The duration of the parent's illness ranged from six months to 22 years. Five of the 19 families were single-parent families.

Adolescents' perspectives on need: There were three themes in the adolescents' narratives that helped them manage their experiences of parental mental illness. These are described below along with the adolescents' quotations to illustrate the themes.

1. Parent-focussed needs

The most articulated need by adolescents was for the ill parent to receive treatment and recover from the illness.

If mother becomes alright, that's enough. Then father [well parent] won't worry anymore, I won't worry anymore. (A06)

I try to 'rewind' her [mother] so that she becomes her old self again, so that she starts doing the things she did before. (A42)

Many also talked about the ways in which the illness had disrupted the parent-adolescent relationship. They described feelings of sadness and grief associated with it, and indicated their wish to have a normal and positive relationship with the parent.

I have tried talking to her [mother] but she won't talk to me. No matter how much I force her to, she didn't even say a word. (A09)

Other mothers would show affection towards their daughters and I would think, if I had a mother, she would do the same to me. Perhaps my mother would have done it, if she were fine. (A24)

Now if I tell her [mother] something, she listens to me. Earlier, I would have to do as she said... I think it was better before- her guiding me. If it was still like that, it would have been nice. (A25)

These quotations illustrate the ways in which changes involving the ill parent could help adolescents.

2. Adolescent-focussed needs

These needs related to the ways in which adolescents felt they themselves could be helped and supported to better deal with the parent's mental illness. Many talked about

their confusions about the illness and wanted to understand more about the illness. Some also talked about wanting to better manage their emotions and cope with the illness, so that they can be supportive of the parent.

He keeps worrying about people talking [referring to father's hallucinations] *and it makes him worse. He isn't able to control it. Why is that, I want to know.* (A12)

Mother insists that there is something inside her ears [referring to the mother's bizarre delusions]. That's a question in my mind: is there something really there? Why does she keep saying that? Or is it her imagination? Or is something really wrong that they can't see in the scans? Mother would not lie, the doctors would not lie. So what is going on? (A17)

I would advise other adolescents - I would assure them that everything will be alright, and their mother will get better and come home, so they must be brave. If they lose courage, who will then support their family? (A29)

At the same time, adolescents also emphasized the need for them to defocus from the illness, and to focus on their own lives and have time to spend with their friends. Many also emphasized the importance of being able to achieve their goals, especially in their education.

[Children] should not take too much stress. If they think too much about it [parent's illness], they will not be able to focus on other things. (A11)

I would tell [other adolescents] to complete their education. [...] If they lament over the fact that this happened to their mother or father, and decide to neglect their studies to look after the parent, they will neither be able to look after their parent nor live their own life well. (A25)

3. Family-focussed needs

This theme described the adolescents' needs to be able to support and contribute to their family and also for the immediate and extended family to be more supportive of each other. When other family members were more supportive and involved, adolescents found it easier to manage.

The family can be a lot of help. I mean, the extended family, like uncles; if they help, then we can be strong. If they do not help, and only criticise, [...] it is hurtful. (A05)

Father [well parent] is there to take care of mother, so I don't have to get too involved and I can focus on my studies. (A43)

Often, families were described as not being open to conversations about the parent's mental illness and did not respond to adolescents' questions about it. This indicated the

need for more open communication in the family.

Grandma once told me that father is unwell, so I must look after the family in the future and study well. When I asked her what had happened, she didn't say anything. Nobody would say anything. (A20)

The next section presents the findings from the interviews with mental health professionals.

Mental health professionals' perspectives on needs of COPMI

Profile of the mental health professional: The six mental health professionals (MHPs) were three faculty and three staff members from the disciplines of psychiatric social work (2), psychiatry (2) and clinical psychology (2). They had specialised experience in varied areas including adult psychiatry, family psychiatry, child and adolescent psychiatry, behaviour therapy and psychiatric rehabilitation. They had clinical and/or research experience of working with children and families affected by parental mental illness. One of the MHPs also had a lived experience of parental mental illness.

MHPs perspectives on the needs of adolescent COPMI: Similar to the adolescents' perspectives, MHPs also described COPMI's needs at three levels- the ill parent, the adolescent, and the family. They additionally described other systemic barriers that would have to be overcome so that adolescent COPMI could be recognized and supported by mental health systems.

1. Parent-focussed needs

MHPs pointed out the need for interventions to support the ill parent in their parenting role.

They [parent with illness] actually have the intention to take care of the child. They very much want to; they want to do good things for the child. So looking at why they are not able to do that and what are the things they can keep in mind while handling their children and how to make sure their illness does not come in the way of doing things for the child or interacting with the child, those skills have to be taught to them. (MHP06)

2. Adolescent-focussed needs

According to the mental health professionals, adolescents' direct needs were to understand the illness, cope with the illness, be supported, be able to detach from the illness and have developmentally appropriate positive experiences.

...to teach them [COPMI] to understand what it is, what they are feeling, why they are feeling

the way they are, is it wrong to feel the way they are feeling or is it okay, to probably normalise the experience... If that is done, it can lead to a big, positive thing. That makes a child resilient in the long run. (MHP02)

Having support groups for these children; at least have an option, if they are comfortable and they want to come together. That might help them understand they are not alone and this is not a challenge or way of life only they are going through, that there are others like them. That can help them make meaning of their own experiences. (MHP05)

2. Family-focussed needs

They also talked about needs at the family-level that could directly or indirectly benefit adolescents such as support and empowerment of the 'well' parent or other adults in the family, and strengthening other relationships in the family, especially the sibling relationship. Some also brought out the need to work with family-level barriers, in order to intervene with the adolescent.

One barrier would be if the family themselves did not want to include the children. Sometimes they want to shield the children from the mental illness- from what is happening. (MHP03)

The sibling bond is very important. Sometimes, this bond is not developed, there is a potential for it, but it has to be promoted. When there is a burden of parental mental illness and the sibling rapport is not well-developed, it will be difficult for them both. (MHP04)

3. System-focussed needs

MHPs talked about the various challenges in delivering interventions to this population at the systemic level and provided suggestions to overcome them. They talked about the lack of resources in mental health and highlighted the importance of creating more awareness, training and allocation of resources for this issue, and generating evidence to show the need and effectiveness of intervention with this population.

We need to create more evidence in terms of what happens to the patient, when the child is brought into treatment. And the second point is that we are also preventing psychological issues in the child, but prevention is yet to get more focus here. (MHP04)

Some of them further discussed ideas to make these interventions relevant to adolescents which would need a different approach than traditionally employed in interventions with adult caregivers.

It should be attractive for adolescents [...] An interesting way of delivering things may be through movies, or through play- many activities, plus some components [of mental health interventions]. (MHP06)

There were some common and some diverse themes between the needs listed by the adolescents and the professionals. These findings are discussed in the next section.

DISCUSSION

The themes from the adolescent and MHP interviews provide various implications for addressing the needs of adolescent children affected by parental mental illness. Adolescents talked about the need for the parent's recovery, but also particularly indicated the need for their parents to fulfil parental roles, such as providing guidance and affection, and this need was echoed by MHPs. This highlights the need to include the domain of parenting, during assessment and while making treatment plans for persons with mental illness. While it may depend on the nature and severity of the illness, where appropriate, persons with mental illness might benefit from interventions focussing on providing support and skills related to parenting. Other studies done with parents with mental illness have said that parenting provides them with a sense of purpose (Evenson, Rhodes, Feigenbaum, & Solly, 2008) and pride (Ackerson, 2003), motivates them to seek treatment (Jones et al., 2016) and gives them an incentive to maintain recovery (Oyserman, Bybee, Mowbray, & Kahng, 2004), which further validates the need to prioritise parenting in routine adult psychiatry practice.

Both adolescents and MHPs also talked about adolescent COPMI's needs for information and support, which is a recurring theme in existing literature with COPMI (Bee, Berzins, Calam, Pryjmachuk, & Abel, 2013; Grové, Reupert, & Maybery, 2016). At the same time, adolescents' need to be able to defocus from the illness and have developmentally appropriate activities was highlighted. This provides the framework for interventions with this population and it might be useful to focus on balancing adolescents' needs to understand and care for the parent, without compromising on their own lives and needs.

The family-focussed needs further indicate the ways in which adolescent COPMI can be supported within their families. Family interventions in India generally include only adult caregivers in the family and concerns of adolescent or younger children are not routinely discussed. The themes from this study indicate that family-level interventions focussing particularly on family roles, communication and cohesion might benefit adolescent COPMI.

The system-focussed needs and recommendations provided by the mental health professionals describe ways in which Indian mental health systems can become more sensitive to the needs of adolescent COPMI. To overcome these challenges, the adoption of family-sensitive policies at the organizational level, coupled with ongoing workforce

training is recommended (Maybery & Reupert, 2009). Inadequacy of resources is a major barrier in not prioritising preventive child and family mental health (Bhargava, Sahu, & Bhattacharya, 2017). In building workforce capacity, training a few specialist professionals, who can go on to provide consultations, carry out advocacy and further capacity-building programmes (Brockington et al., 2011), might be an efficient option for the Indian scenario.

CONCLUSION

Despite a long tradition of involving families in mental health care, children of parents with mental illness have been largely ignored within mental health services. This study provides insights into the unique vulnerabilities and needs of adolescent children of parents with mental illness and provides implications for developing interventions for them. In doing so, it also highlights the need and scope to strengthen preventive and child mental health services in India.

CONFLICT OF INTEREST

The authors have no conflict of interest.

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SPIRITUAL INTELLIGENCE, PEER RELATIONS AND WELLBEING AMONG SCHOOL-GOING ADOLESCENTS

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ABSTRACT

Spiritual intelligence helps to connect and organize the capacities to adapt with life. Adolescent well-being is influenced by peer-relationship. Peer relations provide an important context for support, social comparison, and sharing ideas, while adolescents construct their identities.

The aim of this study was to evaluate spiritual intelligence, peer relationship and wellbeing among school-going adolescents. The objective of the study was to assess and see the correlation between spiritual intelligence, peer relationship and well-being among school-going adolescents.

A cross-sectional study design was used for the present study and convenience sampling was used to select schools (two private schools) from Tezpur, Assam. A total of 370 samples were selected out of 384 samples based on Krejcie & Morgan (1970) method to determine the sample size. School going adolescents were selected using simple random sampling. Informed Consent was taken from those who were willing to participate in the study. Socio-demographic datasheet, Spiritual Intelligence self-inventory, Peer-relationship questionnaire, and Adolescent wellbeing scale were administered. After administration of tools, the data was analyzed using appropriate statistical tools.

Wellbeing has a significant negative correlation with personal meaning production (r=-2.69, p=<0.05), transcendental awareness (r=1.05, p=<0.01) and conscious state expansion (r=1.63, p=<0.01); positive relationship with critical existential thinking (r=.015). It has significant positive relation with victim (r= 3.27, p=<0.01), positive relation with bully(r=0.106) and significant negative correlation with prosocial behavior (r= 2.10, p=<0.01). In regression analysis; spiritual intelligence, victim and prosocial behavior contributed significantly to the predictors of wellbeing [F (4,365) = 19.35, p<0.000]

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accounting at 1.75% variance.

Spiritual Intelligence and peer relation have a significant influence on the wellbeing of the adolescent. Psychosocial intervention is required at school to promote mental health and enhance the wellbeing of the adolescents.

Keywords: Spiritual intelligence, Peer relation, Wellbeing, and Adolescent.

INTRODUCTION:

Adolescents are dealing with the challenges of growth. They are going through puberty, meeting the changing expectations of others, and coping with feelings they might not have experienced before. The most common sources of day-to-day stress for adolescents are school-related problems or pressures; problems with peers, family issues or problems with parents; their own thoughts, feelings, or behaviours, for instance feeling depressed or lonely and getting into trouble because of their behaviour. These problems are everyday experiences for most adolescents.

Spiritual intelligence in a bigger frame can be seen as a form of intelligence because it predicts functioning and adaptation and also offers capabilities and capacities that enable people to solve problems and attain desired goals (Hosseini, Krauss, & Aishah, 2010). Wellbeing comprises of both physical and mental wellbeing. Mental and physical well-being during adolescence is found to be integrally shaped by the day to day life in which children grow and develop (Zukauskiene, 2014). Peer relations have been alternately blamed for some of the more problematic aspects of adolescent functioning and praised for contributing to adolescent health and well-being (Brown, Larson, 2009). Wellbeing plays a vital role in the psychological growth of an adolescent. Studies have shown that the adolescent's knowledge, skills, and opportunities for a healthy, productive life and enjoyment of all human rights are essential for achieving improved psychological health and it is possible only if the wellbeing of an adolescent is good (Zukauskiene, 2014; Laski, 2015). Peer group is one of the most important aspects of the adolescent. During the adolescent years, peer groups become increasingly important because the adolescent possesses more closeness gratifying relationship with friends (Bond, Thomas, Rubin, Patton, 2001; Van Der Wal, De Wit & Hirasing, 2003). Spiritual intelligence is significantly associated with peer pressure on the student's wellbeing. When there is higher peer pressure on students, they have lower spiritual intelligence and wellbeing and vice a versa (Mehta, 2017). The present study was done at, Tezpur, Assam as there has been no study done on spiritual intelligence, well-being and peer relation among adolescents in the North East state of India. Recognizing the above factors is essential when designing interventions to promote well-being among adolescents. The above study can help us in planning adequate psychosocial intervention in formulating and providing specific psychosocial intervention both at the individual family level and the school level. Furthermore, Northeast region, being the cultural hub of India, is also been a youth-

centered place. Therefore, the researcher wants to study the relationship between spiritual intelligence, well-being and peer relationships among adolescents in the northeast region of Sonitpur district, Assam. This study will add more literature in order to understand adolescents and their well-being.

METHOD

A cross-sectional study design was used for the present study and convenience sampling was used to select schools (two private schools) from Tezpur, Assam. A total of 370 samples out of 384 samples were included based on Krejcie & Morgan (1970) method to determine the sample size. School going adolescents were selected using simple random sampling. In the present study, both male and female school going students in the range of 11-17 years who were willing to participate and gave written consent (including parental consent) and who were currently studying in private schools were taken into consideration. Those students who were not willing to give consent were excluded from the study. Permission was taken from the schools to conduct the study. The study was undertaken with the permission of the scientific and ethical committee of LGB Regional Institute of Mental Health, Tezpur, Assam.

The Objectives of the Study:

- To assess spiritual intelligence, well-being and peer relationship among school going adolescents.
- To see the correlation between spiritual intelligence, well-being and peer relationships among adolescents.
- To determine the extent to which spiritual intelligence and peer relationship predict the variability of well-being among adolescents.

Description of Tools:

- **Socio-Demographic Data Sheet:** It includes details regarding age, sex, education, occupation, religion, caste, domicile, family income and the like.
- **The Spiritual Intelligence Self-report Inventory:** Spiritual Intelligence Self-Report Inventory (SISRI) had been developed by King (2008) is a four-factor model of spiritual intelligence for which supportive evidence was reviewed for the capacities of critical existential thinking (CET), personal meaning production (PMP), transcendental awareness (TA), and conscious state expansion (CSE). The Spiritual Intelligence Self-Report Inventory (SISRI-24), displayed excellent internal reliability of Cronbach's Alpha = .920 and Standardized Alpha = .922.

- **Peer Relation Questionnaire (for children):** Peer Relation Questionnaire (for children) was developed by Ken Rigby and Phillip Slee in 1994. It is a 20-item questionnaire with a 4 point Likert scale from 1(never)-4 (very often) designed to see the significance of peer relationships among children. It has 03 subscales which assess bully, victim, pro-social.
- **Adolescent Well-Being Scale:** The adolescent well-being scale was developed by Birleson in 1980, which was derived from the depression self-rating scale for children and assesses both depressive symptoms and well-being in children and adolescents. The scale was developed to assess the well-being of children belonging to the age group of 11-16 years. The responses ranged from 0 (most of the time) to 2 (never). A score above 13 is suggestive of possible depressive disorder. However, the tool is not a diagnostic instrument. Test-retest (r =0.80); and internal consistency (= 0.73-0.90) of the scale are good.

Analysis and Interpretation of Data:

The analysis was done by using SPSS version 19.0. Mean and the Standard Deviation were used to assess the range of continuous variables and frequency and percentage was used for ordinal and nominal variables. Mean and the Standard Deviation were used to assess spiritual intelligence and peer relation among adolescents. Pearson's coefficient correlation was used to see the relationship between spiritual intelligence, peer relation and well-being among adolescents and regression analysis was used to see how spiritual intelligence, peer relation and predict the well-being among adolescents.

Ethical Consideration:

The study was undertaken with the approval of the scientific committee and ethical committee of LGBRIMH. The participants were clearly explained about the purpose of the study and the study was carried out with the Informed Consent of all participants. The confidentiality of the respondents was assured before the study. The collected data was only used for the research purposes.

RESULTS

Table 1: Socio-Demographic of the Respondents

Variables		Frequency N=370	Percent (%) N=370
Sex	Male	191	51.6
	Female	179	48.4
Education	VIII	57	15.4
	IX	167	45.1
	X	102	27.6
	XII	44	11.9
Religion	Christian	4	1.1
	Hindu	337	91.1
	Islam	26	7.0
	Other	3	.8
Ethnicity	Tribal	50	13.5
	Non-tribal	320	86.5
Residence	Rural	73	19.7
	Urban	164	44.3
	Semi-urban	133	35.9
Place of stay	Home	364	98.4
	Hostel	6	1.6
Current stay (with guardian)	Parents	348	94.1
	Mother	12	3.2
	Father	3	.8
	Relatives	4	1.1
	Other	3	.8
Family Type	Nuclear	249	67.3
	Joint	110	29.7
	Extended	11	3.0
No. of siblings	Less than 2	359	97
	More than 2	11	3
Father's education	Professional	47	12.7
	Graduate and post graduate	135	36.5
	Intermediate or post higher school	39	10.5
	High school certificate	110	29.7
	Middle school certificate	31	8.4
	Primary school certificate	7	1.9
	Illiterate	1	.3
Father's occupation	Professional	275	74.3
	Semi-professional	18	4.9
	Clerical, shop owner	44	11.9
	Skilled worker	24	6.5
	Semi-skilled worker	6	1.6
	Unskilled worker	2	.5
	Unemployed	1	.3

Mother's education	Professionals	37	10.0
	Graduate and post graduate	86	23.2
	Intermediate or post higher school	41	11.1
	High school certificate	142	38.4
	Middle school certificate	47	12.7
	Primary school certificate	11	3.0
	Illiterate	6	1.6
Mother's occupation	Professional	45	12.2
	Semi-professional	14	3.8
	Clerical, shop owner	4	1.1
	Skilled worker	9	2.4
	Semi-skilled worker	1	.3
	Unemployed	297	80.3
Income (based on Kuppuswamy scale)	< 36017 Rupees	190	51.4
	18000-36016 Rupees	105	28.4
	13495-17999 Rupees	49	13.2
	8989-13494 Rupees	16	4.3
	5387-8988 Rupees	4	1.1
	1803-5386 Rupees	6	1.6

Table 1 reflects that a majority of students were male (51.6%), studying in class IX (45.1%), belonging to Hindu religion (91.1%) and hailing from non-tribal (86.5%) urban sector (44.3%), residing in home (98.4%), with parents (94.1%) in a nuclear family type (67.3%) with majority of respondents having less than two siblings (97%). In the Table, the respondents' fathers were graduates (36.5%) and professionals (74.3%). A majority of the respondents' mothers were high school passed (38.4%) and unemployed (80.3%) with a family income of less than Rs. 36,017 per annum (51.4%).

