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The National Journal of Professional Social Work (NJPSW) is an official publication of the Indian Society of Professional Social Work (ISPSW). NJPSW is a peer-reviewed/refereed open access, indexed journal, primarily publishing original articles pertinent to social work practice and research. The NJPSW aims to nurture evidence-based practice among professional social workers in India. The journal is published biannually, which also includes the papers awarded at the Annual National Conference of ISPSW. Articles are contributed by eminent educators, practitioners, researchers, scholars and students of social work.

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Indispensable Quality of a Scholarly Online Journal

It gives me immense pleasure to bring out this issue of the National Journal of Professional Social Work. I would like to first share credit with all the authors who have trusted and submitted their precious work to publish with us. Secondly, I acknowledge the President of ISPSW and patron of this journal who granted permission to publish and entrusted me as Honorary Editor. I am also grateful to all the Executive Committee members for their support and encouragement and my esteemed editorial board members for their prompt and positive response for an extensive review and editing of this journal issue.

Publishing an academic journal is a matter of great pride and privilege for any professional association/society or institution. Hence, we in ISPSW have brought out this journal since 2000; we appreciate those who have successfully started and continued to achieve these milestones. Publishing 20 volumes is not an easy job; we however, look forward to improving it.

In the era of limited or no access to computers and networks, availing knowledge was also limited and depended on what book dealers and libraries could offer in the print media. The Budapest Open Access Initiative (BOAI) in 2002 and thereafter, with the constant advancement in digital media and online publishing, open access is now feasible in terms of availability, accessibility and affordability. The open-access online publishing has brought remarkable changes in scientific peer-reviewed journals. Journals are now available both in electronic versions and print.

Publishing a Complete Issue in one PDF vs. Individual Articles

In the traditional journal, publication articles are collected for a period of time after which they are vetted and processed for publication, arranged into a complete volume or issue and published all at once preferably yearly or biannually or quarterly. Very often, this complete volume or issue of a journal is prepared in a single portable document format (pdf); and is uploaded on the website of the association/society or institution which is sponsoring or publishing that particular journal. This is available even in the social media like LinkedIn, Academia.edu, Scribd etc. When the complete volume or issue of a journal is uploaded in a single pdf file, one of the important advantages of online journals which cannot be used is the possibility of having article-level metrics. Article-level metrics is a tool used in a large number of journals. This method measures the number of times an individual paper is used, discussed and shared on electronic media (Gonder, 2018).

In contrast to conventional print publication of a journal, in online publication, single papers are promptly put out to the readers after being peer-reviewed and edited during a particular period, usually over a period of one year. A mixed approach with articles in press offers a blend of advantages. Articles are made accessible to readers as fast as could be reasonably expected, and simultaneously, editors can organize articles into an issue or volume thereafter.

When an article is uploaded separately (not with the complete volume or issue), it is more likely to appear more frequently in search engines like Google and more likely to be researched through search engines like Google Scholar; it also gets indexed automatically on publication if it has followed certain formats which are used in open access journals. Again it will be picked up easily by search engines when searched with appropriate keywords. So, when researchers search for any paper of their desired topic, pdf file of the complete volume or issue will also appear but likely later in the sequence of the search result compared to the article that is uploaded separately; hence there will be less chance for it to get read or cited. A pdf of the complete volume or issue appearing on electronic searches is similar to eating food in the same cooker where it was cooked; obviously it will be not at all convenient and

enjoyable to eat. Whereas an article uploaded independently appears as a properly served food plate to the desired person. It can be even well served in a sophisticated manner by using online and available publishing tools

Minimum Requirements vs. Innovation in Online Open Access Publishing

Handwritten or typed (by typewriter) manuscript submission are bygone; now the editor is getting computer typed manuscripts which gives her/him much more flexibility to make the manuscript compatible to various open-access platforms. This can be more reader friendly in terms of reading, reviewing, summarizing, storing and distributing in various formats through numerous digital mediums.

Contemporary scholarly journal publication is expected to comply with many quality concerns e.g. International Standard Serial Number (ISSN) which is an 8-digit code used to identify newspapers, journals, magazines and periodicals of all kinds and on all media - print and electronic, indexing in good databases, having a high impact factor. In India, listing with University Grants Commission (UGC) Consortium for Academic Research and Ethics (CARE) and registration with Registrar of Newspapers for India (RNI) is compulsory for any periodical.

Apart from the above requirements, grammatically correct, plagiarism-free, peer-reviewed quality content which includes various parameters such as keeping standard and uniform writing style or format, proper updated citation, an interesting and thought-provoking discussion. To maintain the high standard of the journal without adequate resources is a big challenge.

In conclusion, at the moment, I cannot make big promises because of our limited resources but I wish and hope to achieve together with you, all the essential requirements for the National Journal of Professional Social Work in as innovative a way as possible. I humbly and whole hearty request all authors, editorial board members, our seniors, mentors, each member of the society and entire professional social work community to be a part of this endeavour.

REFERENCE

Gonder, J. (2018). Publishing individual articles vs. complete issues. Retrieved 6 December 2020, from https://help.escholarship.org/support/solutions/articles/9000149448-publishing-individual-articles-vs-complete-issues

What is an ISSN? | ISSN. (2020). Retrieved 7 December 2020, from https://www.issn.org/understanding-the-issn/what-is-an-issn/

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Social Work Practice: Emerging Trends and Challenges*

Rishi Ram Singh[1]

INTRODUCTION

I recall vividly the first time I visited the Central Institute of Psychiatry, Ranchi, formerly it was part of Bihar now it is the capital of the state of Jharkhand. The Department, therefore, has to play a lead role, like others, in the field of mental health and social work. Diversity of population of the new state provides a rich context which is indeed challenging. Science and tradition, therefore, have to meet and work together to achieve the goal of enhancing mental health. Field demonstration and social and institutional networking may facilitate new programmes, consolidate earlier ones, and also change policies and streamline programmes of mental health by securing citizen participation.