Table 2: Spiritual Intelligence among Adolescents

Domains of Spiritual Intelligence	Mean	Std. Deviation
Critical Existential Thinking	15	4.40
Personal Meaning Production	12	3.7
Transcendental Awareness	15.9	3.89
Conscious State Expansion	11	3.52

The Result Indicates that the mean score was high in the domain of transcendental awareness (Mean=15.9, SD=3.89), followed by critical existential thinking (Mean=15, SD=4.40), and the conscious state of expansion (Mean=11, SD=3.52) in spiritual intelligence inventory (Table No.2)

Table 3: Peer Relation among Adolescents

Domains	Minimum	Maximum	Mean	Standard Deviation
Bully	06	20	10.6	3.42
Victim	05	18	9.9	2.60
Prosocial	05	16	12.8	2.33

Table 3 indicates that the mean score was high in the domain of prosocial behaviour among adolescents (Mean=12.8, SD=2.33), followed by the bully (Mean=10.6, SD=3.4), and the victim (Mean=9.9, SD=2.60) in peer relationship questionnaire.

Table 4: Correlations between Spiritual Intelligence and well being

	Critical Existential Thinking	Personal Meaning Production	Transcendental Awareness	Conscious State Expansion	Spiritual Intelligence Total
Well-being	.015	-.269**	-.105*	-.163**	-.168

Well-being has a significant negative correlation with personal meaning production (r=-2.69, p=<0.05), transcendental awareness (r=1.05, p=<0.01) and with conscious state expansion (r=1.63, p=<0.01) and well-being has a positive relationship with critical existential thinking (r=0.015) (Table No.4).

Table 5: Correlations between Peer Relation and Well Being

	Bully	Victim	Prosocial
Well-being	.106	.327**	-.210*

Well-being has a significant positive relation with victim (r= 3.27, p=<0.01), positive relation with bully (r=0.106) and significant negative correlation with prosocial (r= 2.10, p=<0.01) as shown in Table No. 5.

Table 6: Regression Analysis of Spiritual Intelligence and Peer relation on Well-being.

MODEL	Unstandardized coefficient		Standard coefficient	T	R^2	F	Sig
	B	Standard Error	Beta				
(Constant)	14.054	1.607	-	8.747	4.18	19.3	0.000***
Spiritual Intelligent Total	-.059	.018	-.161	-3.341			0.001**
Bully	-.034	.061	-.028	-.554			0.580
Victim	.551	.081	.343	6.764			0.000***
Prosocial	-.323	.085	-.183	-3.784			0.000***

Spiritual Intelligence, Victim and prosocial contributed significantly to the predictors of well-being [F (4,365) =19.35, p<0.001] accounting at 1.75% variance. The remaining 98.25% was not attributing to well-being. Spiritual intelligence (Beta=-.161; t=-3.341; p<0.001), Victim (Beta= .343; t= 6.764; p=0.000) and prosocial behavior (Beta=-.183; t=-3.784; p=0.000) strongly contributes to overall well-being among adolescent (Table No. 6).

DISCUSSION

The results showed that respondents have higher spiritual intelligence in the domain of transcendental awareness, critical existential thinking and the conscious state of expansion. Similar results were found in the studies where it was concluded that those with higher spiritual intelligence are more flexible, self-conscious, capable of intuition, holistic toward universe (Ebrahimi, Keykhosrovani, Dehghani, & Javdan, 2012; Kaur, Sambasivan, & Kumar, 2013). Vaughan (2002) stated that spiritual intelligence among adolescents is the consequence of the highest level of individual growth in the fields of cognition, meaning attainment, transcendental and moral communication. Ebrahimi (2015) indicated that spiritual intelligence could be used in the prediction of psychological states and they are considered as predictors for the emotional and psychological well-being.

The present study showed that prosocial behaviour is high among adolescent followed by bullying and victim in the domain of peer relationship questionnaire. Similar inferences

were drawn from other studies which stated that increased similarity among peers provides them with a sense of security and affirms their acceptance into their chosen peer group (Bond, Thomas, Rubin, & Patton, 2001; Van Der Wal, De Wit, & Hirasing, 2003). Peer relationships play a critical role in the development of adolescents, for the acquisition of social skills, for the sense of personal identity and competence. Thus, peer relationships can influence actual and future mental health of the adolescents.

In the present study higher score in well-being scale is indicative of the presence of depression. Well-being has a significant negative correlation with personal meaning production, transcendental awareness, and conscious state expansion. Pawar (2018) in his study also commented that adolescents with depression feel life is hopeless, have a bleak pessimistic view about the future, their communication is poor, they remain inactive in social functioning and are usually unhappy about their lives which in the long run compromise spiritual intelligence in the adolescents. The present study showed that well-being has a significant positive relation with the victim, positive relation with the bully and significant negative correlation with prosocial behaviour. As findings from other studies show that peer relationships are significantly related statistically to less depression, as well as bullying (Sarkova et al., 2014). Iosue et al., (2013) reported that adolescents who reported poor peer relationships scored significantly higher on depression. Similar findings were seen in studies where adolescent were more prone to being victims due to peer pressure (Van Der Wal, De Wit, & Hirasing, 2003; Brown & Larson, 2009). In regression analysis, spiritual intelligence, victim and prosocial contributed significantly to the well-being and prosocial behavior and strongly contributed to overall well-being among adolescents. Studies also concluded that psychological well-being of adolescent is lowered due to victimization and bullying by peer group and in the long run, it also has an adverse effect on spiritual intelligence (Bond, Thomas, Rubin, & Patton, 2001; Van Der Wal, de Wit, & Hirasing, 2003). Studies have shown that spiritual intelligence (conscious state expansion, personal meaning production, transcendental awareness, and critical existential thinking) has a significant association with psychological well-being (Sahebalzamani, Farahani, Abasi, & Talebi, 2013). The current study had some limitations; firstly, selection of the school was restricted to one area; secondly, correlates of the sociodemographic variables were not studied.

IMPLICATIONS OF THE STUDY

The current study has shown the relationship between spiritual intelligence, peer relation and well-being among adolescents. This can be helpful for the mental health professionals to understand the adolescent psyche and the problems, which are there in the society and in their day-to-day lives. In the light of these findings, adolescent

problems can be addressed and a structured psychosocial management program can be provided which can enhance their well-being. Providing a spiritual training programme might also help them. There is a need for promoting mental health in school for enhancing well-being.

CONCLUSION

Spiritual Intelligence and peer relationship have a significant influence on the well-being of the adolescent. Psychosocial intervention is required at school to promote mental health to enhance the well-being of the adolescents. Spiritual intelligence provides students the ability to develop an inner knowledge, the capacity to connect to the "Universal Mind or Big Mind" through deep intuition, the cultivation of oneness with the universe or nature, and the acquisition of problem-solving capabilities that benefit others. Spiritual intelligence training could be helpful as a new psychological and religious construction to decrease psychological distress and to improve the experienced level of mental health among adolescents.

CONFLICT OF INTEREST

Nil

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SELECTED LIFE SKILLS INTERVENTION-AN EFFICACY STUDY

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ABSTRACT

In the present study, an attempt was made to study the efficacy of Life Skills Education program among adolescents.

The Objectives of the study were: to test the efficacy of the life skills intervention program. The sample size of the study was 111 adolescents. Purposive sampling method was used. Life skills scale was used to collect the data. The study used before and after without control group design. The World Health Organisation model training package was used in the training program.

Need assessment showed that the adolescents lacked critical thinking, creative thinking, coping with stress and coping with emotion. Based on the findings of the need assessment, the researcher implemented life skill activities suggested by World Health Organisation. The results showed that there was a significant difference between pre and post mean scores in all the domains ($p<0.001$).

The stage of adolescence is very crucial due to the changes in physical as well as the mental status of the child. Thus, the need of life skill education for this specified group is very relevant.

Key words: Life Skills, Life Skills Intervention Program, Life Skills Education, Life Skills Activities.

INTRODUCTION

Life skills are a large group of psycho-social and interpersonal skills which can help individuals to make appropriate decisions, effective communication skills and skills for developing coping and self-management that helps the individual to lead a productive and healthy life (Kaur, 2018) “Life skills are the abilities for adaptive and positive

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behaviour that enable individuals to deal effectively with the demands and challenges of everyday life." (WHO, 1993)

The importance of life skills education among adolescents lie in the fact that it helps in the transition of the individuals from childhood to adulthood with the healthy development of social and emotional skills. It helps in the development of social competence and problem solving skills which in turn help the adolescents to form an identity of their own. In the context of adolescents, life skills education helps to delay the onset of abuse of tobacco, alcohol etc. It also develops a positive self-esteem among adolescents (Kumar, 2014).

The WHO model of Life Skills training process describes ten life skills: decision making, problem solving, creative thinking skill, critical thinking skill, communication skill, interpersonal relationship skill, self-awareness skill, empathy skill, coping with emotions skill and coping with stress skill (WHO, 2007).

REVIEW OF LITERATURE

Sharma (2003) found that mother's education was significantly associated with increased level of life skills in adolescents. Khera (2012) reported that there is a positive co-relation between core affective life skill and self-concept of adolescents which means those who possess these essential skills have better confidence in all aspects. Parvathy (2015) in her study revealed a significant impact of life skills education training on adolescents. This opens up the arena to conduct more research in this field with modifications and contextualization of training modules. Kaur (2011) reported that the students who were low on test norms were selected for the Emotional quotient (EQ) development program for three months. Following the program, there was a significant increase in the scores of EQ. Bharath & Kumar (2010) in their study revealed that there was a significant difference in some of the aspects such as perceived self-efficacy, better self-esteem, prosocial behaviour and better general adjustment, as an outcome of life skills training. Esmaeilinasab (2011) also found that the life skill program was effective and it improved the score of self-esteem in the participants. The Kazemi (2014) study revealed that there is a significant difference in the experiment and control group. The mean score of self-esteem and communication skills in experiment group, which got life skills training, was higher than the control group. Kumar (2014) pointed out that life skills taught adolescents to communicate with their parents, teachers, adults and peers. They also learnt to take control of their emotions. Nivedita (2016) mentioned in her study that life skills education is necessary for children and adolescents because they are most

vulnerable to behaviour related health problems. Saiedeh Behroz-Sarcheshmeh(2017) found a significant difference in the experimental group between total social skills and subscales of the test (cooperation, assertiveness and self-control). The study found that life skill training is needed to improve the social skills of students with intellectual disability

METHOD

The aim of the study was to study the efficacy of Life Skills Education programme among adolescents. The objectives of the study were to assess the needs of children, to impart the appropriate life skills and to test the efficacy of the intervention. In this study, the researcher adopted the experimental research design before and after without control group. This design includes two level of assessment: Pre intervention assessment (A) and Intervention level-- Post assessment (B).

Purposive sampling method was used to select the sample from the population. Both male and female students from 6th to 10th standard were included in the study with the help of school teachers. Students who had participated in similar studies in the past were excluded. The sample size of the study was 111 adolescents.

Before the intervention, the Informed Assent was obtained from the participant and confidentiality was assured and maintained.

A semi-structured interview schedule was prepared to assess the demographic details of the respondents. The baseline assessment was undertaken by using Life skills assessment scale developed by Vranda (2009). Baseline data collected from the children through interview method was entered in an EXCEL sheet for need assessment. Quartile deviation was calculated to identify the children who have scored low level of scores in the life skills. Their skill-status was categorized as high, medium and low. After analysing the baseline data, the researcher was able to identify the needs of children. The researcher identified those with low level skills and selected the candidates for intervention. Thus, out of 10 life skills; (i) Critical thinking skill (ii) Creative thinking skill (iii) Coping with stress (iv) Coping with emotion were identified for intervention. Based on the need assessment the researcher has planned the activities and conducted the intervention using WHO life skills manual. As per the need assessment, the researcher had planned the intervention strategy, including activities related to critical thinking, creative thinking, coping with stress and coping with emotions. For enhancement of each of the four selected skills (critical thinking skill, creative thinking skill, coping with stress and coping with emotion) separate intervention sessions were undertaken and participants were selected in different intervention groups according to their deficiency in a particular skill. One

month after the completion of the intervention, post assessment was undertaken and postscores were obtained. The data was analysed using SPSS version 21. Significant difference was found between the pre and post intervention scores. To describe the study variables, descriptive statistics was used. To find out the difference between pre and post intervention, student t test was used and correlation was used to see the relationship.

RESULTS

Table 1: Socio-Demographic details:

Variable	Category	N=111	%
Education	6th	6	5.4
	7th	44	39.6
	8th	22	19.8
	9th	26	23.4
	10th	13	11.7
Gender	Male	33	29.7
	Female	78	70.3
Category	GM	13	11.7
	OBC	24	21.6
	SC	57	51.4
	ST	13	11.7
	Minority	4	3.6

Table 1 describes the socio-demographic details of the respondents. The age group of the respondents was 13 to 18 years (M=14±1.62). Out of 111 respondents, 29.7% of them were males and 70.3% of them were females. 11.7% of the respondents belonged to General category. 21.6% of them belonged to OBC category. 11.7% of them belonged to ST category. 3.6% of them belonged to minority category. Majority (51.4%) of the respondents belonged to Scheduled Caste. A majority of the respondents belonged to lower socio-economic background and it shows that respondents were studying in middle and high school.

Table 2: Differences between pre and post intervention scores on various domains

Domain	Observation	N	Mean	SD	t	df	Sig. (2-tailed)
Critical thinking	Pre	67	34.7164	4.36517	-10.230	66	.000*
	Post	67	40.2388	4.13078			
Creative thinking	Pre	40	47.4500	8.26779	-7.304	39	.000*
	Post	40	54.6000	5.70110			
Coping with stress	Pre	49	30.4286	4.89047	-7.433	48	.000*
	Post	49	34.6735	4.64304			
Coping with emotions	Pre	34	33.2353	4.67138	-5.685	33	.000*
	Post	34	36.8824	3.88287			

*Significant at 0.001 level

The Table 2 shows that there is a significant difference between pre and post scores in four domains that the intervention imparted to the group. The Mean and standard Deviation clearly show that post intervention scores are higher than pre interventions. The t test shows that there is a difference between the pre and post intervention in critical thinking, creative thinking, coping with stress and emotion scores ($p<0.001$). Hence, it is concluded that intervention is effective in all the domains.

Table 3: Inter-Correlation Matrix

		AGE	EDUCATION	CRT PRE	CRT POST	CRET PRE	CRET POST	CWS PRE	CWS POST	CWE PRE	CWE POST
AGE	Pearson Correlation	1									
	Sig. (2-tailed)										
	N	111									
EDUCATION	Pearson Correlation	.208*	1								
	Sig. (2-tailed)	.029									
	N	111	111								
CRT PRE	Pearson Correlation	.204	-.086	1							
	Sig. (2-tailed)	.098	.488								
	N	67	67	67							

CRT POST	Pearson Correlation	.272*	-.042	.460**	1						
	Sig. (2-tailed)	.026	.734	.000							
	N	67	67	67	67						
CRET PRE	Pearson Correlation	.052	.126	.823**	.091	1					
	Sig. (2-tailed)	.750	.439	.000	.747						
	N	40	40	15	15	40					
CRET POST	Pearson Correlation	.269	.137	.592*	.401	.663**	1				
	Sig. (2-tailed)	.093	.400	.020	.139	.000					
	N	40	40	15	15	40	40				
CWS PRE	Pearson Correlation	.068	-.164	.210	.046	.283	.566	1			
	Sig. (2-tailed)	.641	.259	.283	.816	.372	.055				
	N	49	49	28	28	12	12	49			
CWS POST	Pearson Correlation	.435**	-.014	.153	.244	.099	.588*	.649**	1		
	Sig. (2-tailed)	.002	.923	.438	.211	.760	.045	.000			
	N	49	49	28	28	12	12	49	49		
CWE PRE	Pearson Correlation	.400*	.062	-.199	-.004	-.137	-.291	.175	.560**	1	
	Sig. (2-tailed)	.019	.726	.536	.991	.670	.358	.414	.004		
	N	34	34	12	12	12	12	24	24	34	
CWE POST	Pearson Correlation	.635**	.028	.060	.035	-.296	-.020	.101	.842**	.631**	1
	Sig. (2-tailed)	.000	.874	.852	.913	.350	.950	.638	.000	.000	
	N	34	34	12	12	12	12	24	24	34	34
*. Correlation is significant at the 0.05 level (2-tailed).											
**. Correlation is significant at the 0.01 level (2-tailed).											

The Correlation Table 3 shows that there is a relationship between age and education; age and critical thinking post scores; age and coping with stress post scores; age and coping with emotion scores of pre and post indicating these variables are interrelated.

Education does not have a correlation with any variable. Critical thinking (pre level) score has a correlation with critical thinking post score, creative thinking pre and post scores. Creative thinking pre score has a relationship with creative thinking post scores. Creative thinking post score has a correlation with coping with stress post scores. Coping with stress pre score has a relationship with coping with stress post scores.

Coping with stress post scores has a relationship with coping with emotions pre scores and coping with emotions post scores. Coping with emotion pre score has a relationship with coping with emotion post scores.

DISCUSSION

Life skills are very important for each individual. Lack of life skills will lead to problems in the individual's life. Like Skills Education is very important from primary to higher education, especially in the stage of adolescence. The researcher has conducted intervention with adolescents after conducting a need assessment. The need assessment clearly showed that the referred adolescents did not require all the life skills and needed few of them only. In whichever skills they were lacking, intervention was imparted to improve those skills. Based on the skills, groups were formed and intervention was imparted. They were very active during the training program. The results show that there was a significant difference in critical thinking, creative thinking, coping with stress and emotion scores between the pre and post intervention ($p<0.001$). These skills are very essential for success in life. After the intervention, significant changes were reported by teachers. Life skills play a vital role in building personality and help to deal with problems in daily life. Identifying the children with lack of skills and conducting intervention in those areas will bring significant changes in one's life.

There are some similar studies which revealed the effectiveness of Life Skill intervention. Parvathy (2015) conducted a study to analyse the knowledge of life skills among adolescents and the impact of life skills education training on their knowledge level. The study found a significant impact of life skills education training on adolescents. The study clearly showed that after the intervention there was significant change in life skills and other areas of adolescents. Bharath & Kumar(2010) in their study revealed that there was a significant difference in some of the aspects such as perceived self-efficacy ($P=0.000$), better self-esteem ($P=0.001$), prosocial behavior ($P=0.001$) and better general adjustment ($P=0.000$). Esmaeilinasab(2011) found that the life skills intervention program was effective and it improved the score of self-esteem in study group subjects.

LIMITATION

The sample of the study is small to give policy level implications. The intervention was undertaken for only four life skills.

IMPLICATIONS OF THE STUDY

As it is discussed, life skills based education play an important role in the healthy and positive growth of the adolescents. Pre and post scores have shown the impact of life

skills interventions in the adolescents. These practice sessions will help the children to enhance their creative thinking ability and also enable them to cope with the challenges in the day to day life. Researcher even observed some changes among the adolescents like some were shy during the early days of the intervention to participate in the activities but gradually underwent changes.

RECOMMENDATION

Many students do not have access to Life Skills Training; In order to make it accessible to all Life skills education can be included in the school curriculum. It can also help to sustain the effectiveness of life skills intervention. Teachers can be trained as life skills educators so that they can provide life skills training to the students on a regular basis.

CONCLUSION

The study clearly shows that Life Skills training programs bring significant changes among adolescents. Life skills are more effective than traditional information-based programs because life skills training uses active learning methods such as discussions, stories, drawings, role play and demonstrations. The researcher conducted Life Skill training using active learning methods which ensured the participation of adolescents in all the life skill activities and it made the intervention effective. Life Skills Education, can bring about desirable changes in adolscents and make them utilize their potentials to the fullest extent.

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A STUDY ON HOPELESSNESS AMONG TRIBALS IN VALPARAI HILLS, TAMIL NADU

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ABSTRACT

Tribals are indigenous people living in forest areas who depend on forests to eke out a livelihood.

Objective of the study is to assess the hopelessness and its correlates with background characteristics of the tribals.

There were 165 tribals in two selected settlements and all of them were included as respondents in this research. To collect the required data, the hopelessness scale developed by Beck et al., (1974) was used. The reliability of the tool was also established.

The results shows that the average age of the respondents was 45.7 years, half of them were females (51%) and 77% of the respondents were married. A majority (94.7%) of them were literates, but most of them were school dropouts at middle school level. Their average level of education was 6.6 years of schooling. Their main occupation was agriculture. The average family income and expenditure of the respondents was Rs. 8169 and Rs.2533 respectively. The mean score of the hopelessness of the respondents was 9.02. The low and high level of hopelessness constitute 58 % and 42 % respectively. ANOVA results showed difference in levels of hopelessness based on socio-demographic variables. Further, the correlation result shows that age is positively correlated with hopelessness whereas it is negatively related to personal and family income.

The tribals seem to face higher hopelessness while their income is low. Hence, steps must be taken to implement viable employment generation programmes to increase their income which will reduce the hopelessness among the tribal people.

Keywords: Kadar Tribes, Background characteristics, Hopelessness

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INTRODUCTION

According to Majumdar (1961) a tribe is a social group with territorial affiliation, endogamous with no specialisation of functions, ruled by tribal officers, hereditary or otherwise, united in language or dialect, recognising social distance from other tribes or caste but without any stigma attached (as) in the case of caste structure following tribal traditions beliefs and customs, illiberal of naturalization of ideas from alien sources, above all conscious of homogeneity of ethnic and territorial integration. According to the World Bank (1982) Tribals can be defined as 'those ethnic groups typically with stable low energy sustained yield economic systems, as exemplified by hunters, gatherers, shifting or semi-permanent farmers, herders or fisherman. The tribal groups are presumed to form the oldest ethnological sector of the national population'. Article 366 (25) of the Constitution of India refers to 'Scheduled Tribes' as those communities, who are scheduled in accordance with Article 342 of the Constitution'. This Article says that only those communities who have been declared as such by the President through an initial public notification or through a subsequent amending Act of Parliament will be considered to be Scheduled Tribes (Government of India, 2012). Hopelessness is a powerful emotion that often contributes to a dark or low mood and may adversely affect the way one perceives the self, other individuals, personal circumstances, and even the world. Often hopelessness can have a significant influence on human behaviour, as it may reflect an individual's negative view of the future. Hopelessness is listed as a symptom of many behavioural and mental health issues, such as depression, anxiety, bipolar, post traumatic stress, substance dependency and suicidal ideation (Goodtherapy.org, 2018)

REVIEW OF LITERATURE

Various studies have been conducted on the mental health of tribals. Gentile (1991) observed that psychological, sociological; spiritual and environmental factors were the determinants of quality of life. Hence quality of life is equated with adequate income and material possessions, good physical health and quality of care, psychological rewards such as feelings of self-worth and self-esteem and social factors such as relationship with others and communication. Husain et al., (2007) reported that education status was correlated with depression. Yadav et al., (2013) reported that more than two thirds of the tribal students had low self-esteem. Singh and Dewan (2018) indicated that 79% of tribal women have scored high level of desperation and stress than the non-tribal women. Basu et al., (2018) indicated that there is a high prevalence of social problems like illiteracy, unemployment, financial dependence, morbidities and stress among the elderly tribes.

From the review of earlier literature, it is revealed that there is no study on hopelessness among the tribal people in India. In order to fulfil this research gap, this study on hopelessness of tribal people was conducted.

METHOD

The main Objective of the present research was to assess the hopelessness and its correlates with background characteristics of the tribals. In order to measure the research objective, the researcher formulated a null hypothesis that there is no statistically significant difference in the mean score of hopelessness across the background characteristics of the respondents. Cross sectional descriptive design was used for the study.

Method and Participants: The researcher purposively selected Kadar tribes in Valparai Hills, Coimbatore district, Tamil Nadu. As per the revenue records, there are six Kadar settlements in Valparai. Among the six settlements, the researcher selected two Kadar settlement namely Nedungunram and Udumanparai settlements, as the forest department gave permission for these two settlements only. There were 165 adult members in both settlements. For the present research, the researcher selected all the adult members. At the time of data collection, the researcher was not able to collect the data from fifteen adult members due to the nature of their occupation and migration to other places. Hence, the researcher conducted the interview among 150 adult tribal members. Thus, census method of sampling was adopted in this study.

Inclusion and Exclusion Criteria: The study was conducted only among Kadar tribes and other tribes like Mudhuvan, Irular who live in the same forest areas were excluded as their culture is different. Adult members aged 18 and above only were included in the study.

Ethical Considerations: Since all the six Kadar settlements in Valparai hills are located inside the reserved forest area, written permission was obtained from the forest department for conducting research. As there was high movement of wild animals inside the forest, the forest department gave permission to conduct research only in two settlements, namely Nedungunram and Udumanparai, for the safety of the researcher. As Kadar tribes are primitive and controlled by traditional tribal leaders, oral permissions were obtained from the leaders of the respective settlements by explaining the purpose and benefit of the research to them. The tribal leaders in turn informed the members of their respective settlements to cooperate with the researcher for the data collection. The respondents were given the opportunity not to participate or to withdraw from the interview at any time for any reason.

Tools of Data Collection: A semi-structured Interview Schedule was prepared to collect the personal information and socioeconomic conditions of the respondents. In order to measure the hopelessness of the respondents, the researcher used the hopelessness scale developed by Beck et al., (1974). Each response was assigned a '0' or '1' score and the total hopelessness score is the sum of the scores of individual items. The possible range of scores is from 0 to 20. The reliability value of the hopelessness scale is alpha 0.558. The researcher administered the interview schedules through face-to-face interviews with the respondents. The respondents were interviewed during their leisure time at their homes as well as in their place of work. On an average, five respondents were interviewed per day. The average time taken to interview each respondent was about 45 minutes. The researcher took 30 days for collecting the data from the respondents during the month of October 2017.

Analysis of Data: After the completion of the data collection, all the interview schedules were checked for completeness of responses and edited. To analyse the data, the researcher used SPSS software version-24 (IBM Corp., 2017). The analysis was carried out with the help of frequency distributions, ANOVA, t-test and stepwise regression analysis.

RESULTS

Background Characteristics of the Respondents: The results show that the respondents in the middle age group constitute 61% and their average age is 45.73 years. The male and female respondents constitute 49% and 51% respectively. A majority (77%) of them were married. A vast majority (95%) of them were literates ranging from primary to collegiate education. However, the average year of schooling was only 6.6. It means that their level of education was up to 6th or 7th standard only. There after, they dropped out from school education. This may due to the lack of middle and high school facilities in their settlement itself or nearby. A little higher than half (59%) of the respondents were engaged in agriculture followed by labourers in tea and coffee plantations (27%) and involved in hunting and collection of forest products (9%) to make out a livelihood. Their average monthly income was Rs.8,169/- with a minimum of Rs. 2,000/- to a maximum of Rs. 19,000/- per month. The average family expenditure was Rs. 2,533/-with a minimum of Rs. 500/- to a maximum of Rs. 5,000/- per month. It is to be noted that the monthly family expenditure was very less when compared with their monthly family income. A vast majority (95%) of them were living in nuclear family. All the families were living in their own houses with tiled roof. The average number of rooms in their home was 3.5 with a minimum of three rooms to a maximum of four rooms. All the houses were electrified and provided with protected drinking water supply through street pipes/taps. Further the finding revealed that 95% of the families have mobile phones and the average number of mobile phones owned by a family was 1.7 ranging from 1 to 4 mobile phones per family.

Level of Hopelessness: The results has been classified into 'low' to 'high' categories based on the mean score in order to measure the level of hopelessness. The findings indicate that a little less than half (46%) of the respondents scored high level of hopelessness score.

Hopelessness and Background characteristics:

Table 1: One-Way ANOVA Between Hopelessness and the Background Characteristics of the Respondents

SN	Variables		N	Mean	SD	DF	F / t	Sig.
1	Age Group	Young (35 or <)	35	6.77	2.860	2 147	25.254	0.000 p< 0.001
		Middle (36 - 59)	91	8.87	3.081			
		Old (60 &>)	24	12.88	4.307			
		Total	150	9.02	3.750			
2	Sex	Male	74	8.53	3.840	1 148	2.551	0.112 p> 0.05
		Female	76	9.50	3.620			
		Total	150	9.02	3.750			
3	Marital Status	Married	115	8.30	3.418	1 148	-4.565	0.000 p< 0.001
		Single	35	11.40	3.852			
		Total	150	9.02	3.750			
4	Education	Illiterate	8	10.00	5.043	4 145	.207	0.934 p> 0.05
		Primary	48	8.88	4.374			
		Middle	51	8.84	2.866			
		High School & H. Sc.	40	9.20	3.797			
		Graduates	3	9.33	4.041			
		Total	150	9.02	3.750			
5	Occupation	No work	7	10.00	3.162	3 146	3.485	0.017 p< 0.05
		Agriculture	88	9.59	3.612			
		Plantation Worker	41	8.51	3.716			
		Coll. of Forest Products	14	6.43	3.995			
		Total	150	9.02	3.750			
6	Family Income	5000 or <	34	11.03	3.873	2 147	9.162	0.000 p< 0.001
		5001 - 10000	78	8.91	3.423			
		10001	38	7.45	3.547			
		Total	150	9.02	3.750			

7	Family Expenditure	2000 or <	68	9.69	4.090	2	2.038	0.134
		2001 - 4000	75	8.44	3.492	147		p> 0.05
		4001 &>	7	8.71	1.604			
		Total	150	9.02	3.750			
8	Type of Family	Joint Family	8	8.62	3.926	1	-.305	0.761
		Nuclear Family	142	9.04	3.753	148		p> 0.05
		Total	150	9.02	3.750			

Age and Hopelessness: Panel 1 of Table1 reveals that the mean score of hopelessness was higher among the old age (12.9) when compared with young (6.8) and middle (8.9) age group respondents. The ANOVA result (F=25.254, p< 0.001) shows that there is a statistically very highly significant difference between the age group of the respondents in the mean score of hHopelessness.

Occupation and Hopelessness: Panel 5 of Table 1 reveals that the mean score of hopelessness was higher among the respondents who were not engaged in any type of work (10.0) when compared with the respondents who were engaged in agriculture (9.6), followed by plantation workers (8.1) and those who were involved in hunting / collecting forest products (9.3). The ANOVA result (F=3.485, p< 0.05) also shows that there is a statistically significant difference between the occupation of the respondents in the mean score of hopelessness.

Family Income and Hopelessness: Panel 6 of Table 1 reveals that the mean score of hopelessness was comparatively higher among those respondents who were earning Rs. 5,000 or less (11.03) when compared with other income categories. Further, it is also noted that the family income of the respondent increases as the hopelessness score decreases. The ANOVA result shows that there is a statistically very high significant (F= 9.162, p< 0.001) difference between the family incomes of the respondents in the mean score of hopelessness.

Marital Status and Hopelessness: Panel 3 of Table 1 reveals that the mean score of hopelessness was higher among the respondents who were single (unmarried/ widowed/separated/destitute) (11.4) when compared with married (8.3) respondents. The t test result (t= -4.565, p< 0.001) shows that there is a statistically very highly significant difference between the marital status of the respondents in the mean score of hopelessness.

However, the ANOVA results in Panel 4 & 7 and t test results of in panel 2 & 8 of Table 1 shows that there is no statistically significant differences.

Based on the above results, the Research Hypothesis was true in the context of the age, marital status, occupation, and family income.

Background Characteristics and Hopelessness of the Respondents:

The correlation test was carried out between the background characteristics (age, education, income, expenditure) of the respondents and the hopelessness score to find out the relationship between these variables.

Table 2: Zero order Correlation between the Background Characteristics and Hopelessness score

Variables	Age	Edu.	R. inc.	F. Inc.	F. Exp.	Hopeless
Age	1					
Education	***-.265	1				
Respondent income	**-.231	.131	1			
Family income	***-.261	.006	***.340	1		
Family expenditure	**-.233	$^{@}$.140	**.213	*.201	1	
Hopelessness score	***.470	-.012	**-.247	***-.361	*-.163	1
*** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$ &$^{@}$ $p < 0.10$						

Table 2 reveals that, age is positively correlated with hopelessness (r = 0.470, p< 0.001) whereas it is negatively correlated with respondent's personal income (r = -0.247, p< 0.001), family income (r = -3.361, p< 0.01) and family expenditure (r = -0.163, p< 0.5) and there is relationship between the education of the respondents and hopeless score.

IMPLICATIONS & SUGGESTIONS:

Even though 95% of the tribals were literates, their education was up to the middle school level. i.e., they had dropped out at 7th standard itself. This was due to the lack of school facilities close to their settlements. Hence, it is suggested that school facilities must be provided close to their settlements, so that they can continue their education till high school level without dropping out from the school.

During the interview, it was reported that the children of the tribal forest settlements were influenced by their peer groups since their childhood. Most of their hobbies were roaming around the village, hunting, collection of fruits and roots in the forest, playing with their peer groups and the like. Further they were not able to restfully be seated in one place for a satisfactory period of time to receive academic inputs and concentrate on education, which resulted in their becoming dropouts. They were also unable to mingle with the non-tribal children in schools as well as in the residential hostels. In order to solve this problem, there is a need for providing career guidance and counselling, besides providing education in their settlements itself (forest as the classroom) by non/informal

way of education adopting play/activity based learning at primary/middle school level of education through committed NGOs.

Further, it is suggested that the children camps (comprises of both tribal and non tribal children) can be organised in tribal settlements itself so that the tribal children acquainted with non tribal children / learn group living so that dropout of tribal children from primary/middle schools can be prevented.

A village level committee must be formed along with the school teachers not only to ensure the school admissions but also to prevent the occurrence of dropouts.

Parents themselves involve their children in the forest-based occupation and care of their younger ones which also leads them to neglect education.

Since two thirds (67%) of the respondents depend on forest-based agriculture and collection of forest products/natural resources like honey, seeds, medicinal leaves, roots and the like, a cooperative society can be formed covering the tribal settlements to market their forest and agricultural products through which they can raise their family income.

LIMITATION

As the study was conducted only in two tribal settlements, the findings of this study may be generalised to the tribal people who have similar characteristic features only.

CONCLUSION

It is concluded that a majority of the respondents are in the middle age group, with the male and female respondents being almost equal in number. Among the total respondents, nearly two fifths of them scored higher level of hopelessness. Further, the tribals seem to face higher hopelessness while their income is low. Thus, hopelessness is associated with family income of the respondents. Hence, there is a need for implementation of forest and agriculture-based viable income generation programmes to increase their family incomes which will reduce the hopelessness among the tribal families.

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OUTCOME STUDY OF DISABILITY MANAGEMENT FOR PERSONS WITH SCHIZOPHRENIA LIVING IN THE COMMUNITY

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ABSTRACT

Schizophrenia is a major mental illness affecting the normal functioning of the brain that has a measurable impact on many aspects of the life of those who are affected by it. Among many areas of impairment, severe deficits in functioning are observed in daily living, family life, social interactions and employment.

The aim of the study was to examine the outcome of a brief intervention package (on disability management) for the persons with Schizophrenia (PWS) living in the community.

Criteria-based sampling technique was employed to derive a sample of 31 participants who attended OPD of Institute of Psychiatry, Kolkata. This was an outcome study, pre-post experimental design without a control group. Participants were initially assessed with Indian Disability Evaluation Assessment Scale and Social Occupational Functioning Scale, after which, a structured intervention was conducted. Soon after the intervention, post- assessment was done in the same parameters and data was analyzed.

It was found that PWS has a significant impairment in the socio-occupational functioning area and has a moderate percentage of disability before the intervention. After the psychosocial management, significant improvement has been noticed in socio-occupational functioning and the level of disability also decreased.
The present study demonstrated the feasibility and efficiency of a psychosocial intervention package on the management of impairment and disabilities for PWS which helped them improve impairment and disability.

Key words: Psychosocial management, Disability, Socio-occupational functioning, Schizophrenia

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INTRODUCTION

Schizophrenia is a severe, chronic and incapacitating brain disorder that affects various aspects of behaviour, thought and emotion. Schizophrenia occurs in 1 per cent of the general population making it the most common of the severe mental illnesses (Pennington, 2002). It is considered as a major psychotic disorder with impact on the person's functional capacity, eventually resulting in functional deficits which are difficult to recover (Viertio, 2011; Harvey et al., 2007). These deficits are manifested in the areas of self-care, relationships, work, and social life, which in turn, affect the individual's ability to understand and act according to social norms (Devaramane, 2011). Severe disability is the result of both positive and negative symptoms of schizophrenia. It not only causes personal diminution for the PWS but it also disturbs their family members, peer group and anyone associated with them. Disability arising out of severe mental illness is defined as an inability to perform at a desirable level in activities such as self care, social relationship, work and situational appropriate behaviour (WHO, 2001). Some of the fundamental areas that disability affects in an individual's functioning includes personal hygiene, social interaction, money management, work habit, leisure time activities, interpersonal relationship, time management, communication, crisis management, household activities, emotional expression and decision making (American Psychiatric Association, 1997).