Mary Richmond in the 19th century began to pay attention to the social aspects of medicine, law, psychology and education to relieve social suffering and enhance social functioning through individualisation which was later called social casework. Victims of social ills needed material relief and psychosocial intervention to adjust in the society and also make their contribution. Her two publications 'What is Social Casework? and 'Social Diagnosis' clearly show the various dimensions of social maladjustment and organised efforts to deal with them. Over the years, it was realised that people's (client's) participation and their families' social and collateral resources can be harnessed to make the adjustment and change smooth and effective. Subsequently, other books on social casework to provide individualised help were published. The emergence of social group work showed the group as a resource for effective socialization within groups and communities. Study of the power structure, dynamics of leadership and change expanded the horizons of social work encompassing social policy, law and social action. However, individualisation remained the 'core' of social work practice.

After the Earth Summit (1991), World Summit on Social Development (1995), Millennium Development Goals (2000) and Sustainable Social Development, the area of social work and human service professions, among others, has expanded. This implies that social work has to shift from clinical and institutional to the developmental approach regardless of specialization in order to achieve sustainable development Goals (N=17). Health for all should now include mental health for all and be addressed by all the specialities. Now professions face the challenge of taking services to the communities, discharge their social responsibilities, build and sustain bonds with people, especially marginalised groups by adopting Inter-disciplinary and differential approaches to prove their relevance. Large scale migration during Corona Pandemic has shown the failure of socio-economic, state and professional support systems and has driven people to fate due to the wide gap between promise and performance. It is in this changing context that I propose to share my thoughts with you. Perception of the times of Mary Richmond has now changed beyond measure in terms of goals, approaches and new

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perspectives. Dimensions of methods of social work and their blending and usage in different situations thus demand plurality of methods.

While going through the Souvenir (2020) I came across messages of important personages. An article 'Time to Introspect in Psychiatric Social Work Education' by I. A. Shariff and N. Janardan (pp.20-32) highlights psycho-social service, research in psycho-social intervention, collaboration and cooperation with schools of social work, study, diagnosis and treatment, history of medical and psychiatric social work at TISS and process of evaluation of cognition and emotion for action. I would, however, like to add such aspects also as social, economic and ecological which is quite clear during the times of Corona. In my assessment, the contribution of medical and life sciences is about one fifth or so in this case. But that of social, psychological, economic, policy and ecology is much more. Service delivery through trial and error or measures based on law and innovations are being applied in tandem. Under the revised course content of the article, there is a reference to group work in psychiatric social work, community work, and family studies. These have been recognized in the course content. Unit 5 however mentions about social casework. I would like to draw attention to the prefix ‘social’ before work, particularly which should be seriously examined as a concept distinct from its general meaning. The authors however have stated: “casework is a general social work and as such it has nothing to do with any area of psychiatric social work”. If it is so, will ‘social’ be dropped to reconceptualise “psychiatric work”? I believe that the social history of social work and its evolution in several inter-dependent branches and fields cannot be ignored. It will be a travesty of history. In my view, therefore “psycho" or "social" includes the person (persons), relationships, society, beliefs, culture, entity (unit), group, family, neighbourhood, community and environment. Also, there are different kinds of care: terminal and community care, halfway or daycare, aftercare and occupational placement in society as also charity and organ donation. There is even a reputed journal: Culture, Medicine and Psychiatry. This shows that any discipline which claims itself as a profession, has to serve society and deleting 'social' will be a threat to its existence. It may even be contested through public interest litigation by professionals or social activists. This article refers even to the UGC’s Second Review Committee Report on Social Work Education, 1980. Contradictions abound in this article. This Association, therefore, needs to clarify its position for all concerned. In fact, all professional work (even laboratory work) is individualized before it reaches the stage of trial, validation and application. This is the core of social work. During Corona pandemic, the interested professionals, lay, donors, scouts and guides, NSS, institutes of mental health and medical sciences, multiple administrative departments, support groups i.e. Self-Help Groups, Mahila Mandals/Panchayats etc. are being roped in to contain the infection. The WHO has defined health broadly in terms of physical, mental and social (even spiritual) well-being. It would therefore be better to trace the evolution of psychiatric social work retrospectively through the background papers of the last 50 years from the pages of the Souvenirs. The Corona pandemic has only broadened the field of social work practice.

FIELD, FIELD PRACTICE AND FIELDWORK

Field practice encompasses both the traditional and new areas as indicated in the Introduction. The reason why I wish to make the distinction between the three terms is important because, from a ‘social’ point of view, they are understood differently. The field is an imagined or proven area of practice chosen by a profession to apply its theory into practice and develop and refine its approach to achieve a desirable outcome. Fieldwork however is

interpreted by the institutions of social work education according to their convenience rather than professional rigour. It may range from visits, observation to action, participatory action with specific outcome and review thereof. Day and full-day residential camps, participation in the annual or fortnightly programmes of the NGO's, State/Central Governments and civil society or corporate groups are part of this engagement.

Field practice seeks to validate theory in action and participatory research. It is practice-led to enhance professionalization and integration. It may cover social activism, and even symbolic participation in social movements to achieve goals as defined by the profession. It has been said that definition of social work should be revised every ten years because societal changes are ongoing which make new demands, give rise to sub-fields or disciplines, new perspectives, and approaches to the participation of citizens. In the history of social work, one can see the emergence of charity, its organization, relief work by friendly visitors and caseworkers, group and community workers, settlement movements, neighbourhood houses, welfare policies, laws, and programmes. With the demise of welfare states, the focus has changed now towards citizens, groups, families and society as main actors.

Social work practice implies living social work to serve society rather than to live off society. The dimensions of the field practice are geographical, psychosocial, individual, familial, communal (in the technical sense), economic, and ecological etc. It is to envision, an area for planned immersion, emergence, re-vision, innovation and action. In order to strengthen the learning process, the institutions of social work may experiment with Practice sabbaticals either alone by faculty, student-faculty or faculty-NGO-students. Several perspectives may be adopted through the process of reflection. i.e. human rights, social justice, developmental, curative, preventive, rehabilitative, eclectic, solution-finding, and ecological. In The Times of India (February 26, 2020) there is a report on a proposed partnership between India and the USA on mental health where social work can play an effective role to enable and empower people by adopting an interprofessional and interdisciplinary approach.

The global upheaval caused by the Corona Pandemic cannot be dealt with by any field of specialization in social work. The WHO has sounded an alarm about its further spread. States are re-clamping partial or full lockdowns. If social work does not join to make a difference, people will anyway find ways to survive. It is estimated that 80% mentally ill do not seek treatment. Why? The question leads to why social work, and for that matter, any allied profession exists then? This is indeed a challenge for social work. Will social casework through the process of individualization remain unconcerned? Has this pandemic only a psychiatric dimension? Do clinical Psychology and Counselling have no role? In my view, any seeking, receiving or providing of service through personal attention i.e. individualization, is a rudimentary form of social casework to help people to help them themselves.

LATEST PUBLICATIONS ON SOCIAL WORK PRACTICE

Four books have been published during 2019-20 which are relevant in the discussion on social work practice. Fifty educators have shared their experiences. Ratna Verma in Manan (2019) has recounted her experience of working in different organisations or situations, including Child Guidance Clinics, and Resident Welfare Association. Her contribution in such fields as counselling, single motherhood, rehabilitation, suicide prevention, family court, domestic violence, consultant to Jawahar Lal Nehru University to run a diploma course on

counselling, consultancy to State Welfare Advisory Board, National and State Commissions for Women, etc. Other contributors have shared their experiences from diverse fields which are still relevant. Field practice in Social Work in Verma's work includes spirituality also.

Roshni Nair, et al has emphasized social development, human rights, universalized and contextualized social work practice. Vishnu Mohan Das, et, al have highlighted rights-based, evidence-based practice, and network analysis. But it is more oriented to instruction than practice.

Murli Desai et al (2020) have followed the life journey approach. Sixteen social work educators have recounted their engagement in social work practice. Their journey covers childhood, professional education, practice, research, pre and post-retirement engagements and so on. These include diverse areas as establishing schools in slums, concurrent fieldwork as block fieldwork, psychological development centre, HIV-AIDS, T.B, camps for Juvenile delinquents, and mentally ill, schools for children in the orthopaedic ward, field action projects, leprosy eradication work, sponsorship, child labour, slums, transgender work, Narmada Bachao Andolan, youth movement, migrants, adoption and foster care, peace work, dowery related violence, Anganwadis, relief camps, family social work, disaster management, rape survivors and so on. An innovative form of social work practice is more evident in this book and Manan than the other two. It will be interesting to examine how social, mental (psychiatric), economic and ecological aspects are interlinked and inclusive, rather than isolated. Social casework, therefore, has much to do rather than 'nothing' in psychiatric social work practice. Both institutional, and non-institutional domains are inter-disciplinary. But there is more emphasis on procedure and instruction in the two publications than on practice which is striking in the work of Ratna Verma and Murli Desai.

In the context of corona pandemic, isolation, quarantine, shelters, the addition of wards, community tracing, blood and plasma donation, use of masks, physical distancing, closures and unblocking, sanitization, suicide, evasions, migration, joblessness, depression, etc. show the need for social intervention and the limitations of epidemiology, serology, medicine and psychiatry. The importance and use of social work need to be re-examined for containment along with co-morbidities and variance in data etc. during corona emergency. New addictions like narcissism, WhatsApp, selfies, Facebook, and porn etc. are as much social as pathological.

SOCIAL WORK PRACTICE AND SOCIAL DEVELOPMENT GOALS

Social change is ubiquitous and gives rise to new needs. This is why occupations develop into professions which are born, grow, differentiate and decline. Therefore they have to prove their relevance. Inequities also persist and call for global, state and citizen's action. Inequalities take different forms. For example, economic becomes social, infotech-digital and developmental. The Sustainable Development Goals adopted by the United Nations provide a framework to build an equitable global society. Professions must contribute through their knowledge and experience to achieve these goals for building an equal, just, and secure world for people, planet and posterity. These are to be achieved through global partnership. In the context of social work and mental health, poverty, hunger, inequality, disease, inequity, water security and climate change may be treated as stressors to be dealt with through local and global action. First eight goals can be grouped as human rights and the rest as ecological or environmental rights. These encompass all the disciplines and professions and their special

fields. As far as social sciences are concerned, all these stressors are fields of intervention along with the concerned state departments, NGO's, corporates, and citizen groups. A new and holistic approach is called for because no entity can achieve them alone. The time frame for the achievement of these goals is fifteen years. The NITI Ayog has published at least two Status Reports covering the different sectors. There is therefore a need to establish liaison with them. Each human service profession should also bring out their own status reports along with their engagements and outcome. It may be noted that we have entered the phase of de-globalization the impact of which needs to be assessed in order to reorient their action by the concerned professions.

CONCLUDING REMARKS

As far as social work is concerned, these goals provide a blueprint for innovative practice by imagining, exploring, and conceptualizing new fields for action, Inter-professional practice will benefit all. Practice retreats or sabbaticals may be used for inter-professional updates. Social work practice thus is not a subject to write only books or pass an examination; it is a change in feeling, thinking and behaviour, it is a living experience and a merger of the head, heart and action; and development of an integrated self to serve society. It is a change in lifestyle to change those of others by removing blockages for effective social functioning, social enrichment and social empowerment is a change in perspective which spurs creativity and innovation through citizen participation. During the International Year of Family (1994) celebration, the UN brought out nineteen papers which open up new dimensions for practice. So is the case with other Celebrations organised by the UN on different themes. They may be used as guidelines for practice as also other reports of the United Nations along with Country reports. They will help to carve out new areas for professional intervention.

Corona has defied all specialisms. Therefore "casework has nothing to do" is an absolutist view. Can it not do even referral to mental health institutions or psychiatric social work departments? Human service professions address human needs and distress and ameliorate them to enhance social development and bring about a desirable change in the human condition. Professional practice, social work included, is determined by needs. Therefore it should shift where the need is most. Inter-professional, collaboration can strengthen social resources for a larger benefit. Corona is the latest example. During floods, famines or droughts, cyclones and earthquakes, evacuation and resettlements leading to rehabilitation, normalcy, peace and security all the professions join handset different stages. A reductionist view has been rejected a long time ago. Changing needs, the intensity of distress, concentration of services, level of infrastructure, degree of people's participation, availability of social and economic resources, blending of people's perception with those of professions demand differential practice and even if a uniform policy programme and law: exist for the urban, rural, hilly, tribal and coastal area, they call for differential and innovative approach. These factors impact social work practice to which is ever-changing according to the context, gravity of the situation and emerging challenges and opportunities. Seizure of opportunities will strengthen people and professions. Change in perspective guides practice. Therefore making a list of practice areas is futile. Needs determine the form, breadth, depth, and dynamics of practice by focussing on people fist and professions latter. Engagement with social, political, Judicial, and administrative entities at all levels is part of the practice.