Even though schizophrenia can be disabling, with effective treatment, including good access to proper medications and psychosocial intervention, PWS can live reasonably normal lives. The key phrase here is 'reasonably normal'. So, despite the widespread misconception that PWS have no chance of recovery or improvement, the reality is much more hopeful. In many countries, there are various government programs and community services that may be helpful as part of schizophrenia treatment, management and recovery. In the current scenario of Kolkata (India) the facilities are available in a scattered way, and private care is still costly. Even if facilities are available, the level of awareness and utilization of the resources is not yet properly developed. Most of the psychiatric hospitals and nursing homes here primarily prefer the pharmacological treatment over non-pharmacological one. Hence this present study is an attempt to establish the feasibility and efficacy of psychosocial management of disability among PWS. The aim of the study was to examine the outcome of a brief intervention package (on disability management) for PWS living in the community.

METHOD

Pre-post experimental design without control group was adopted for the present study which was a hospital-based outcome study conducted at a tertiary care centre in Kolkata, India. Forty PWS were diagnosed as per ICD-10 (WHO, 2007) criteria in the age range

of 18 – 50 years of either sex with minimum 6 months of illness duration and clinically stable; living in the community and attending OPD of a tertiary care centre were selected through criteria-based sampling. Out of forty, 31 participants who completed both pre and post intervention assessment were taken for final analysis. In cases where there were major changes in drugs or hospitalization during the study period, these were also not included in the final analysis. PWS with any major physical illness or disability, mental retardation, neurological disorder and substance dependence except nicotine and caffeine were excluded. Family members of PWS with any major mental or physical illness or disability, mental retardation, neurological disorder and substance dependence except nicotine and caffeine and those who have severe family conflict were excluded as well.

After taking Informed Consent from PWS and their family members, initially socio-demographic and clinical data was taken from all the participants using a specially designed proforma for the study, then Indian Disability and Assessment Scale (IDEAS,2001), Social Occupational Functioning Scale (SOFS)(Saraswat et al.,2006) were administered to assess the level of disability and socio-occupational functions of the PWS. Subsequently, need-based psychosocial interventions were conducted and after the intervention, the post intervention assessment was done using IDEAS and SOFS. Data was analyzed using Statistical Package for the Social Sciences 16thversion (SPSS 16). Descriptive statistics were calculated along with correlation and comparative profile in pre and post intervention was done by using Wilcoxon signed rank test.

Intervention package included initial full length clinical assessment of PWS and their family members, monitoring compliance for intervention, psychoeducation, activity scheduling, skill training to address communication and interpersonal relationship problems, intervention to address impaired socio-occupational functioning, engaging in any vocation or productive work, referral counselling and post intervention assessment.

A pilot study on 3 cases was conducted to check the suitability and feasibility of the tools to be used in the study before the actual study.

Ethical Clearance: Taken

RESULTS

Socio-Demographic Profile of the PWS

The Mean age of PWS in the present study was 33.19 $\pm$8.70. More than half (52%) of the PWS were male and a large majority of them were Hindus (84%) followed by Muslim (16%). There were equal number of married and single PWS- 15 (48%) each, and only 1

(3%) person was a widow. Less than half of PWS hailed from the rural area (48%), followed by the same number of the sample hailing from the urban and suburban area (26% each). Almost one-third of the PWS i.e., 10 (32%) were educated up to the fifth standard, followed by equal numbers 5 (16 %) of each who were educated up to eighth, tenth and up to graduation. Less than half (48%) of them belong to nuclear families, followed by those in joint families (36%) and the rest of them from extended families (16%) with an average of 5 family members in each household. With regard to the occupation, most of the PWS were unemployed (45%), followed by 10 (32%) homemakers, 1 (3%) each involved in service or trade occupation, skilled, semi-skilled and unskilled occupation, industrial work and crafting and rest 3 (10%) of them involved in some other professions. Their mean income was Rupees 1838.7+ 5.62

Clinical Profile of the PWS

The mean age of onset of illness was 26 years. Mean duration of illness and duration of treatment were 85.74 ±76.11 months and 79.16 ±76.69 months respectively. A large number of PWS (80.6%) were not undergoing any psychosocial intervention. Mean of number of hospitalizations was 0.19± 0.65. Whereas 18 (58.1%) PWS had no side effects, 13 (41.9%) of them still had some side effects, 21 (67.7%) had no positive family history of psychiatric illness.

Socio-Demographic Profile of the Family Members of PWS

In terms of the relationship with family members of PWS, 12 (39%) were parents, 10 (32%) persons were spouses, 7 (23%) were siblings and 1 (3.2%) each were off-springs. Mean age of family members was 45.03±1.8 years. A majority of family members were males (58%) and a majority (90%) of them were married. In terms of education, 23% were educated up to the tenth standard, 6 (19%) persons were educated up to eighth standard and 5 (16.1%) persons were educated up to twelfth standard. Among them, 11(36%) were homemakers, 6 (19.4%) were involved in business and 4 (12.9%) in agricultural work. Mean family income was Rupees 7138.70±6.45. Mean duration of family members having contact with PWS was 25.64±8.92 years. Mean time of family members spending time outside the family was 6.83±6.50 hours every day.

Table 1: Comparative Profile of Impairment on Pre and Post Intervention

Areas of Impairment	Negative Ranks	Positive Ranks	Ties	Z
Bathing and Grooming	10	1	20	-2.673**
Clothing and Dressing	8	1	22	-2.333*
Eating, Feeding and Diet	8	2	21	-2.153*
Neatness and Maintenance	14	0	17	-3.416**
Conversational Skills	22	1	8	-4.153***
Social Appropriateness/politeness	17	1	13	-3.572***
Social Engagement	23	1	7	-4.290***
Money Management	8	1	22	-2.326*
Orientation/Mobility	20	2	9	-3.751***
Instrumental Social	16	1	14	-3.532***
Recreation/Leisure Activity	26	0	5	-4.604***
Work	27	0	4	-4.640***
Respect	10	0	21	-2.970**
Independence/Responsibility	19	1	11	-3.440**
Total Score	30	0	1	-4.788***

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

***Correlation is significant at the 0.001 level (2-tailed).

Table 1 shows the comparative profile of impairment in different areas of socio-occupational functioning in the pre and post intervention group among the PWS which was done by using the Wilcoxon signed rank test. All the areas of impairment in socio-occupational functioning has statistically significant difference on the pre and post intervention groups (0.05 level in clothing and dressing, eating- feeding- diet and money management domains; 0.01 level in bathing and grooming, neatness-maintenance activities, respect for property & independence/responsibility domains and 0.001 in conversational skills, social appropriateness/politeness, social engagement, orientation/mobility, instrumental social skills, recreation/leisure, work and in total score domains).

Table 2: Comparative Profile of Disability on Pre and Post Intervention

Areas of Disability	Ranks	N	Z
Self-Care	Negative Ranks Positive Ranks Ties	11 0 20	-3.127**
Interpersonal Activities	Negative Ranks Positive Ranks Ties	21 1 9	-4.041***
Communication & Understanding	Negative Ranks Positive Ranks Ties	19 0 12	-4.065***
Work	Negative Ranks Positive Ranks Ties	25 0 6	-4.452***
Global Score	Negative Ranks Positive Ranks Ties	30 0 1	-4.800***
Severity of Disability	Negative Ranks Positive Ranks Ties	20 0 11	-4.379***

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

***Correlation is significant at the 0.001 level (2-tailed).

Table 2 shows the comparative profile in different areas of disability on pre and post intervention among the PWS which was done by using the Wilcoxon signed rank test. All the areas of disability have a statistically significant difference on the pre and post intervention groups (0.01 level in self-care domain and 0.001 in interpersonal activities, communication & understanding, work , global score and the severity of disability domains).

Psychosocial Issues

Apart from the above findings on impairments and disability measured with two tools IDEAS and SOFS, some psychosocial issues were found on the qualitative clinical assessment as well. Poor compliance to medicine and psychosocial intervention was fairly apparent. There were also stigma and discrimination experienced by PWS and their family members from the society which affects their self-esteem and confidence. A common finding was in the form of misinformation or lack of information about

mental illness among family members. A significant barrier to employment of PSW was employer's attitude. Many employers underestimated their ability or feared the PWS's unpredictable behavior. A few family members complained that employers may be unduly concerned that individuals with serious mental illnesses like schizophrenia will have poor attendance, will perform poorly or will need accommodations that will be too costly. In some cases, the family itself lacked belief that PWS can work or can be engaged in any productive work (even in their own household work). All these issues were addressed with adequate concern during the course of the intervention and subsequently, the improvement was also measured in the post intervention assessment.

DISCUSSION

The overall functioning of schizophrenia can have a very limited view when interpreted only in terms of psychopathology (Luckoff, 1987), so instead of just symptoms, socio-occupational functioning impairments and disability were assessed and psychosocial management was provided in order to address areas of impairments and disability.

In the present study, the mean age of PWS was 35.18 years which indicates that a majority of the participants were in their mid 30s with 16 male and 15 female PWS which is almost equal in number. Though the study did not use a random sampling method it could still be considered as an indication that schizophrenia is equally prevalent in men and women, which is reflected in many other studies as well (Saha et al., 2005; Bhugra et al., 2005; Versola-Russo, 2006; Ochoa et al., 2012). It was also found that 45.2% of the participants were unemployed and most alarming fact is, among the unemployed participants 78.6% of them are unemployed because of their illness (schizophrenia) which is consistent with the study by Chowdhury et. al. (2018). Another supporting finding to the present study is by Anthony (1995) where it was found that only 25% of PWS were employed. Even though some studies do have different findings, like the one by Srinivasan &Thara (1998) wherein they found an annual rate of employment of 63–73% in the first 10 years of follow-up in people with first episode schizophrenia.

The mean age of onset of illness in this study was found to be 26 years which is consistent with the study done by Sham et al. in 1994, who found that schizophrenia is a disease that typically begins in early adulthood; between the ages of 15 to 25. The majority of the PWS, 25 (80.6%), were not undergoing any psychosocial treatment. It may be one of the reasons for the presence of higher level of disability or impaired socio-occupational functioning. Another reason for not undergoing any psychosocial treatment could be limited availability of psychosocial treatment services in different parts of the country (Hazra et al., 2012).

From the present study, it was found that the PWS had impairment in the different areas of functioning especially in the areas of work, respect for property, recreation/ leisure activities, conversational skills, social engagement and instrumental social skills which play a very important role in daily living. It is consistent with several previous studies (WHO, 2001; Hansley, 2000), that revealed schizophrenia affects the individual's functioning such as social interaction, money management, work habit, leisure time activities, interpersonal relationship, personal hygiene, time management, communication, crisis management, household activities, emotional expression and decision making.

While intersecting the areas of difficulties, one major and most common issue found among the PWS in the present study was difficulty in communication and a deteriorating interpersonal relationship. Through brief communication enhancement training, the difficult areas of communication and interpersonal relation of the PWS with their family members were addressed. Stigma and discrimination experienced by family members from society were again an issue found in many cases which affected the self-esteem and confidence of both the PWS and their family members. Different studies such as Shrivastava et al. (2011), Gonzalez-Torres et al. (2007) and Jackowska (2009) have supported the same finding. In the intervention package, these issues were addressed in the form of ways of handling the stigma and discrimination coming from society, tactfully. Focusing on and utilizing the positives rather than the negatives responses of the society was considered. In Psychiatric Social Work such approaches have been shown to be effective by Sahu (2015). Poor compliance to medicine and psychosocial interventions was also a common issue which was found in the form of misinformation or lack of information about mental illness from family members. Keeping that reason in mind psychoeducation was included in the intervention program. Magliano et al. (2006) and Bauml et al. (2006) in their study supported the efficacy of psychoeducation in schizophrenia. Difficulty in the areas of daily living and maintaining personal hygiene was found in some PWS. Through activity scheduling, their day-to-day lifestyle is helped to change by targeting their self-care, personal hygiene, time management and the like. Planning a balanced activity schedule was the target for each individual. Dogra et al. (2009) in a study found that activity scheduling does have an impact on the negative symptoms of the PWS. Apart from these significant areas of target, most of the PWS were found to be unemployed or facing difficulties in the area of work. This area was related to difficulty in the area of communication, understanding and making relationships. So, as these areas were addressed, special focus was given to the area of work as well. For those who were unemployed they were made to identify potential sources of income, their level of interest in working, their work-related abilities and

disabilities, learning job skills, advantages of working, facilitating brainstorming about all the skills and abilities that would help him/her to be successful in any job that was focused on.

From the present study, significant improvement was found in all the domains of socio-occupational functioning especially in the areas of conversational skills, social appropriateness/politeness, social engagement, orientation/mobility, instrumental social skills, recreation/leisure activity and work which are important for daily living. In the post intervention assessment of disability, significant improvement in all the domains of disability especially to the interpersonal activities, communication & understanding and work domain were found as well.

Among many, one supportive study by Kern et. al. (2009) promoted functional recovery in schizophrenia through psychosocial treatments. It has been studied overall that these treatments provide a range of promising approaches to help PWS achieve better outcomes far beyond symptom stabilization. This finding was consistent with a study by Thara et al. (1998) where management of social disabilities in PWS were evaluated in terms of negative symptoms, social disabilities and psychological impairments and after one year, a significant decline in some negative symptoms and improvement was found in certain disabilities.

The present study findings suggested positive outcomes in managing different socio-occupational functioning impairments and reducing overall severity of disability with an adequate psychosocial intervention.

LIMITATIONS

Small sample size, the absence of a controlled group and the inclusion of drug naïve samples were some of the limitation of the study.

CONCLUSION

The present study demonstrated the feasibility and efficiency of a psychosocial intervention package on the management of impairment and disabilities for PWS which helped them to live a less disabled and impaired life than before.

The present study which is among the very few intervention-based outcome studies on management of disability in West Bengal and specifically in Kolkata can be considered as an evidence of effectiveness and viability of the psychosocial intervention as a part of the management plan in a tertiary care setting for the PWS.

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TROUBLED CHILDREN IN CUSTODY DISPUTES: THE NEED FOR DEVELOPMENT OF STANDARD PARENTING GUIDELINES FOR CHILD CUSTODY CASES IN INDIA

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ABSTRACT

Divorce proceedings, while in themselves being complex and emotionally draining, may become further complicated if the partners are contesting for the custody of the child. The high-conflict custody cases and lack of cooperation between the separating parents have caused emotional and behavioral disorders in the children involved as observed in our clinical practice at a tertiary-care hospital in South India. This study highlights the parenting practices and issues in high conflict child custody cases and their detrimental impacts on the child's mental health.

By utilizing a retrospective case study method, an effort has been made to describe issues of parenting in cases seen at a tertiary-care hospital in South India. The children involved were referred for evaluation and intervention in the context of child custody conflicts and were subsequently diagnosed with emotional and behavioral disorders.

The case study describes the cases with regard to their custody arrangements and nature of parent-child interactions and family dynamics. In this context, these children were found to have symptoms of aggression, social withdrawal, death wishes and other psychological problems.

Overall, these cases showed distinct patterns in parenting and their detrimental impacts on these children. These findings reflected the need for both parents to adopt child-friendly parenting strategies to avoid loyalty conflicts in the child and foster healthy connectedness in domains such as communication patterns, consistency in parenting styles, rituals in parent-child sub-system and parental involvement. It emphasizes the need and relevance of developing parenting guidelines for child custody cases in India. It also highlights the importance of incorporating systematic child-friendly custody evaluation processes in the legal proceedings in order to ensure the best interests of these children.

Key Words: Children, Divorce, Parenting, Child Custody, Family Court

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INTRODUCTION

Over decades, researchers have extensively studied about divorce and its impact on the lives of the couples, their adjustment, predictors and the like. The change in the family structure post-divorce has caused adjustment issues in not only the adults but also the children involved in the process of separation and divorce. Most studies in the field show that children of divorce display more problems than other children in social and academic areas (Fransson et al, 2016, King, 2002). They also suffer from depression and anxiety symptoms along with somatic issues. Research has shown that families which maintain effective roles in nurturance and mutual support and maintain some family rituals after the divorce are likely to minimize maladjustment of their children. Hence, it is important that divorcing parents come to terms with household decisions and show consistency in their parenting roles. Both parents' active involvement is contingent and determinant of the child's better adjustment and psychological development post-divorce or separation (Simons et al., 1999).

With divorce becoming a widespread phenomenon in India, it has consequently resulted in contesting for the custody of the child. The lack of cooperation between the separating parents in high-conflict custody cases has resulted in emotional and behavioral disorders in these children. It is therefore evident that parental conflict and animosity post separation have a detrimental impact on these children (Portes, Howell, Brown, Eichenberg& Mas, 1992). This has been observed in our clinical practice at the tertiary care hospital in South India. This study highlights the issues in the parenting practices adopted by the parents in high conflict child custody cases and how it has detrimentally impacted the children's mental health.

The purpose of a child custody evaluation (CCE) is to conduct a thorough, scientifically sound evaluation of a family in order to help the court determine what living arrangement and parenting plan would best meet the needs of the children. The purpose is therefore as follows (Rohrbaugh, 2007; APA, 1994):

- Assess the child's psychological and developmental needs
- Assess the parenting capacities of parents
- Determine the best fit between the child's needs and parental capacities, in order to serve the best interest of the child.

The need for standard parenting guidelines in child custody cases are as follows:

- The children exposed to dysfunctional parenting are at risk for long-term psychological issues.
- Listening to the child's opinion is a way to protect their best interest.
- Theoretically, the law guides and controls child custody evaluations based on the vague standard of 'best interests of the child', without any specific guidelines.
- The importance of specialized medico-legal assessments by family therapists, child therapist and other mental health professionals within the legal context.
- The factors associated with children's living arrangements and parental cooperation in joint custody promotes the child's mental health.
- The significance of equal involvement of nonresident parents to promote the quality of the parent-child relationship and to avoid any loyalty conflict in the child.

Relatively few research studies have been conducted specifically on child custody evaluation in the context of child rights, mostly in Western literature. However, according to the National Commission for Protection of Child Rights (NCPCR) in 2009 response to a petition filed under Right to Information Act (RTI, 2005), no studies have been done in this area. In this background, it is important for mental health professionals to understand this need for child-centric evaluation procedures in the determination of the child's custody and the mechanism for enforcing standard parenting guidelines in the Family Courts of India.

METHOD

By utilizing the retrospective Case Study method, an effort has been made to describe issues of parenting in cases seen at a tertiary-care hospital in South India. The children involved were referred for evaluation and intervention in the context of child custody disputes and were subsequently diagnosed with emotional and behavioral disorders.