REFERENCES

1. Department of Psychiatric Social Work and Indian Society for Professional Social Work. (2020). Souvenir: XXXVIII Annual National Conference (PP.20,22,24,25)
2. Murli Desai et al. (2020). Social Work Education in India: Journeys in Social Work Education in India: Emerging Reflections. New Delhi: Rawat.
3. Ratna Verma (ed). (2019). Manan: Reflections on Social Work Education and Practice. Pune: BookGanga.com.
4. Roshni Nair et al. (2020). Field Instruction in Social Work Education. London/New York: Taylor and Francis Group.
5. Vishnu Mohan Das: et al (2020). Field Work in Social Work Training: New York: Routledge Taylor and Francis Group.

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Predictors of Hopelessness among Youth Living in Slums of Bengaluru City

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ABSTRACT

Background: Hopelessness is more than just a feeling. It is a mental state in which one finds life empty and the future to be meaningless. It can derail one's life altogether. Youth, including those living in slums, have the potential to rise and win over their challenges. However, the feeling of hopelessness can be a significant barrier to break. **Objectives:** To determine whether there are any differences between demographic and socio-economic variables (independent variable) on more than one continuous dependent variable: resilience and hopelessness score (one-way MANOVA) and to identify the significant predictors of hopelessness among youth living in two slums in Bengaluru city. **Methodology:** A total of 285 youth living in two slums in Bengaluru city were chosen using simple random sampling. The Beck Hopelessness Scale was used to measure hopelessness among the respondents. Step-wise multiple regression analysis was used to identify the significant predictors of hopelessness among the respondents. Moreover, the unstandardised and standardised regression path analysis was done. **Results:** The results indicate that lack of education is the biggest significant predictor of hopelessness among the youth living in slums, having about 32 per cent influence (cause) on feelings of hopelessness. **Conclusion:** The lack of education seems to be a major reason for hopelessness among youth living in slums in the present study.

Keywords: Youth, hopelessness, mental health, slums

INTRODUCTION

Background of the study: In recent decades, there has been a significant amount of debate about the age group which can be considered as youth. The United Nations (2019) considers those who are between the ages of 15-24 years to be youth and has estimated that the youth constitute 16 per cent of the global population which is a significant number of people. Youth in India constitute 34.8 per cent of the total population (Ministry of Statistics and Programme Implementation-GOI, 2017). Although there is not an accurate estimate of the number of youth living in slums, it is undoubtedly a significant number since India is not a developed nation as of today. Hopelessness, which is a loss of faith in one's life and one's future, has also been found to be a core feature of depression (Beck et al., 1974). One may ask as to why it is so important to measure hopelessness and detail the factors that cause it. It's because hopelessness has been identified as a risk factor for suicide attempts among youth (Mustanski and Liu, 2013). In India, suicide among youth is a major area of concern. In fact, according to the World Health Organization (2019), youth in India are the most vulnerable group as far as suicide is concerned. In this scenario, it is important to discover the factors that determine hopelessness among youth, especially those living in slums who are often kept at the margins of society.

Review of literature: To gain a deeper understanding of the problem at hand and to get acquainted with the existing knowledge on this subject, the researchers examined existing studies on this matter. Pharris et al (1997) found that for girls, being able to enjoy school, attention and care from members of the family, and other factors helped reduce hopelessness.

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Although there were no protective factors against hopelessness that were discovered for boys in their study, enjoyment of school and strong academic performance, among other factors were found to help protect the boys from suicide. Joiner (2001) in his study pointed out that negative attributional style was a risk factor for hopelessness among youth. Gibb et al (2001) in their study reported that emotional maltreatment during childhood was related to hopelessness among youth. Boland et al (2005) identified three important disruptive factors that predicted hopelessness among youth. They were- change in mother figure, exposure to violence, and stress. Taliferro et al. (2009) reported that youth who engaged in some physical activity every week were less likely to feel hopeless. Stoddard at al. (2011) in their study discovered that youth who had established a strong connection with their mother at an early age were less likely to feel hopeless. Stewart et al. (2011) discovered that there was a perfect link between feeling hopeless and drinking among youth in their study. Based on an examination of existing literature related to this particular topic, a research gap has been identified. It can be stated that there is a dearth of studies on hopelessness among slum youth, especially in developing nations such as India where the proportion of youth population is at its all-time high. Moreover, there is a need to identify the predictors of hopelessness among such youth who have significantly different living conditions compared to youth in general. To fill this research gap, the present study was undertaken.

Objectives:

(i) To study the resilience, hopelessness and its correlates with demographic and socio-economic characteristics of the youth living in slums in Bengaluru city
(ii) To determine whether there are any differences between demographic and socio-economic variables on resilience and hopelessness score
(iii) To identify the significant predictors of hopelessness among the youths and to portray the findings diagrammatically through a path diagram.

Hypothesis: There will be no statistically significant relationship between the background characteristics and hopelessness score of the youths.

METHODS AND MATERIALS

Research Design: A descriptive research design was adopted to describe the significant predictors of hopelessness. The present research is also cross-sectional in nature since data were collected at only one point in time to assess the socio-demographic characteristics and the study dimensions. It is proposed that when resilience is treated as a dependent variable, the background characteristics of the respondents will be treated as independent variables. On the other hand, when hopelessness score is treated as a dependent variable, background characteristics and resilience score of the sample respondents will be treated as independent variables.

Inclusion and exclusion criteria: The city of Bengaluru was selected for the research as the researchers are familiar with the city. Youth aged 15-29 years living in two selected slums have been included in the study. The study was restricted to two slums due to the constraints of time and money.