Case Studies:

Case 1

Master T is a thirteen-year-old boy, studying in seventh grade in a private school. Following his parents' divorce, they were given joint physical and legal custody of the boy. Since the custody order, the child had to spend equal time at the residences of both parents, wherein the child was reported to have been subjected to physical and emotional abuse by the father. The father used to not give permission to the child to attend school picnics or extracurricular activities and continued to abuse his custody rights and express his anger of the marital separation on the boy. Subsequently, the child developed symptoms of anger outbursts, irritability, and suicidal ideas and stopped schooling. In this context, the child was referred to the hospital for mental health evaluation and intervention. As

part of the mental health intervention, a detailed report of the child's experiences of maltreatment by the father and their detrimental effects on the child's mental health was given to the family court and appropriate recommendations were made. Currently, the boy is under the custody of the mother, continues to be seen in therapy, has resumed schooling and is recuperating well.

Case 2

Miss D is a ten-year-old girl, studying in fifth grade in a private school. Following her parents' divorce, the sole custody was given to her mother with visitation rights to the father during her school vacations. The girl lives with her mother and stepfather. Upon the return of the child from her vacations with her biological father, the child accused her stepfather of sexually abusing her, following which the stepfather was taken into police custody. In this context, the child was referred to the hospital for mental health evaluation and intervention. Upon assessment, the child confessed that the false allegations of sexual abuse was done under the threat of self-harm and suicide by her biological father. The detailed mental health assessment report was sent to the court, following which the stepfather was released from jail. Currently, the girl is residing with the mother; however, the biological father continues to have visitation rights. The continuation of the visitation rights despite the incident of false abuse allegations would be a deterrent to the child's mental health.

Case 3

Miss S is an eight-year-old girl, studying in third grade in urban Bengaluru. Since the separation of her parents, she was in sole custody of her mother with visitation rights to the father on weekends. Her older sibling was in the custody of the father with no visitation rights for the mother. However, the mother was inconsistent with the custody-related court orders claiming that the child did not want to see the father. The father alleged that the mother had coached the child against wanting to see him. As a result, the father resorted to more litigation and the child was taken to the police station for visitation purposes. This resulted in the child being subjected to numerous court proceedings and forceful and coerced visitations. In this context, the child had emotional issues and was referred to the hospital for mental health evaluation and intervention. Upon assessment, the child was found to have symptoms of separation anxiety and fearfulness. The parents were psycho educated about the need for cooperative parenting and conjoint sessions with the child to address her anxiety symptoms. The detailed evaluation report with the recommendations for the need of parental cooperation in the child's treatment was sent to the court. However, despite the court orders, the parents are not cooperating for parenting interventions.

Case 4

Master A is a twelve-year-old boy who was in the sole custody of his mother with visitation rights to the father on weekends and holidays. The mother accused the father of intimate partner violence and denied access of the child to him and relocated with the child. After several months of litigation, the father was able to get the court to order for the child's mental health evaluation. In this context, the child was evaluated in the hospital and reported to have experienced emotional and physical abuse by the mother. The child also expressed his wish to be with the father. The report with recommendations for the termination of the mother's custody rights as well as the psychiatric evaluation of the mother was sent to the court. Following this, the child is currently living with the father and is progressing satisfactorily.

Case 5

Miss J is a fourteen-year-old girl who was in interim custody of her father with visitation rights to the mother on weekends and holidays. The proceedings of the court case have been ongoing since 2014, and despite the court order, the father continues to deny the child's access to the mother, including telephonic contact. In this context, upon the petition of the mother to the family court, the child was ordered to be brought to the hospital for a mental health evaluation. However, despite, the repeated appointment reminders via telephone, the father said he is unable to bring the child as she is unwilling to come to the hospital and that her residential school will reopen the following week. Hence, the psychiatric evaluation could not be initiated. The court was informed about the same. However, no legal action was taken for the contempt of court.

Case 6

Master N is a twelve-year-old boy who is in the interim custody of his mother with visitation rights to the father on weekends and holidays. During the time of visitation, the father used to be permissive with the child and indulge him with expensive gifts. Following the periods of visitation, the child demanded that the mother buy him expensive toys, and used to be aggressive and defiant towards her. When the mother attempted to discipline the child, he got aggressive towards her, refused to go to school and expressed his wish to be only with his father. In this context, the child was referred to the hospital by the court for mental health evaluation, wherein he was diagnosed with Oppositional Defiant Disorder. The treating team recommended the court to mandate the father for parenting intervention sessions to address the issues of inconsistent parenting. However, the father did not adhere to the treatment plan and the child continues to have behavioural issues.

DISCUSSION

It was observed that in most of the above cases the custodial parent was the mother with the father having visitation rights. The study describes the cases with regard to the parameters of child custody determination in Indian family court and the parent-child dynamics it entails. In case 1, the joint custody was against the best interests of the child, resulting in traumatic experiences and psychiatric disorder in the child. The parental mental health evaluation prior to custody determination would have been useful for the well-being of the child. In case 2, the false allegations of sexual abuse by the child was conspired by the parent with visitation rights. There was a termination of visitation rights in this case which may result in long term consequences like loyalty conflict. In case 3, the non-cooperative parenting and parental hostility resulted in childhood anxiety and related attachment issues. There was a lack of parenting coordination interventions with the parents at the time of custody order. In case 4, the existence of gender biases in the custody evaluation and determination is highlighted. This had resulted in child abuse and maltreatment by the mother and denial of parental rights of the father. In addition, the parental psychiatric evaluation would have helped in a non-biased determination of the child's custody. In case 5, the longstanding legal proceedings and delay in justice to the parent who is denied child access is highlighted. There is also no provision of legal action for the contempt of court in custody cases. In case 6, the inconsistency in parenting style has resulted in behavioral issues in the child, indicating the need for parenting interventions and standard parenting guidelines in all the high conflict child custody cases. There is, hence, a need for specialized mental health training of legal personnel involved in the child custody evaluation process or liaison with mental health professionals for the same.

In developed countries, they list specific factors in their statutes for courts to consider in determining the best interests of the child, which psychological evaluators in family court proceedings are typically expected to take account of (Wattenberg, Kelley & Kim, 2001; Zumbach, &Koglin, 2015). These factors commonly relate to the child's circumstances, the parent or caregiver's circumstances and the caregiver's capacity to parent. Additionally, caution is taken to see that the best interest of the child is a principle that remains to be applied specifically in each case, which makes a psychological evaluation both indispensable and challenging. When ruling on parental responsibility matters, the family judge should have regard to the agreements entered by the parents; the wishes and feelings of the minor child; the age of the child; the ability of each of the parents to fulfill his or her responsibilities and to respect the rights of the other parent; forensic expertise or any expertise having regard especially to the age of the child; any welfare reports as well as any history of violence or psychological pressure exercised

or existing between the parents (Bogacki & Weiss, 2007; Artis, 2004; Grietens, 2005). However, in India, despite the echoing of the term 'the best of interests of the child' in its family court legislations, the existing mechanism neither addresses the issues of child rights violation nor does it emphasize on the mental health needs of the children involved in custody disputes (Child Rights Foundation, 2014).

CONCLUSION

Overall, these cases have shown distinct patterns in the parenting styles, parent-child dynamics and their detrimental impact on the child's well-being in cases of high conflict child custody cases. These findings have reflected the need for both the parents to adopt child-friendly parenting strategies to avoid loyalty conflicts in the child and foster healthy connectedness in domains such as communication patterns, consistency in parenting styles, rituals in parental sub-system and parental involvement. It emphasizes the need and relevance of developing parenting guidelines in child custody cases in India. The parents involved, need to be psycho-educated about the detrimental impact of the high conflict custody battle and the need for cooperative co-parenting strategies. This case series is a step towards understanding the need for child-centric custody evaluation procedures in India, helping research scholars and practitioners in the field of child mental health to understand child custody related consequences. This study proposes recommendations for therapeutic interventions for parents to focus on cooperative parenting plans to protect the child from loyalty conflicts and promote mental health. This being a case study, it highlights the need for prospective empirical studies in the area of child custody disputes. The primary reason for non-cooperation between parents in child custody cases is due to the lack of standard parenting guidelines and lack of parental consensus thereof in the parenting plan of the child post the separation or divorce. Child mental health professionals have a vital role in creating awareness across the judicial system as well as the other stakeholders in this regard. The most fundamental principle underlying child rights is the inherent right of every child to be brought up in the secure comfort of a nurturing family environment and to enjoy the love and affection of both its parents (U.N. Charter for Child Rights, 1989). India being a signatory of United Nations Convention on the Rights of the Child since 1992, its legal system urgently needs to implement judicial measures and guidelines to safeguard the child's best interests in the child custody proceedings. Hence, this scenario of troubled children caught amidst custody battles reflects the alarming need for policy level initiatives in the family courts of India for bringing a positive change in the lives of the children involved.

DECLARATION

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A STUDY ON PREDICTORS OF QUALITY OF LIFE OF HIV/AIDS-INFECTED WIDOWS

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ABSTRACT

The Present study aims at assessing the predictors of quality of life of the HIV/AIDS-infected widows.

For the purpose of the study, the researcher has selected Tiruchirappalli district. There are 1110 HIV/AIDS-infected widows registered in NPT+, Tiruchirappalli District, of which the researcher selected 333 persons as a sample. To find out the predictors of quality of life of the HIV/AIDS-infected widows, the researcher used Impact of Event scale developed by Horowitz et al. (1979), Trauma Symptom Checklist by Briere &Runtz (1989), Internalised AIDS Related Stigma Scale (IARSS) by Kalichman et al. (2005), and WHOQOL-HIVBREF Instrument by WHO (2002).

The results revealed that the seven predictors viz. Trauma symptom, current age, family income, internalised AIDS related symptom, total impact of event, CD4 count and education, under consideration have explained about 40.2 percent of variance in Quality of life.

Based on the findings the researcher suggested the effective intervention strategies through regular counselling.

Keywords: HIV/AIDS, Quality of Life, Widows.

INTRODUCTION

HIV/AIDS continues to be a massive development challenge for humanity as it deprives families, communities and entire nations of their young and most productive people (Basavaraj, Navya, & Rashmi, 2010). Human immunodeficiency virus (HIV) / Acquired immune deficiency syndrome (AIDS) is a chronic infection that affects not only the person's physical condition, but also the social relations, psychological aspects, financial aspects and quality of life (Cardona-Arias & Higuita-Gutierrez, 2014). Quality of life is a term that is popularly known as overall sense of well-being and includes aspects such as happiness and satisfaction with life as a whole (WHOQOL group, 1998). The term Quality of Life (QOL) refers to the general well-being of individuals and societies. Measuring quality of

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life is currently at the forefront of various fields of science (Rashmi, & Kundapur, 2017). QOL can be defined as a subjective multidimensional evaluation of one's functioning and well-being in day-to-day life (Raj et al., 2011). Given the longevity achievable with the current prophylactic and therapeutic strategies for PLWHA, quality of life has emerged as a significant measure of health outcome and quality of life enhancement as an important goal (Deshmukh et al., 2014). Assessing quality of life is useful for documenting the patients' perceived burden of chronic disease, tracking changes in health over time, assessing the effects of treatment and quantifying the return on health care investment (Hays et al., 2000).

REVIEW OF LITERATURE

Various studies have been carried out on the quality of life of HIV infected persons. A study among 200 HIV-infected adults at an urban public outpatients' clinic, Blalock et al. (2002) noticed that the employed respondents reported a significantly higher level of perceived overall QOL than unemployed. A study by Skevington (2012) highlighted that the older HIV adults had better QOL than expected, on 11 dimensions: negative feelings, social inclusion, and several environmental and spiritual facets. A cross-sectional study by Da Silva et al. (2013), among people living with HIV, found that lower education level and believing to be ill were associated with poor QOL. Deshmukh et al. (2014) have done a study among 754 HIV-positive persons, which highlights that women had poorer quality of life than men; they also reported that women had significantly lower scores in social relationships and environmental domain of quality of life. Liping et al. (2015) examined quality of life among 403 HIV-infected persons and reported that those who are young, with higher levels of education, higher CD4 count and good access and adherence of ART, are likely to have better QOL among PLWHA in Zhejiang province. Surur et al. (2017) carried out a study among 400 HIV/AIDS-infected persons who are taking ART. Their results highlight that a majority of the respondents have good physical health. They also concluded that sex, age, educational status, residence and marital status are statistically significantly related to at least one domain of health-related quality of life.

The reviews of earlier literatures reveals only a few attempts that were made to study the relationship between the quality of life and the background characteristics of the HIV-infected widows. It is found that there have been no recent studies among HIV-infected widows with specific on trauma symptom, impact of event, Internalised AIDS-related stigma and quality of life, comprehensively. In view of this research gap, the researcher has proposed to conduct an in-depth study to investigate the trauma symptom, impact of event, stigma and quality of life of HIV/AIDS-infected widows in Tiruchirappalli district

METHOD

The main objective of the present research is to identify the major predictors as well as their extent of net effects on the overall quality of life, of the HIV-infected widows, with multivariate technique.

Method: The researcher purposively selected Network for Positive People in Tiruchirappalli (NPT+).There are 1110 HIV/AIDS-infected widows registered with that agency. The sample size was decided by adopting Krejcie and Morgan (1970) formula. Accordingly, 333 (30%) HIV-infected widows were selected as the sample for the study. The individual respondents were selected through simple random sampling technique by adopting lottery method. At the beginning of each interview, consent was obtained from each respondents.

Tools of Data Collection: To collect the required data, the researcher used Impact of Event scale(IES) developed by Horowitz et al. (1979)consisting of 15 items based on 4-point rating scale (higher score indicates higher impact of event),Trauma Symptom Checklist (TSC) by Briere &Runtz (1989) with 33 items (higher score indicates higher trauma symptoms), Internalised AIDS Related Stigma Scale (IARSS) by Kalichman et al. (2005) with five items (higher the score higher the internalised AIDS related stigma), and WHOQOL-HIVBREF (WHO, 2002) instrument consist of 31 statement (higher the score indicates higher quality of life).The reliability (Alpha) value for the Impact of Event Scale (0.916), Trauma Symptoms Checklist (0.917), Internalized AIDS Related Stigma Scale (0.571), and Quality of Life (0.898) scales was also established. The average number of schedules completed in a day were 2 and the time taken for each schedule was approximately 2 hours.

The data was collected from November 2015 to April, 2016. Moreover, stepwise multiple regression analysis, as well as structural equation modelling, has been carried out. Histogram, P-P and scatter plots were used to check the linearity, homoscedasticity, and normality of residuals. The residuals were found to be normally distributed in multiple regression analysis as shown in Appendix -1. The data was analysed using SPSS-AMOS-24 (IBM, 2017).

RESULTS

Socio-Demographic Characteristics of the HIV-infected widows

The analysis of socio-demographic characteristics of the respondents revealed that two third of the respondents (66%) belong to middle age group (36-59 years), the average age of the respondents is 39.9 years. Similar findings were reported in a study conducted by Patel et al. (2009) where the average age of the HIV-infected widows was 36.4 years.

The mean age of the respondents at the time of marriage was 19 years. A vast majority (94 per cent) of the respondents are Hindus and more than one third (38%) of the respondents belong to the most backward community followed by backward community (31 per cent).

About 29 per cent of the respondents are illiterates, almost a quarter of the total respondents have studied up to primary school level (22 per cent) and their average year of schooling was 5.5. A little higher than half (54 per cent) of the respondents are agricultural labourers, about 16 per cent of the respondents are unemployed. The average monthly income and monthly expenditure of the respondents is Rs. 2830 and Rs.3790 respectively. A majority (73 per cent) of the respondents' family income is Rs. 5000 per month or less.

A majority (67 per cent) of the respondents come from small families consisting of 3 members or less, the average number of family members of the respondents is 3.07 and 72 per cent of the respondents belong to nuclear families.

HIV/AIDS-related Aspects: The findings of the study highlight that the average years of having HIV/AIDS by the respondents is about 8.21 years. More than three-fourth (79 per cent) of them mentioned that the virus had been transmitted to them mainly through their husbands. A majority of the respondents are taking ART (84%) and use the regular counselling services (87%). Nearly half (47 per cent) of the respondents are in CD4 phase II.

Measurement of Psychosocial Dimensions Related to HIV/AIDS Infected Widows

The mean scores of Impact of Event, Trauma Symptom Checklist, Internalised AIDS-Related Stigma and Quality of Life were 46.83, 29.16, 3.26 and 72.26 respectively.

Identification of Major Predictors of the Quality of Life of HIV-infected widows:

In order to find out the major predictors as well as their individual contribution of the overall scores of current age, education, family income, CD4 count, Trauma symptom (TSC), Impact of Event (IES), and Internalised AIDS-Related Symptom (IARSS), on Quality of Life (QOL) of the HIV-infected widows, a stepwise multiple regression analysis has been carried out. The objective of multiple regression analysis is to predict the changes in the dependent variables in the response to changes in the independent variables. This objective is most often achieved through the statistical rule of least squares. In the stepwise regression, the method of selecting variables for inclusion in the

regression model that starts by selecting the best predictor of the dependent variables. With this method, one could extract the most predicted independent variables of dependent variable under consideration (Hair et al., 1998).

Column 1 of Table 1 is the model being reported in this analysis. Column 2 shows the predictor variables. The first variable (constant), referred as the Y interreceptor, the height of the regression line when it crosses the Y axis. In other words, this is the predicted value of QOL when all other variables are 0 (IDRE, 2016).

The R^2 value, in Column 4 is a measure of how much of the variability in the outcome is accounted for by the predictors (Field, 2009). Model 1 (in column 2) refers to the first stage in the hierarchy when only TSC score is used as predictor. For the first model (in column 4), its value is 0.16, which means that the TSC score alone accounts for 16% of variation in the QOL of HIV infected widows.

In the second model, this value is increased to 25.2% variation in the QOL of HIV-infected widows. In the third, fourth, fifth, sixth and seventh model this value increased to 32.5%, 35.6%, 37.9%, 39.3%, and 40.2% variations respectively in the QOL of HIV infected widows. The b value (unstandardised) tells us about the relationship between the QOL score and the each predictors (TSC, current age, family income, IARSS, IES, CD count and education). If the value is positive, it can be concluded that there is a positive relationship between the predictors and the outcome variables, whereas, a negative coefficient represents a negative relationship (Field, 2009).

For these data the predictors: Family income, CD4 count and education of the respondents have positive b vale indicating positive relationship. So as family income, CD4 count and education score increases the quality of life score also increases. Trauma symptom, current age, internalised AIDS-related stigma, and impact of event have negative b value indicating negative relationship. So the trauma symptom, current age, internalised AIDS-related stigma, impact of event score increases the quality of life score of the respondent decreases. The b value also highlights to what degree each predictor affects the outcome variables if the effects of all other predictors are held constant.

The standardised beta (b) values provide a better insight into the importance of the predictor in this model. The standardised beta value for trauma symptom is -0.400, current age is -0.305, family income is 0.283, internalised AIDS-related stigma is -0.192, impact of event is -0.156, CD4 count is 0.124, and education is 0.99.

The ‘t’ value for trauma symptom score ($t = 7.941, p<0.001$), current age ($t = 6.352, p<0.001$), family income ($t = 5.992, p<0.001$), internalised AIDS-related stigma ($t = 3.976, p<0.001$),

impact of event (t = 3.461, $p<0.001$), CD4 count (t = 2.785 , $p<0.01$) and education (t = 2.144, $p<0.05$) are significant predictors of quality of life of the respondents from the magnitude of the 't' statistics, we can see that the trauma symptom had more impact than the other predictors.