Sampling: The researchers purposefully selected Bengaluru City as one of the researchers was well acquainted with the city. Bengaluru city has a total of 198 wards. Using the lottery method, the researchers selected ward number 42 which has four slums - Sanjaygandhi Nagar, Kaveri Nagar, Nilagiri Thoppu and Coolie Nagar. Once again using the lottery method, the researchers selected Snajaygandhi Nagar and Nilagiri Thoppu for the present study. Through a benchmark survey, it was found that there were 498 youth aged 15-29 years (Government of India., 2014) in these two areas. Hence, these 498 youth constitute the

universe of the present study and the 285 youth who were then selected using tippet number table from the 498 youth, constitute the sample in the present study.

Ethical considerations: The respondents were informed about the purpose of the study and oral consent was obtained from them before collecting the data. Hence, all the respondents in the present study willingly participated in the present study.

Methods of data collection: The data were collected through face to face interview with the respondents. An average of five respondents was interviewed per day during the period of March-May, 2017. The average time spent on each respondent was approximately an hour.

Tools: To collect data related to the socio-economic and demographic background of the respondents, a self-prepared interview schedule was used. To assess the feelings of hopelessness among the respondents, the hopelessness scale developed by Beck et al. (1974) was employed. It has three sub-components and a total of 20 items. Item number 1, 5, 6, 10, 13, 15, and 19 cover the first factor - 'feelings about the future'. Item number 2,3,9,11,12,16,17 and 20 cover the second factor - 'loss of motivation' and item number 4,7,8,14, and 18 cover the third factor - 'future expectation ' The score ranges from 0 to 20. A higher score is indicative of high hopelessness. The reliability of the scale was found to be 0.605. To measure resilience among the respondents, the 25 items *Connor-Davidson Resilience Scale (2003)* was employed. It has a total of four factors – hardiness, optimism, resourcefulness, and purposefulness. The total score ranges from 0-100. A higher score means higher resilience. The reliability value of the scale was found to be 0.917.

Statistical analysis: The collected data was analysed using SPSS-AMOS- 24 (IBM Corp, 2017). Histogram and p-p plots were used to check the linearity and normality of residuals. The distribution of the residuals was found to be normal. This can be observed in diagram 1 (histogram), diagram 2 (p-p plots), and diagram 3 (scatter plots).

Diagram 1: Histogram of regression standardised residual

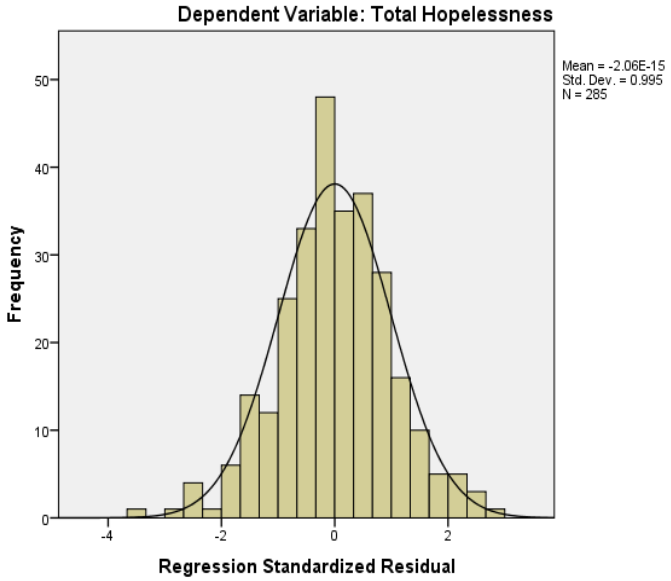
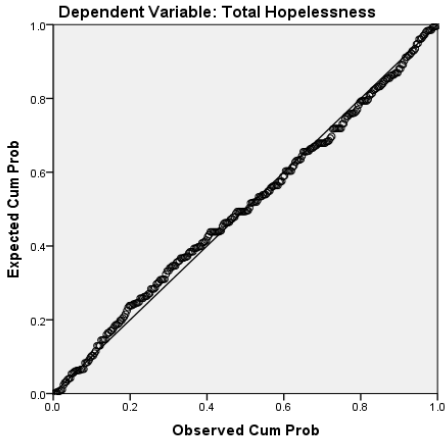
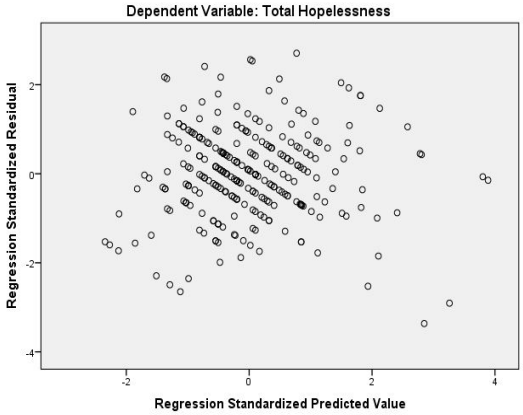


Diagram 2: Normal P-P plot of regression standardised residual



From diagram 2 it can be said that the data points are all almost close to the ideal line (Field, 2016).

Diagram 3: Scatter plots of regression standardised residual



From diagram 3, it can be inferred that in general, there is a low negative correlation between the regression residuals.

RESULTS AND DISCUSSION

Background characteristics of the sample respondents: With regard to the background characteristics of the respondents, it can be stated that those who were in the age group of 15-19 years constitute the single largest majority of the total respondents. The average age of the respondent was 20.7 years. Majority of the respondents were found to be male, unmarried, followers of Hinduism and belonging to scheduled caste. With regard to the nature of the family, it was discovered that majority of the respondents lived in medium-sized and nuclear families. Majority of the respondents had studied up to high school/higher secondary school, having completed an average of 9.41 years of education. It was also found that majority of the respondents were unemployed/not working as a result of which the majority also did not have an income of their own. Most of the respondents' families had a monthly family income of Rs. 10,001-20,000 and monthly expenditure of Rs. 10,000 or less. The mean income of the respondents' families was found to be Rs. 18,926.84. A little more than half of the respondents lived in tiled houses with two rooms as well as inbuilt toilets and water supply. Majority of the respondents had access to mass media such as television and newspaper. Due to the proliferation of technology, almost all of the families had a minimum of one mobile

phone at home. All of the respondents had an electricity supply at home. Majority of the respondents lived in houses that were owned by them or their parents. Finally, the majority of respondents do not consume alcohol.