On the whole, the percentage variance explained by a single factor, that is trauma symptom is about 16% in model 1, whereas such a percentage has consistently increased to 25%, 32.5%, 35.6%, 37.9%, 39% and 40.2% respectively when additional variables such as current age (model 2), family income(model 3), internalised AIDS-related symptom (model 4), total impact of event (model 5), CD4 count (model 6), and education (model 7) are included.

Regression Path Analysis using Structural Equation Modeling

From the data obtained in path analysis (Table 2 and Path Diagram 1), it can be inferred that when the factor 'trauma symptom' score goes up by 1 unit, 'quality of life' score down by 0.226 units. When 'age' goes up by 1 unit, 'quality of life' score goes down by 0.579, when 'family income' goes up by 1 unit, 'quality of life' score goes up by 0.001 units. When 'Internalised AIDS-related stigma' goes up by 1 unit, 'quality of life' goes down by 1.932 units.

Details about the Co-variances between the independent variables are displayed in Table 2 and Path Diagram 1. The findings reveal that the co-variance between 'IES& CD4 count' (-837.910), 'family income & IARSS' (-1002.210), 'age & family income' (5775.402), 'TSC&IARSS' (5.235), 'TSC & IES' (40.879),'age & education' (-6.594) and 'family income & education' (3656.846) of the respondents is statistically very highly significant ($p<0.001$). The covariance between 'TSC & family income' (-6369.497), 'family income & CD4 count' and 'IARSS & education' of the respondents is statistically highly significant ($p<0.01$). The covariance between 'TSC and age' (11.701) of the respondents is statistically moderately significant ($p<0.05$).

Further, it is obvious to note that while covariance (Table 2 and Path Diagram 1) between 'TSC & age' (t = 2.363, $p<0.05$), 'age & family income' (t = 3.927, $p<0.001$), 'TSC & IARSS' (t = 5.968, $p<0.001$), 'TSC & IES' (t = 3.590, $p < 0.001$), 'family income & CD4 count' (t = 2.875, $p < 0.01$) and 'family income & education' (t = 4.259, $p < 0.001$) are positively significant. Whereas, 'TSC & family income' (t = -2750, $p < 0.01$), 'IES & CD4 count' (t = -3.206, $p < 0.001$), 'family income & IARSS' (t = -4.033, $p < 0.001$), 'age & education' (t = -3.610, $p < 0.001$) and 'IARSS & education' (t= -2.894, $p < 0.01$) are negatively significant.

As far as the standardised beta coefficients are concerned, the results in Table 2 as well as Path Diagram 2, indicate that when there is an increase in family income, education

and CD4 count by one standard deviation each, there is an increase in the quality of life by 0.190, 0.099 and 0.120 standard deviation respectively. On the other hand, when there is an increase in trauma symptom, age, internalised AIDS-related stigma and impact of event score by one standard deviation, there is a decrease in the quality of life by 0.214, 0.343, 0.193 and 0.132 standard deviation respectively.

Details about the correlations between the pairs of variables are also seen in Table 2 and also in the Path Diagram which indicate that while there is a positive correlation between Education & CD4 count (r=0.089). Trauma symptom is positively related to age (r=0.131), IARSS (r=0.347), IES (r=201) and negatively related to family income (0.153), CD4 count (0.090) & education (0.079). Impact of event is negatively to education (r=0.038) and CD4 count (r=0.009). Family income is positively related to CD4 count (r=0.160) &education (r=0.240) whereas, negatively related to IES (r=0.108) and IARSS (r=0.227). Age is positively related to IARSS (r=0.101), family income (r=0.221), and negatively related to CD4 count (0.016) & education (0.202).

Thus it is evident that the independent variable: Trauma symptom, current age, family income, internalised AIDS-related symptom, total impact of event, CD4 count and education together have accounted for 40.2 per cent of variance in the dependent variable: quality of life (Table 1 & Path Diagram 2) and all these seven independent variables also turned out to be significant predictors of quality of life of HIV-infected widows in the present study. In other words, 59.8% of the variance remains unexplained.

CONCLUSION

On the whole, the percentage of variance explained by a single factor, trauma symptom is about 16.1%, whereas such a percentage is consistently increased to 25%, 32.5%, 35.6%, 37.9%, 39% and 40.2% respectively, when additional variables such as current age, family income, internalised AIDS-related symptom, total impact of event, CD4 count, and education are included. The overall results suggest that trauma symptom score has turned out to be the most powerful predictor of the quality of life of HIV-infected widows. It must be noted that although the other socio-demographic characteristics of the respondents were included in the analysis, it was found that they did not influence the quality of life of the HIV/AIDS-infected widows in a major way.

BREF quality of life assessment. Psychological medicine, 28(3), 551-558.

Appendix – I

Test of Homoscedasticity and Normality of residuals

The histogram, P-P and scatter plots were used to check the linearity, homoscedasticity, and normality of residuals that the residuals are normally distributed in multiple linear regression analysis.

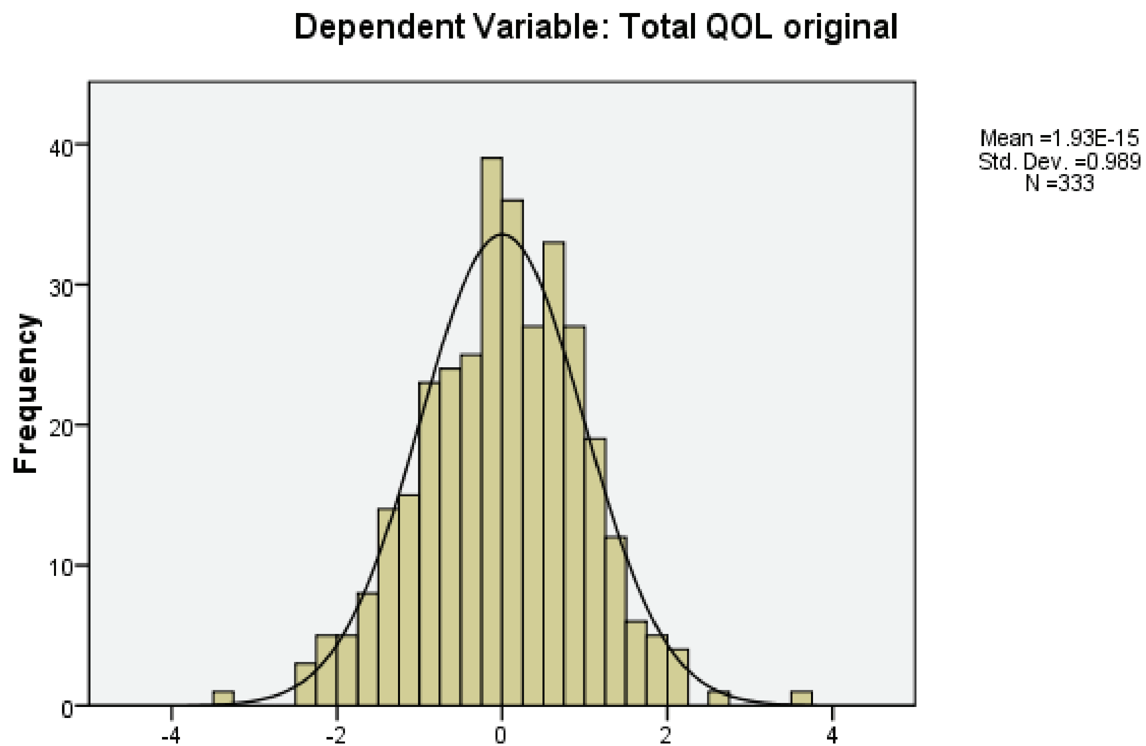


Figure – 1: Histogram of Regression Standardised Residual

The histogram in Figure – 1 indicates that the residuals approximate a normal distribution. Further it shows that in linear regression analysis, there is no tendency in the error terms

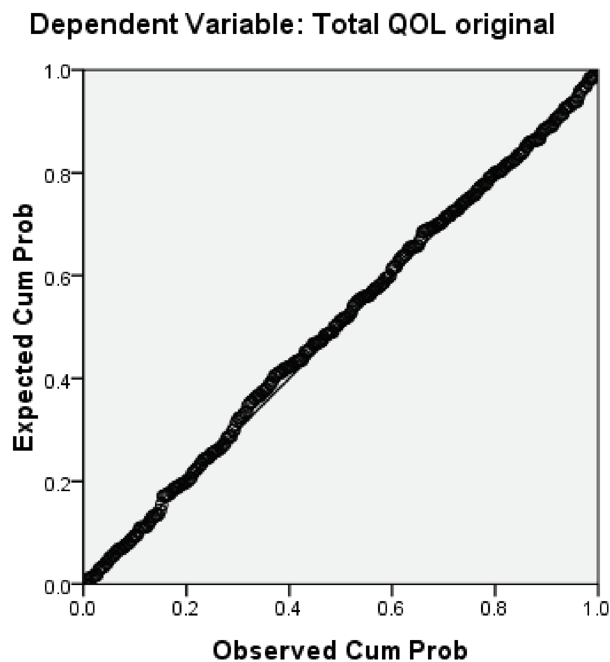


Figure –2: Normal P-P plot of regression standardised residual

A P-P plot in diagram - 2 can also be used to assess the assumption that the residuals are normally distributed. It is good if residuals are lined well on the straight dashed line (Kim, 2017). The figure – 2 echoes the histogram in figure-2 and the data points all fall close to the 'ideal' diagonal line (Field, 2016). The distribution is considered to be normal to a certain extent that the plotted points match the diagonal line with no strong deviations. This indicates that the residuals are normally distributed (Statistical Solutions, (2017).

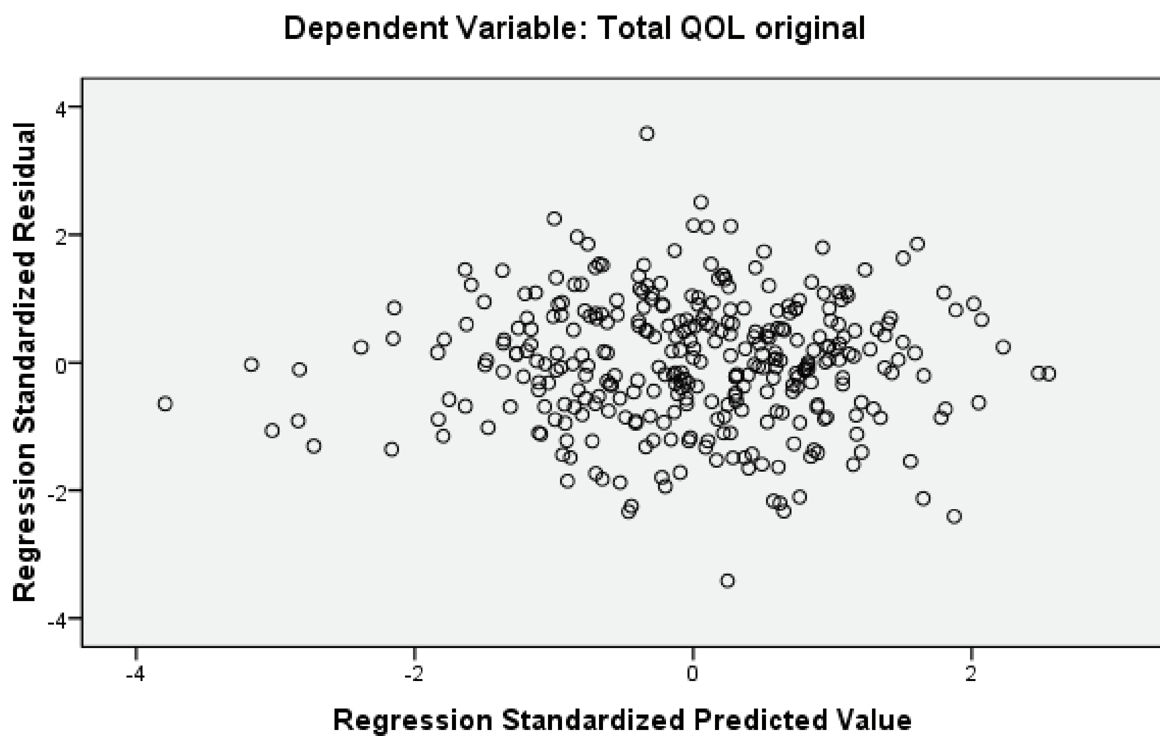


Figure - 3: Scatter plot of Regression Standardised Residual

In order to perform the linear Regression Analysis there is a need to check whether there is a linear relationship in the data (Statistical Solutions, 2017). For that the scatter plot test was conducted. The scatter plot in Figure – 3 indicates a good positive linear relationship between the predictor variables: current age, education, family income,CD4 count, Trauma symptom (TSC), Impact of Event (IES), and Internalised AIDS Related Symptom (IARSS), and the outcome variable: QOL. The correlations between these variables are significant and conclude that there is a linear relationship between these variables which allows us to conduct a linear regression analysis and not violating the linearity assumption.

Table 1: Results based on step-wise Regression Analysis on QOL of HIV/AIDS-infected persons

Model	Predictor variables	R	R^2 x 100	Change in R^2 x 100	B	SE b	b	t value	p value
1.		Dependent Variable- Performance Score							
	(Constant)	0.400	16.0	16.0	85.093	1.678		50.707	
	Trauma Symptom				-0.423	0.053	-0.400	-7.941	0.000
2.	(Constant)	0.502	25.2	9.2	104.366	3.424		30.484	0.000
	Trauma Symptom				-0.381	0.051	-0.360	-7.497	0.000
	Current Age				-0.514	0.081	-0.305	-6.352	0.000
3.	(Constant)	0.570	32.5	7.4	102.317	3.274		31.255	0.000
	Trauma Symptom				-0.325	0.049	-0.308	-6.618	0.000
	Current Age				-0.631	0.079	-0.375	-7.947	0.000
	Family Income				0.001	0.000	0.283	5.992	0.000
4.	(Constant)	0.597	35.6	3.1	106.122	3.342		31.751	
	Trauma Symptom				-0.264	0.051	-0.250	-5.228	0.000
	Current Age				-0.597	0.078	-0.354	-7.630	0.000
	Family Income				0.001	0.000	0.244	5.158	0.000
	IARSS				-1.921	0.483	-0.192	-3.976	0.000
5.	(Constant)	0.616	37.9	2.3	112.356	3.749		29.971	
	Trauma Symptom				-0.228	0.051	-0.216	-4.487	0.000
	Current Age				-0.639	0.078	-0.379	-8.205	0.000
	Family Income				0.001	0.000	0.238	5.101	0.000
	IARSS				-1.937	0.475	-0.194	-4.074	0.000
	Total IES				-0.116	0.034	-0.156	-3.461	0.001
6.	(Constant)	0.627	39.3	1.4	108.530	3.957		27.429	
	Trauma Symptom				-0.222	0.050	-0.210	-4.421	0.000
	Current Age				-0.623	0.077	-0.370	-8.056	0.000
	Family Income				0.001	0.000	0.217	4.647	0.000
	IARSS				-2.012	0.471	-0.201	-4.269	0.000
	Total IES final				-0.101	0.034	-0.136	-2.992	0.003
	CD4 Count				0.006	0.002	0.124	2.785	0.006
7.	(Constant)	0.634	40.2	0.8	105.481	4.184		25.208	
	Trauma Symptom				-0.226	0.050	-0.214	-4.520	0.000
	Current Age				-0.579	0.080	-0.343	-7.269	0.000
	Family Income				0.001	0.000	0.190	3.939	0.000
	IARSS				-1.932	0.470	-0.193	-4.107	0.000
	Total IES				-0.098	0.033	-0.132	-2.912	0.004
	CD4 Count				0.006	0.002	0.120	2.720	0.007
	Education				0.287	0.134	0.099	2.144	0.033

Table 2 : Results based on Regression Path Analysis on QOL of visually impaired persons using structural equation modeling

Variables							
S.No				**Estimate**	**S.E.**	**C.R.**	**P**
1	**B weights**						
	totalqol	<---	totaltsc33	-.226	.050	-4.569	.000
	totalqol	<---	age	-.579	.079	-7.347	.000
	totalqol	<---	finc	.001	.000	3.981	.000
	totalqol	<---	tiarss	-1.932	.465	-4.151	.000
	totalqol	<---	TotalIESfinal	-.098	.033	-2.944	.003
	totalqol	<---	edu	.287	.132	2.167	.030
	totalqol	<---	CD4count	.006	.002	2.749	.006
2	**Co-variances**						
	Edu	<-->	CD4count	106.128	66.040	1.607	.108
	totaltsc33	<-->	age	11.701	4.952	2.363	.018
	TotalIESfinal	<-->	edu	-2.840	4.073	-.697	.486
	finc	<-->	TotalIESfinal	-6410.825	3283.198	-1.953	.051
	totaltsc33	<-->	finc	-6369.497	2316.030	-2.750	.006
	tiarss	<-->	CD4count	-3.123	19.099	-.164	.870
	Age	<-->	tiarss	.958	.522	1.834	.067
	TotalIESfinal	<-->	CD4count	-837.910	261.322	-3.206	.001
	tiarss	<-->	TotalIESfinal	1.274	1.184	1.077	.282
	finc	<-->	tiarss	-1002.210	248.516	-4.033	.000
	Age	<-->	finc	5775.402	1470.580	3.927	.000
	totaltsc33	<-->	tiarss	5.235	.877	5.968	.000
	totaltsc33	<-->	TotalIESfinal	40.879	11.386	3.590	.000
	totaltsc33	<-->	CD4count	-295.020	181.150	-1.629	.103
	age	<-->	TotalIESfinal	-18.158	7.072	-2.568	.010
	age	<-->	CD4count	-33.754	113.181	-.298	.766
	age	<-->	edu	-6.594	1.827	-3.610	.000
	finc	<-->	CD4count	153637.527	53432.856	2.875	.004
	tiarss	<-->	edu	-.886	.306	-2.894	.004
	totaltsc33	<-->	edu	-4.124	2.863	-1.440	.150
	finc	<-->	edu	3656.846	858.540	4.259	.000
3	**Variances**						
	totaltsc33			142.650	11.072	12.884	.000
	Age			56.119	4.356	12.884	.000
	Finc			12199587.335	946871.612	12.884	.000
	Tiarss			1.598	.124	12.884	.000
	TotalIESfinal			289.982	22.507	12.884	.000
	Edu			18.963	1.472	12.884	.000
	CD4count			75763.119	5880.358	12.884	.000
	e1			95.365	7.402	12.884	.000

	βWeights (coefficient)				
	totalqol	<---	totaltsc33	-.214	When trauma symptom goes up by 1 standard deviation, QOL goes down by 0.214 standard deviations
	totalqol	<---	age	-.343	When age goes up by 1 standard deviation, QOL goes down by 0.343 standard deviations
	totalqol	<---	finc	.190	When family income goes up by 1 standard deviation, QOL goes up by 0.190 standard deviations
4	totalqol	<---	tiarss	-.193	When IARSS goes up by 1 standard deviation, QOL goes down by 0.343 standard deviations
	totalqol	<---	TotalIESfinal	-.132	When IES goes up by 1 standard deviation, QOL goes down by 0.132 standard deviations
	totalqol	<---	edu	.099	When education goes up by 1 standard deviation, QOL goes down by 0.099 standard deviations
	totalqol	<---	CD4count	.120	When CD4 goes up by 1 standard deviation, QOL goes down by 0.120 standard deviations

	Correlations				
	Edu	<-->	CD4count	.089	Correlation between Education &CD4 count is 0.089
	totaltsc33	<-->	Age	.131	Correlation between trauma symptom & age count is 0.089
	TotalIESfinal	<-->	Edu	-.038	Correlation between IES & education is - 0.038
	finc	<-->	TotalIESfinal	-.108	Correlation between family income &IES is - 0.108
	totaltsc33	<-->	Finc	-.153	Correlation between trauma symptom & family income is - 0.153
	tiarss	<-->	CD4count	-.009	Correlation between IARSS & CD4 count is 0.009
	age	<-->	Tiarss	.101	Correlation between age & IARSS is 0.101
	TotalIESfinal	<-->	CD4count	-.179	Correlation between IES & CD4 count is - 0.179
	tiarss	<-->	TotalIESfinal	.059	Correlation between IARSS & IES is 0.059
	finc	<-->	Tiarss	-.227	Correlation between family income & IARSS is - 0.227
5					
	age	<-->	Finc	.221	Correlation between age & family income is 0.221
	totaltsc33	<-->	Tiarss	.347	Correlation between trauma symptom & IARSS is 0.347
	totaltsc33	<-->	TotalIESfinal	.201	Correlation between trauma symptom & IES is 0.201
	totaltsc33	<-->	CD4count	-.090	Correlation between trauma symptom & CD4 count is - 0.090
	age	<-->	TotalIESfinal	-.142	Correlation between age & IES is - 0.142
	age	<-->	CD4count	-.016	Correlation between Age & CD4 count is - 0.016
	age	<-->	Edu	-.202	Correlation between age & Education is - 0.202
	finc	<-->	CD4count	.160	Correlation between family income & CD4 count is 0.160
	tiarss	<-->	Edu	-.161	Correlation between IARSS & Education is - 0.161
	totaltsc33	<-->	Edu	-.079	Correlation between trauma symptom & Education is - 0.079
	finc	<-->	Edu	.240	Correlation between family income & Education is 0.240

Diagram 1: Path Diagram between the independent variables – Trauma symptom, current age, family income, internalised AIDS related stigma, impact of event scale, CD4 count, education and the dependent variable: quality of life: Graphic output of Standardised estimate (β)

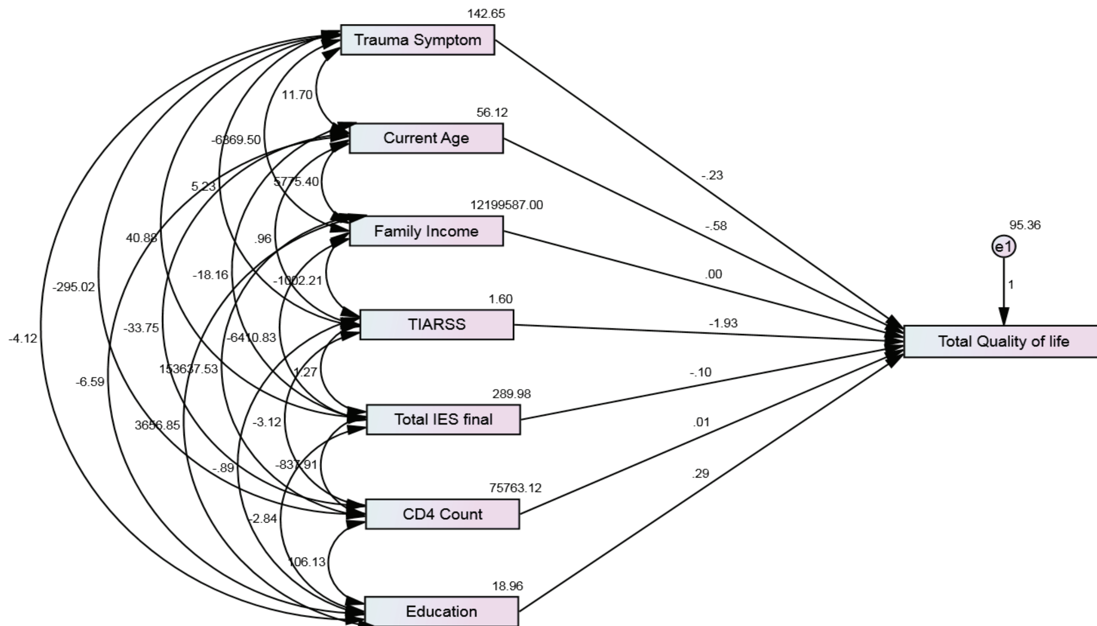
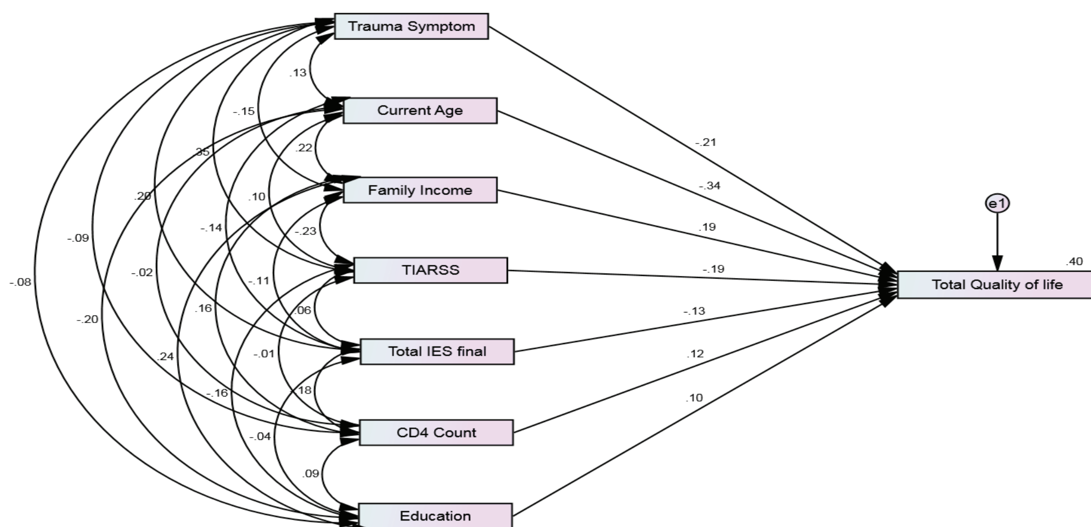


Diagram 2: Path Diagram between the independent variables – Trauma symptom, current age, family income, internalised AIDS related stigma, impact of event scale, CD4 count, education and the dependent variable: quality of life: Graphic output of Un-standardised estimate (b)



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A STUDY ON THE DETERMINANTS OF MENTAL HEALTH AND QUALITY OF LIFE OF VISUALLY IMPAIRED PERSONS

Sethuramalingam V.

ABSTRACT

Visually impaired persons have to not only put twice the effort into everyday tasks that are simple for sighted persons but also have to bear the burden of mental illness as a direct result of their visual impairment.

The objectives of the research are to find out the level of social support, hopelessness, work and social adjustment, mental health and quality of life and to identify the major predictors as well as their extent of net effects on the overall quality of life of the visually impaired persons with an appropriate multivariate technique.

There are 396 visually impaired persons living in the study areas, of which 276 (158 male and 118 female) visually impaired persons were selected as sample. The respondents were selected using simple random sampling technique adopting lottery method. Appropriate tools were used to collect the required data and the reliability values were also established. To find out the major predictors as well as the extent of their net effects on the overall quality of life, step-wise multiple regression and path analyses has been carried out.

The findings show that the three predictors: mental health, social support, and work and social adjustment have explained 58.9 per cent of variance in quality of life.

The outcome of the research will be useful for evolving effective intervention programmes for the visually impaired persons to enhance their mental health and quality of life.

Keywords: Visually Impaired, Social Support , Hopelessness , Work and Social Adjustment, Mental Health, Quality of life.

INTRODUCTION

Globally, 1.3 billion people live with vision impairments of which 36 million are blind (Bourne et al., 2017; WHO, 2018). In India, 5.03 million are visually impaired and 0.72 million are mentally ill (Government of India, 2015). Visual impairment is undoubtedly

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a seriously challenging disability. Over the years, there have been a number of studies that have examined the day-to-day struggles of visually impaired persons that reflect the physical consequences of being visually impaired. It is now being acknowledged that mental health, which is a vital component of healthy living, could be threatened by physical disability as well. Visually impaired persons have to, not only put twice the effort into everyday tasks that are simple for sighted persons, but also have to bear the burden of mental illness as a direct result of their visual impairment as well as an indirect result of the same in the form of financial struggles that stem from limited opportunities for education and employment.

Considering the fact that the researcher has worked with visually impaired persons for a significant period of time, it has been noticed that there is a paucity of studies on the mental health of visually impaired people. This fact birthed certain questions in the mind of the researcher: What is the socio-economic background of the visually impaired persons living in the study area? What is the level of social support, hopelessness, work and social adjustment, mental health and quality of life (QOL) of the visually impaired? Most importantly, whether the QOL in the visually impaired persons was influenced by their background characteristics, social support, hopelessness, work and social adjustment, and mental health? In order to answer these questions, the researcher has carried out the present research work.

REVIEW OF LITERATURE

Various studies have been carried out on the mental health and quality of life of visually impaired persons. Brown and Barrett (2011) indicated that higher levels of visual impairment are associated with more depressive symptoms and lower life satisfaction. After studying the level of stress and coping strategies adopted by adolescents with visual impairment. Hallemani et al., (2012) came to the conclusion that there is a statistically significant association between the stress levels of adolescents with visual impairment. Sethuramalingam et al., (2012) reported that the self-esteem was higher among the visually impaired than the orthopedically impaired persons. Abateneh, et al., (2013), substantiate the claim that prevalence of psychological distress was significantly higher in patients with visual loss compared to patients with normal vision. However, Erol and Ergun (2013), found that there is a weak relationship between social comparison and hopelessness. Adigun, et al., (2014) in their study reported that the visual impairment was found to be associated with advancing age, low education, and unemployment. Most patients were found to have good quality of life. Dev, et al., (2014) concluded that health related quality of life was significantly associated with age. As age increased, quality of life scores gradually reduced. Scores for all quality of life dimensions except

general health and mental health, gradually decreased with age. Meyer-Rochow, et al. (2015), noted that the income of blind working men does not match that of the seeing population. A feeling of hopelessness in addition to economic hardship could then lead to depression, culminating in self-harm. According to Alshehri (2016), visual impairment has negative impacts on different aspects of life including social, psychological, and physical health. However, Cho, et al., (2015) reported that visual impairment was not associated with poor mental health. Khorrami-Nejad (2016) indicated that participants without stereoscopic vision had significantly lower QOL scores in the social and leisure domains than other participants.

From the review of earlier literature, it is found that there have been no recent studies among visually impaired persons with specific focus on mental health, hopelessness, social support, work and social adjustment, and quality of life, comprehensively. In view of this research gap, the researcher has proposed to conduct an in-depth study to examine the mental health and quality of life of visually impaired persons in Tiruchirappalli district.

METHOD

Objectives: The study has the following objectives: (i) to find out the level of social support, hopelessness, work and social adjustment, mental health and quality of life of the visually impaired persons, and (ii) to identify the major predictors as well as the extent of their net effects on the overall quality of life of the visually impaired persons.

Ethical Consideration: Before collecting the data, permission was obtained from the leaders of the residential welfare association of the visually impaired persons in study areas. The purpose and benefit of the research was explained to them in detail. The researcher assured to the respondents that data collected will be used only for the research purpose and will be kept confidential. Oral consent was obtained from the respondents also regarding the study. The respondents were given the opportunity not to participate or to withdraw from the interview at any time for any reason.

Inclusion and Exclusion criteria: There is no official data on the visually impaired persons in Tiruchirappalli district in Tamil Nadu. Even though there is a welfare association for the visually impaired persons in Tiruchirappalli, there is no updated list of members with their residential addresses for contact. Moreover, the district revenue administration formulated a special housing scheme for the rehabilitation of the homeless visually impaired persons and allotted houses for them in Gandhinagar and Dheeranmanagar in Tiruchirappalli district, Tamil Nadu. Hence, the researcher purposively selected Dheeranmanagar and Gandhinagar in Tiruchirappalli district,

Tamil Nadu as the government had constructed houses under a 'special housing scheme' for the visually impaired persons for their rehabilitation. Therefore, the researcher did not include other visually impaired persons other than the abovesaid residential colonies.

Selection of Respondents:

There are 396 visually impaired persons living in these areas, of which 296 (75%) were selected as sample for the study using simple random sampling technique by adopting lottery method. During the process of data collection, 16 respondents were unavailable due to the nature of their occupations. Four respondents expressed their inability to provide information to the investigators. Hence, the sample size constitutes 276 (70%) visually impaired persons.

Research Design: Descriptive research design was adopted for the present study. Through such design one can observe a particular phenomenon or dimension and its related issues, and thereby, describe the same in a lucid manner. The present research is also cross sectional in nature since data was collected at only one point in time to assess the socio-demographic background and the subject dimensions such as, social support, hopelessness, work and social adjustment, mental health and quality of life of the respondents at the point of data collection. Further, a correlation design has also been used to determine whether an increase or decrease in one variable corresponds to an increase or decrease in the other variable. In the present research, the demographic, socio-economic variables, social support, hopelessness, work and social adjustment and mental health were used as independent variables and the quality of life was used as dependent variable.

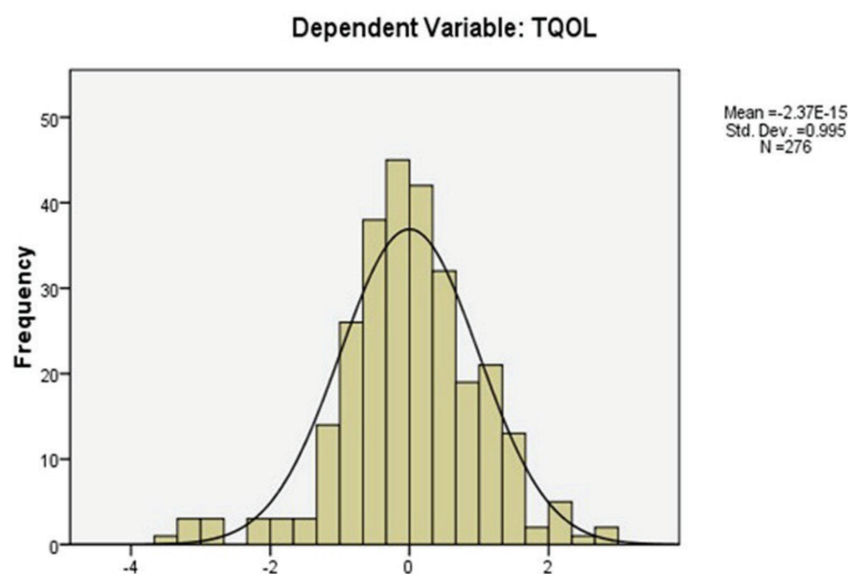
Tools of Data Collection: To collect the required data, the researcher used Social Support Scale (Zimet et al., 1988), Hopelessness Scale (Beck et al., 1974), Work and Social Adjustment Scale (Mundt et al., 2002), MHI-38 (Veit & Ware, 1983), and WHOQOL-BREF (WHO, 2004). The reliability value for social support (0.942), hopelessness (0.694), work and social adjustment (0.982), mental health, (0.962) and WHOQOL=BREF (0.933) scales were also established. A pretest was conducted with five respondents in order to check whether there were any problems in the interview schedule. Some problems were detected and accordingly, the researcher made necessary changes such as adding, removing, and modifying certain questions in order to address those problems. Moreover, the researcher realised that there was a need to conduct the interviews in the vernacular language in the present context.

Methods of Data Collection: Besides personal observations, personal interview technique was adopted to elicit information from the respondents. The data was collected during the months of March – December 2017 through face-to-face interviews

with the visually impaired persons. On an average, the researcher collected data from three/four respondents per day which took an average of one hour per respondent. Hence, the researcher took an average of 90 days for data collection. Data collection took 10 months because on some days the respondents were not available due to the nature of their occupation.

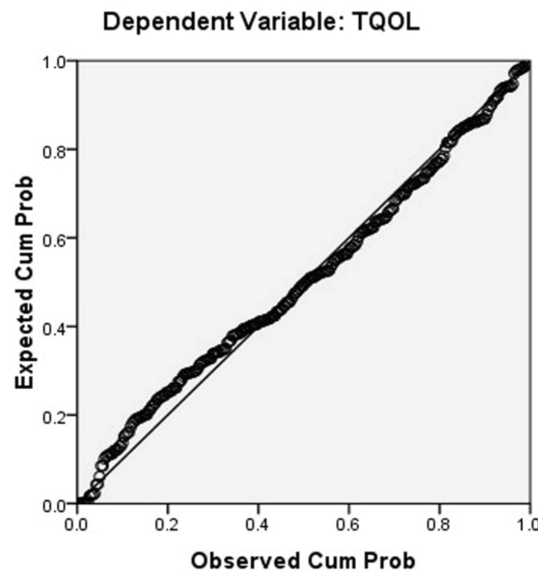
Analysis of Data: The data was analysed using SPSS –AMOS -24 (IBM Corp, 2017). The analysis was carried out with the help of frequency distribution apart from statistical techniques such as stepwise multiple regression and path analysis. Histogram (figure - 1), p-p plot (figure - 2) and scatter plot (figure - 3) were used to check the linearity, homoscedasticity, and normality of residuals. The residuals were found to be normally distributed in multiple linear regression analysis.