Level of Resilience and Hopelessness: The respondents have been classified into low and high categories based on the mean score of the subject dimensions. The mean score of resilience was 61.96 with a score range of 36-90, and that of hopelessness was 11.81, with a score range of 11-20. It was also found that majority of the respondents scored 'low' on resilience (56.1%) and 'high' on hopelessness (56.8%), scales.

One-way Multivariate Analysis of Variance (MANOVA): One-way Multivariate Analysis of Variance (One way MANOVA) is a statistical tool used to determine whether there are any statistically significant differences between the independent variable (category variable) on more than one continuous dependent variable. In the present section, age group, sex, marital status, religion, social standing, education, drop out status, occupation, family income, size and type of family, and ownership and type of houses of the respondents (youth living in slums) were used as *independent variables* while resilience and hopelessness scores were used as the *dependent variables*. The result shows that there are statistically significant differences in resilience and hopelessness among youth living in slums based on their age group ($F(4,256)= 13.173$, $p<0.001$; Wilks' Λ =.836, partial η^2 = 0. 086); Gender ($F(2, 282)= 8.214$, $p<0.001$; Hotelling's Trace =.058, partial η^2 = 0. .055); Marital Status ($F(4,562)=22.368$, $p<0.001$; Wilks' Λ =.836, partial η^2 = 0.137); Religion ($F(4,562)= 11.786$,$p<0.001$; Wilks' Λ =.851, partial η^2 = 0.077); Education ($F(8, 558)= 20.047$,$p<0.001$; Wilk's Λ=0.603, partial η^2 =0.05); Drop out status ($F(2, 282)= 23.526$,$p<0.001$;Hotelling's Trace=0.167, partial η^2 = 0.143; Occupation ($F(3,273)= 5.140$,$p<0.001$; Wilks' Λ =.898, partial η^2 = 0. 052); Family Income ($F(4, 562)= 18.682$,$p<0.001$; Wilks' Λ =0.779, partial η^2 = 0.117); Size of family ($F(4, 562)= 13.454$,$p<0.001$; Wilk's Λ=0.833, partial η^2 =0.087); Type of family ($F(2,282)= 7.838$,$p<0.001$; Wilk's Λ=0.833, partial η^2 =0.053), and Ownership of house ($F(2, 282)= 3.474^b$,$p<0.01$; Wilk's Λ=0.952, partial η^2 =.024). Whereas there was no statistically significant difference in Social standing ($F (6, 560) = .759$, $p>0.05$; Wilk's Λ=0. .984, partial η^2 =0.008), and Type of House ($F (2, 282) =1.274$, $p> 0.05$; Hotelling's Trace =0. 009, partial η^2 =0.009).

Correlation between the background characteristics and hopelessness score

From the results displayed in table 1, it can be inferred that there is a positive correlation at a very high level ($p<0.001$) between hopelessness score of the respondents and their age and age at marriage and a positive correlation between hopelessness score of the respondents and years of drinking at a moderately high level ($p<0.1$). Meaning- as the age, age at marriage, and years of drinking increases so do the respondents' hopelessness score. On the other hand, a negative correlation was discovered between the hopelessness score of the respondents and their education, monthly family income and monthly family expenditure at a very high level ($p<0.001$) and between their hopelessness score and number of family members at a high level ($p<0.01$) has been also been observed. Meaning, as the number of years of education, amount of monthly family income, expenditure, and family size increases, the hopelessness score of the respondents' decreases.

Table -1: Zero-order correlation between the hopelessness score and the background characteristics of the youth living in Slums

Variables	AGE	BO	AAM	REDU	RMI	MFI	MFE	NFM	YDK	HOP
AGE	1									
BO	0.063	1								
AAM	***.642	0.102	1							
REDU	**-.186	*-.138	***-.287	1						
RMI	***.513	-0.001	0.116	***-.200	1					
MFI	*-.131	**.156	***-.314	-0.048	***.227	1				
MFE	*-.131	**.164	***-.299	-0.05	**.169	***.932	1			
NFM	***-.312	*.133	***-.336	-0.048	*-.134	***.552	***.588	1		
YDK	***.366	-0.024	***.160	***-.229	***.391	0.005	0.015	-0.086	1	
HOP	***.322	0.111	***.409	***-.567	0.105	***-.248	***-.226	**-.201	**.163	1

Note: BO-birth order, AAM-age at marriage, REDU- respondent's education, RMI-respondent's monthly income, MFI-monthly family income, MFE-monthly family expenditure, NFM-number of family members, YDK-years of drinking, HOP-Hopelessness score

Regression Analysis – Predicting hopelessness

Table 2- displaying the results of the stepwise multiple regression analysis

Model	Predictors	R	R^2 x 100	ΔR^2 x 100	b	SE b	β	t	p
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
		Dependent Variable : Hopelessness							
1	(Constant)				17.884	0.547		32.683	.000
	R.Education	.567	32.2%	32.2%	-0.645	0.056	-0.567	-11.589	.000
2	(Constant)				23.733	0.890		26.666	.000
	R.Education	.667	44.5%		-0.614	0.051	-0.540	-12.145	.000
	Resilience			12.3%	-0.099	0.013	-0.352	-7.915	.000
3	(Constant)				22.120	1.071		20.646	.000
	R.Education	.677	45.9%		-0.575	0.052	-0.506	-11.025	.000
	Resilience				-0.083	0.014	-0.296	-6.057	.000
	Age at marriage			1.3%	0.047	0.018	0.134	2.644	.009

A stepwise multiple regression analysis was carried out to find out the significant predictors of hopelessness among the respondents. The results are displayed in table 2

The model number can be seen in **column 1**. The predictor variables, i.e., constant (hopelessness), education, monthly family income, and age can be observed in **column 2.** R, which represents the correlation between the predicted and observed values can be seen in **column 3**. R square, a measure that indicates the closeness of the data with the regression line is seen in **column 4.** The improvement in the R square when is next predictor is included is called R square change. This can be observed in **column 5.** The relative importance of the independent variable is represented by the unstandardized beta (b) weight. This can be seen in **column 6**. **Column 7** shows the standard error of B**.** A more refined picture of the importance of the predictors is observed through the standardised beta (β) weight in **column 8**

Finally, the Critical Ratio also known as t value can be observed in **column 9.Column 10** shows the p-value.