Figure – 1: Histogram of Regression Standardised Residual



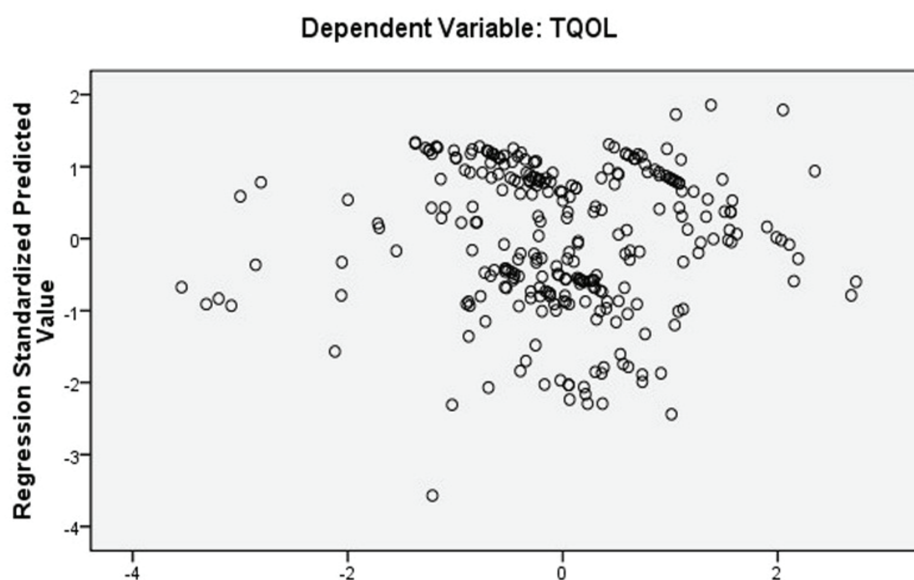
The histogram in Figure – 1 indicates that the residuals approximate a normal distribution. Further, it shows that in linear regression analysis, there is no tendency in the error terms to a certain extent.

Figure –2: Normal P-P plot of Regression Standardised Residual



A p-p plot in Diagram - 2 can also be used to assess the assumption that the residuals are normally distributed. It is good if residuals are lined well on the straight dashed line (Kim, 2015). The Figure – 2 echoes the histogram and the data points all fall close to the 'ideal' diagonal line (Field, 2016). The distribution is considered to be normal that the plotted points match the diagonal line with no strong deviations. 'This indicates that the residuals are normally distributed' (Statistical Solutions, 2017).

Figure - 3: Scatter plots of Regression Standardised Residual



In order to perform the linear regression analysis there is a need to check whether there is a linear relationship in the data (Statistical Solutions, 2017).For that the scatter plot test was conducted. The scatter plots in Diagram-3 indicate a good positive linear

relationship between the predictor variables: mental health, social support and work and social adjustment score and the outcome variable: QOL. The correlations between these variables are significant and conclude that there is a linear relationship between these variables which allows us to conduct a linear regression analysis and not violating the linearity assumption.

RESULTS

Background Characteristics of The Visually Impaired Persons: The results showed that the average age of the respondents is 43.73 years. Most (91%) of them were married and their average age at marriage was found to be 28 years. The average age at marriage for male and female respondents was 28.5 and 28.0 years respectively which indicate that there is not much difference between both male and female respondents with regard to their age at marriage. A majority (89%) of the marriages were inter-caste in nature (exogamy). This is contrary to the report of Dhar, who reported that marriage in India is primarily based on social stratification of a caste system, which condemns inter-caste marriages, and the couples who try to defy this norm faces dire consequences, (Dhar, 2013), even murdered by their family members/relatives in Tamil Nadu and in other states in India as well. However, the prevalence of inter-caste marriages is common among the visually impaired in the study area. One reason for this is perhaps the lack of people who are visually impaired in the same caste or the refusal to marry blind men by the brides and vice versa, even if they are close relatives or belong to their own caste. Hence, in such a scenario, the high prevalence of inter-caste and inter religious marriages among the visually impaired is expected. Usually, the marriages for the visually impaired occur with the help and guidance from NGOs where they are employed or are undergoing mobility training, skill training and the like. Almost all the respondents (99%) live in nuclear families with an average of 3.3 members. This is a little lower than the Tamil Nadu state average household size of 3.9 members and the national average of 4.8 members (Census of India, 2011). Enquiries revealed that financial considerations are the main reason behind the rise of small families among the visually impaired. One-fourth (25%) of the respondents were illiterates. Their average level of education was 7.2 years (middle school level), with postgraduation being the highest educational attainment. Nearly two-thirds of the respondents (63.4%) are engaged in sales. Their average monthly family income and expenditure were Rs. 6,548 and Rs. 2,559 respectively. A majority (88%) of the respondents live in their own houses which were constructed by the Government of Tamil Nadu for their rehabilitation. Due to the efforts taken by the Department of Social Work, Bharathidasan University, all the houses were electrified, including street lights. All the respondents have access to protected drinking water, supplied through street pipes and 60 % of the respondents

have access to television in their homes which was provided by the Government of Tamil Nadu, free of cost. On an average, each respondent's family has 1.7 mobile phones. Almost all (99%) the respondents have access to toilets which is a little higher (95.6%) than the usage of toilets in rural India (NSSO, 2016).

Vision Impairment Related Aspects: Among the total respondents, 85% were totally blind and 15% were partially blind. A majority (74%) of them lost their vision after birth due to infectious diseases like measles and other diseases that were avoidable / preventable. This finding is contrary to the findings of the WHO (2017) which reported that cataract (47.9%) was the leading cause of visual impairment in the world except in developed countries.

The respondents' average age at vision loss was 6.5 years while 36% of them lost their vision by birth itself. A little more than one fourth (26.8%) of the respondents' families have had a history of blindness and 23.2% of the respondents have siblings who are also blind. It was reported that a majority (84%) of the respondents' spouses were also blind, nine percent of the blind men had married sighted women while two of the blind women had married sighted men.

Level of Mental Health: The mean score of social support scale was 4.88 with a score ranging 2-7, the hopelessness scale was 7.01 with a score range of 0-19, the work and social adjustment scale was 14.63 with a score range of 5-37, mental health instrument was 169.54 with a score range of 57-226 and the QOL scale was 55.40 with a score range of 29-76. It was also found that a majority of the respondents scored 'high' on social support (61%), mental health (57%), QOL (52.9%) and 'low' on hopelessness (53.6%) and work and social adjustment (53%) scales.

Identification of Major Predictors of The Quality of Life of Visually Impaired Persons:

In order to find out the major predictors as well as their individual contribution of the overall scores of social support (SS), hopelessness, work and social adjustment (WSAS), mental health (MH), and selected background characteristics on the QOL of the visually impaired persons, step-wise multiple regression analysis has been carried out. The objective of the multiple regression analysis is to predict the changes in the dependent variable in response to changes in the independent variables. This objective is most often achieved through the statistical rule of least squares. In the step-wise regression, the method of selecting variables for inclusion in the regression model starts by selecting the best predictor of the dependent variables. With this method, one could extract the most predicted independent variables of dependent variable under consideration (Hair et al., 1998).

Column1 of Table 1 is the model being reported in this analysis. Column 2 shows the predictor variables. The first variable (constant), referred as the Y intercept, the height of the regression line when it crosses the Y axis. In other words, this is the predicted value of QOL when all other variables are 0 (IDRE, 2016).

The R^2 value, in column number 4 is a measure of how much of the variability in the outcome is accounted for by the predictors (Field, 2009). Model 1 (in Column 2) refers to the first stage in the hierarchy when only mental health score is used as the predictor. For the first model (in Column 4), its value is 0.519, which means that the mental health score alone accounts for 51.9 % of variation in the quality of life of visually impaired persons.

Table 1: Results based on Step-Wise Regression Analysis on QOL of visually impaired persons

Model	Predictor variables	R	R^2 x 100	Change in R^2 x 100	b	SE b	b	C.R. / t	p value
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
		Dependent Variable- QOL of Visually Impaired Persons							
1	(Constant)	0.721	51.9	51.9	28.908	1.572		18.394	.000
	Mental Health				0.156	0.009	0.721	17.206	.000
2	(Constant)	0.763	58.2	6.3	23.184	1.719		13.486	.000
	Mental Health				0.111	0.011	0.514	10.147	.000
	Social support				2.727	0.426	0.324	6.400	.000
3	(Constant)	0.771	59.4	1.2	31.161	3.240		9.617	.000
	Mental Health				0.091	0.013	0.421	7.062	.000
	Social support				2.251	0.452	0.268	4.986	.000
	WSAS				-0.151	0.052	-0.176	-2.889	.004

In the second and third models, this value increases to 58.2 % and 59.4 % of the variance in QOL score. Therefore, whichever variables are entered in the model in step 2 and step 3, they account for an extra 6.3 % and 1.2 % of the variance in QOL score.

The unstandardised beta (b) value (in Column 6) explains the relationship between QOL score and each predictor variables. If the b value is positive, there is a positive relationship between the predictor and the outcome, whereas a negative coefficient

represents a negative relationship (Field, 2009). For these data, the predictors: mental health (0.091) and social support (2.251) have a positive relationship with QOL. On the other hand, there is a negative relationship between work and social adjustment (-0.151) and QOL. That is, as the mental health and social support scores increases the quality of life score also increases, whereas with an increase in the work and social adjustment score, there is a decrease in the QOL score.

The standardized beta (β) values (in Column 8) provide a better insight in the importance of the predictor in this model. The standardised beta value with regard to mental health is 0.421, with regard to social support it is 0.268, and with regard to work and social adjustment, it is -0.176.

The C.R / t and p value (in column 9 &10) indicate that mental health (t= 7.062, $p < 0.001$), social support (t= 4.986, $p < 0.001$), and work and social adjustment (t= - 2.889, $p < 0.01$) are significant predictors of QOL. Moreover, from the magnitude of the t-statistics and the p value, it can be inferred that the mental health score had the highest impact on the QOL of the visually impaired persons among all the predictors.

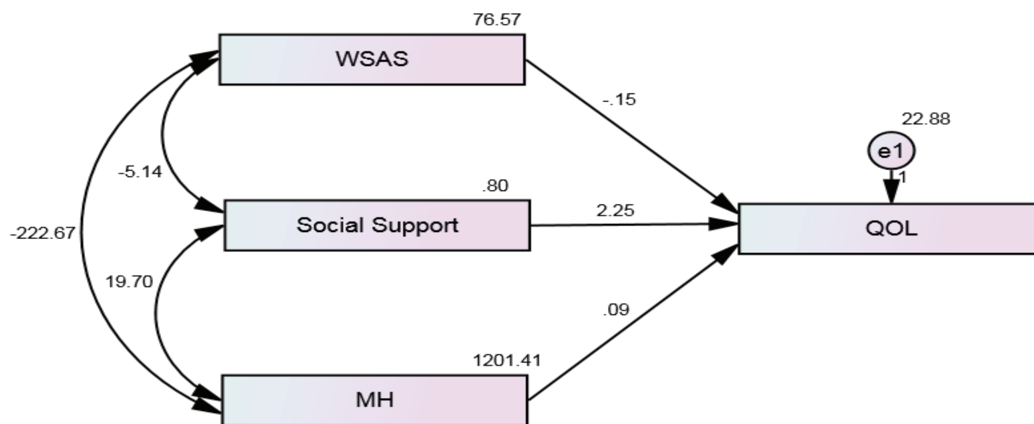
On the whole, the percentage variance explained by a single factor, that is, mental health score is about 51.9% in model 1 (which means that mental health score alone accounts for 51.9% of the variation in QOL of visually impaired persons), whereas such a percentage has consistently increased to 58.2%, and 59.4%, respectively when additional variables such as social support score (model 2), and work and social adjustment score (model 3) are included.

Regression Path Analysis using Structural Equation Modeling :

Path analysis is a form of multiple regression statistical analysis used to evaluate causal models by examining the relationships between a dependent variable and two or more independent variables. Using this method one can estimate both the magnitude and significance of causal connections between variables (Crossman, 2017).

From the data on un-standardised beta weights (b) obtained in path analysis (Panel 1 of Table 2 and Path Diagram 1 also see Panel 3 of Table 1), it can be inferred that when the factor 'mental health score' goes up by 1 unit, 'QOL goes up by 0.091 units. When 'social support score' goes up by 1 unit, 'QOL score' goes up by 2.251 units and when 'work and social adjustment score' goes up by 1 unit, 'QOL score' goes down by 0.151 units.

Regression Path Diagram: 1 Graphic output for Un-standardised Estimates (b)



Regression Path Diagram: 2- Graphic output for standardised Estimates (β)

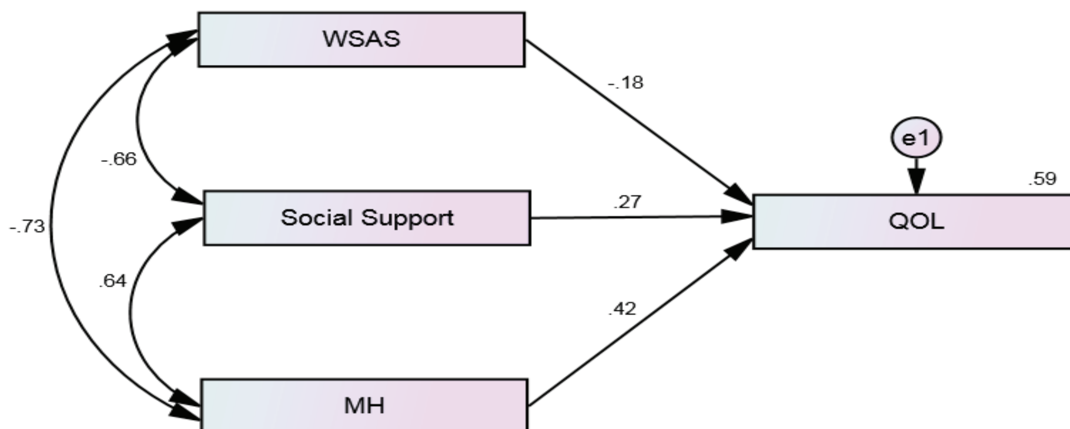


Table 2: Results based on Regression Path Analysis on QOL of visually impaired persons

SN	Variables			Estimates	S.E. b	C.R/ t.	p
1	(1)			(2)	(3)	(4)	(5)
	b Weights						
	QOL	<---	MH	0.091	0.013	7.101	0.000
	QOL	<---	SS	2.251	0.449	5.013	0.000
	QOL	<---	WSAS	-0.151	0.052	-2.905	0.004
2	Co-variances						
	WSAS	<-->	SS	-5.14	0.564	-9.114	0.000
	SS	<-->	MH	19.70	2.214	8.897	0.000
	WSAS	<-->	MH	-222.67	22.690	-9.814	0.000
3	Variances						
	WSAS			76.57	6.530	11.726	0.000
	SS			0.80	0.068	11.726	0.000
	MH			1201.41	102.457	11.726	0.000
	e1			22.88	1.951	11.726	0.000
4	β Weights				(Coefficient)		
	QOL	<---	WSAS	-0.18	When WSAS goes up by 1 standard deviation, QOL goes down by 0.176 standard deviations		
	QOL	<---	SS	0.27	When SS goes up by 1 standard deviation, QOL goes up by 0.268 standard deviations		
	QOL	<---	MH	0.42	When MH goes up by 1 standard deviation, QOL goes up by 0.421 standard deviations		
5	Correlations						
	WSAS	<-->	SS	-0.66	Correlation between WSAS&SS is-0.658		
	SS	<-->	MH	0.64	Correlation between SS &MH is 0.636		
	WSAS	<-->	MH	-0.73	Correlation between WSAS&MH is-0.734		
6	Squared Multiple Correlation Estimate				Error Variance		
	R^2		QOL	0.594 or 59.4%	The error variance of QOL score is 40.6 %		

Details about the *co-variances* between the independent variables are displayed in panel 2 of table 2 and path diagram 1). The findings reveal that the covariance between 'work and social adjustment & social support (-5.14), 'social support & mental health' (19.70), and 'work and social adjustment & mental health' (-222.67), of the respondents is statistically very highly significant level (p< 0.001).

Further, it is obvious to note that while the co-variance (Panel 2 of Table 2 and Path Diagram 1) between 'social support & mental health' (t = 8.897, p < 0.001) is statistically very highly significant and positive direction, whereas, the co-variances between 'work and social adjustment & mental health' (t = -9.814, p < 0.001), and 'work and social adjustment & social support' (t = -9.114, p < 0.001) are highly significant but in the negative direction.

From Panel 3 of Table 2, (variance) it can be deduced that the probability (p) of getting a critical ratio (also called z score / t value) for all the variables as large as 11.726 in absolutevalue (0.000) is less than 0.001. In other words, the variance estimates for work and social adjustment, social support and mental health are significantly different from zero at the 0.001 level and thereby, have turned out to be highly significant.

As far as the *standardized beta coefficients (*β) are concerned, the results in panel 4 of table 2 as well as path diagram 2 indicate that when there is an increase in social support and mental health by one standard deviation each, there is an increase in the QOL by 0.27 and 0.42 standard deviation respectively. On the other hand, when there is an increase in work and social adjustment by one standard deviation, there is a decrease in the QOL by 0.18 standard deviations.

Details about the *correlations* between the pairs of variables are seen in Panel 5 of Table 2 and also in the Path Diagram 2 which indicate that while there is a positive correlation between social support score and mental health score (r = 0.64), whereas the work and social adjustment score is negatively correlated with social support score (r = -0.66) and mental health score (r = -0.73).

Thus, it is evident that the predictors: 'social support', 'work and social adjustment', and 'mental health' together have accounted for 59.4 % of variance in the outcome variable: QOL (table 1 and path diagram -2) and all these three independent variables also turned out to be significant predictors of QOL of visually impaired persons in the present study. In other words, 40.6 % of the variance remains unexplained.

IMPLICATIONS OF THE STUDY

The findings reveal that a majority of the respondents are illiterate and school dropouts. Hence, there is a need to emphasize and promote formal education for children who are visually impaired through school admission drives and by setting up a monitoring committee in each block comprising of teachers and village elders to ensure that visually impaired children are admitted in special schools and by also ensuring that those who have dropped out are re-admitted.

The findings also indicate that a majority of the respondents are engaged in the sale of small items such as key chains, agarbattis, candles and the like, purchased from the local market. However, it has to be noted that this does not provide them with a substantial profit. Hence, it is suggested that they could be trained in producing such items through self help groups as well as cooperative societies so that they can increase their profits and family income. It was observed that the visually impaired persons who are engaged in sales need the assistance of a daily wage labourer who can take them from one place to the other, to sell their products. This cuts into their profits. One solution to this would be to provide the respondents with some free space to sell their products. Such an arrangement could be made public places like bus stands and railway stations, places of worship, academic institutions and industrial premises, and large government/private complexes. Since it has been found that a considerable number of the respondents have a low level of social support (43%), mental health and quality of life (47%) and a high level of hopelessness (46%) and work and social adjustment problems (47%), there is need for providing counseling to them to improve their mental health.

CONCLUSION

On the whole, the percentage variance explained by a single factor- mental health, is about 51.9%. This variance increases to 58.2% and then to 59.4%, when additional variables such as social support and work and social adjustment are included. The overall results suggest that the mental health score of the visually impaired has turned out to be the most powerful predictor of the overall quality of life of the visually impaired persons. It must also be noted that although hopelessness and background characteristics of the respondents were included in the analysis, they did not influence the quality of life of the visually impaired persons in a major way. It is hoped that the outcome of this research will be useful in evolving effective intervention strategies for the visually impaired persons to enhance their mental health and quality of life.

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