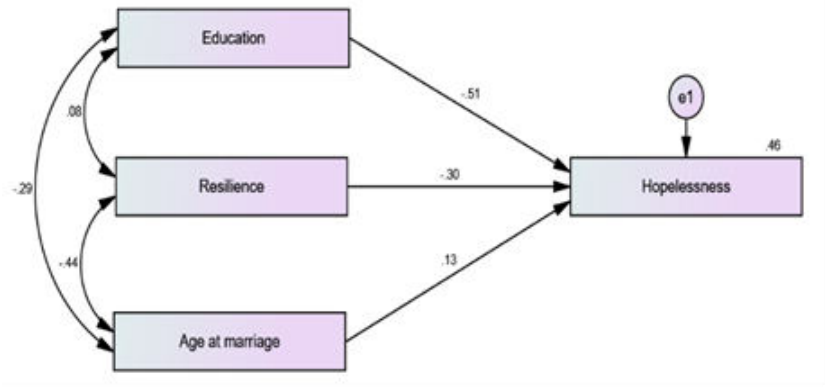
The results in table 2 indicate that the education of the respondents has 32.2 per cent influence on the hopelessness score of the respondents (see column 5). The resilience of the respondents has 12.3 per cent influence and the age at marriage has 1.3 per cent influence on hopelessness experienced by the respondents. Hence, on the whole, the three significant predictors, i.e., education, family income, and age, together have a total of 45.9 per cent influence on the hopelessness of the respondents, with education being the single largest significant predictor of the same (see column 4).

From the unstandardized beta (b) weight (see column 6) it can be inferred that when the education of the respondent goes up by one year, the hopelessness score reduces by 0.575 units. Similarly, when the resilience score of the respondents increases by one unit, the hopelessness score of the respondent decreases by 0.083 units. Finally, when the respondents' age at marriage increases by one year, the hopelessness score decreases by 0.047 units.

Regression path analysis using structural equation modelling

"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).

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



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

Table - 3: Regression Path Analysis on Hopelessness score among Slum Youth

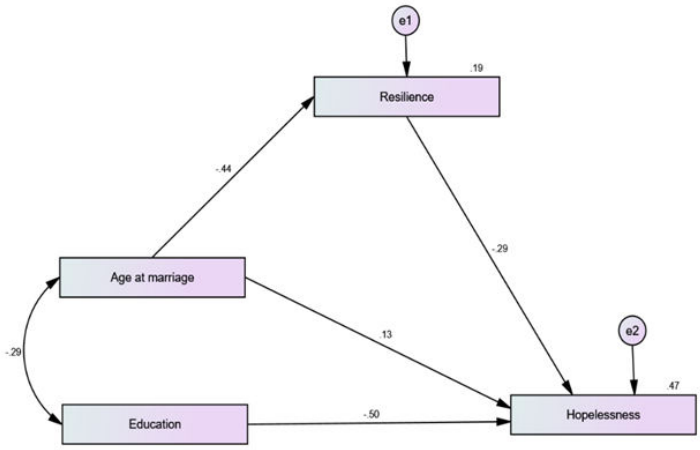
S. N	Variables						
	b weights			Estimates	S.E. b	C.R / t.	p
	(1)			(2)	(3)	(4)	(5)
1	Hopeless	<---	Edu	-.575	0.052	-11.084	.000
	Hopeless	<---	Agema	.047	0.018	2.658	.008
	Hopeless	<---	Res	-.083	0.014	-6.089	.000
2	**Co-variances**						
	Agema	<--->	Res	-46.245	6.856	-6.745	.000
	Edu	<--->	Res	2.509	1.950	1.287	.198
	Edu	<--->	Agema	-7.523	1.618	-4.649	.000
3	**Variances**						
	Edu			8.109	0.681	11.916	.000
	Agema			84.733	7.111	11.916	.000
	Res			132.328	11.105	11.916	.000
	e1			5.671	0.476	11.916	.000
4	**βWeights**				(Coefficient)		
	Hopeless	<---	Edu	-.506	When Education goes up by 1 standard deviation, hopelessness goes down by .506 standard deviations		
	Hopeless	<---	Agema	.134	When age at marriage goes up by 1 standard deviation, hopelessness goes up by 0.134standard deviations		
	Hopeless	<---	Res	-.296	When resilience goes up by 1 standard deviation, hopelessness score goes down by .296 standard deviations		
5	**Correlations**						
	Agema	<--->	Res	-.437	Correlation between age at marriage & resilience -0 .437		
	Edu	<--->	Res	.077	Correlation between education & resilience is 0.077		
	Edu	<--->	Agema	-.287	Correlation between education & age at marriage is -0.287		
6	**Squared Multiple Correlation Estimate**				**Error Variance**		
	R^2		Hopeless	0.459 or 46%	The error variance of hopelessness score is 54%		

Path Diagrams 1 and 2 are diagrammatic representations of the results of the unstandardised and standardised regression path analysis. Here, hopelessness was considered as the dependent variable while education, resilience, and age at marriage were considered to be the independent variables. However, the results also indicated that the model was not a perfect fit. This motivated the researchers to consider the possibility that the nature of the relationship between the dependent and independent variables could be something other than what was assumed. In panel 2 of table 3 and path diagram 1, information related to the *co-variances* between the independent variables can be observed. As far as the *standardised beta coefficients (*β) are concerned, the results in panel 9 of table 2 indicate them. Details about the *correlations* between the pairs of variables can be observed in panel 5 of table 2 and also in path diagram 2. From the said table, it can be stated that the three significant predictors- education, resilience, and age at marriage together account for about 46 per cent of the hopelessness score of the respondents in the present study. Hence, the cause of the remaining 54 per cent of the variance is unknown.

Model Fit Summary

Based on the conceptual model and the following structural model were developed with the sample data. The resulting structural model is presented in Path Diagram 3

Path Diagram- 3 - Graphic output for Modified Standardised Estimates



Path diagrams 3 indicate the revised /modified standardised graphic output. In this model both resilience and hopelessness, scores act as dependent variables. When resilience is treated as the dependent variable, age at marriage is treated as an independent variable. On the other hand, when hopelessness is treated as the dependent variable, age at marriage, education and resilience are treated as independent variables. $\chi^2 = 0.911$, df = 1, p = 0.340, RMSEA: it is equal to 0.000 (< 0.05 is acceptable), GFI: 0.998 (> 0.95 is acceptable) and it is concluded that the present model is supported by the sample data (Bian, 2011).

Limitations: The researchers have assumed that all slums have similar characteristics. This may be true for most slums in India. However, it may not be true in the case of all slums all over the world. The present study included two slums and only a decent sample size due to the constraints of time. Moreover, only those youth who were aged 15-29 were included in the study.

CONCLUSION

Form the results, it can be inferred that the single largest majority of the total respondents were in the age group of 15-19 years and had studied up to 9th standard, on average. The majorities, hailed from medium-sized nuclear families, were unemployed and did not have an income of their own. With regard to the level of resilience and hopelessness of the respondents, it was found that the majority of the total respondents had a low level of resilience and a high level of hopelessness. The results of the multivariate analysis of variance show that age, sex, marital status, religion, education, occupation, size of the family, type of family and ownership of home determine the hopelessness and resilience of the respondents at a statistically significant level. The correlation analysis revealed that there was a positive correlation at a very high level between hopelessness score of the respondents and their age and age at marriage and a positive correlation between hopelessness score of the respondents and years of drinking at a moderately high level. A negative correlation was discovered between the hopelessness score of the respondents and their education, monthly family income and monthly family expenditure at a very high level and between their hopelessness score and number of family members at a high level. Based on the results of the multiple regression analysis as well as its diagrammatic representation through the path analysis, it is apparent that education plays a very important role in the mental health (including resilience) of youth living in the slums, in the present study. A troubling finding is a fact the researchers observed a significant number of the respondents dropping out of school. By dropping out of school and thereby discontinuing their education, the respondents put themselves at the risk of harbouring feelings of hopelessness. Another aspect observed by the researchers during data collection was the prevalence of consumption of alcohol by youth

in the slums and the tolerant attitude towards drinking in general. It was also observed that this maladaptive behaviour of drinking at a young age encourages the youth to skip or drop out of school. Eventually, instead of being educated, a significant majority of the respondents were found to seek employment in low paying jobs with little or no opportunities for career growth or financial progress. Hence, it is suggested that there could be awareness programmes conducted in slums with similar characteristics with regard to the importance of education to ensure that at least the next generation of youth in slums are not victims of the lack of education but rather the beneficiaries of education.

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Declaration of Interest: None.

Ethical Clearance: taken by the doctoral research committee.

REFERENCES

Beck, A. T., Weissman, A., Lester, D., & Trexler, L. (1974). The measurement of pessimism: the hopelessness scale. *Journal of consulting and clinical psychology*, *42*(6), 861.

Bian, H. (2011). Structural Equation Modeling with AMOS II. Retrieved from http://core.ecu.edu/ofe/statistics research/SEM%20with%20AMOS%20II.pdf

Bolland, J. M., Lian, B. E., &Formichella, C. M. (2005). The origins of hopelessness among inner-city African-American adolescents. *American Journal of Community Psychology*, *36*(3-4), 293.

Crossman, A. (2017). Understanding Path Analysis: A Brief Introduction. In https:// www. thoughtco.com/path-analysis-3026444

Gibb, B. E., Alloy, L. B., Abramson, L. Y., Rose, D. T., Whitehouse, W. G., & Hogan, M. E. (2001). Childhood maltreatment and college students' current suicidal ideation: A test of the hopelessness theory. *Suicide and Life-Threatening Behaviour*, *31*(4), 405-415.

Government of India. (2014). *National Youth Policy-2014*. New Delhi: Ministry of Youth Affairs & Sports

IBM Corp (2017). *IBM, SPSS Statistics for Windows, Version 24.0.* Armonk, NY: IBM Corp.

Joiner Jr, T. E. (2001). Negative attributional style, hopelessness depression and endogenous depression. *Behaviour Research and Therapy*, *39*(2), 139-149.

Ministry of Statistics and Programme Implementation (2017). *Youth in India*. Social Statistics Division. New Delhi, New Delhi.

Mustanski, B. & Liu, R. T. (2013). A longitudinal study of predictors of suicide attempts among lesbian, gay, bisexual, and transgender youth. *Archives of sexual behaviour*, *42*(3), 437-448.

Pharris, M. D., Resnick, M. D., & Blum, R. W. (1997). Protecting against hopelessness and suicidality in insexually abused American Indian adolescents. *Journal of Adolescent Health*, *21*(6), 400-406.

Stewart, S. H., Sherry, S. B., Comeau, M. N., Mushquash, C. J., Collins, P. & Van Wilgenburg, H. (2011). Hopelessness and excessive drinking among Aboriginal adolescents: The mediating roles of depressive symptoms and drinking to cope. *Depression research and treatment*, 2011. doi:10.1155/2011/970169

Stoddard, S. A., Henly, S. J., Sieving, R. E. & Bolland, J. (2011). Social connections, trajectories of hopelessness, and serious violence in impoverished urban youth. *Journal of youth and adolescence*, *40*(3), 278-295.

Taliaferro, L. A., Rienzo, B. A., Pigg, R. M., Miller, M. D., & Dodd, V. J. (2009). Associations between physical activity and reduced rates of hopelessness, depression, and suicidal behaviour among college students. *Journal of American College Health*, *57*(4), 427-436.

United Nations (2019). *World Youth Report: Youth and the 2030 Agenda for Sustainable Development*. United Nations. New York.

World Health Organization (2019). Suicide. Retrieved from http://www.searo.who.int/india/topics/suicide/en/

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Research Paper: ISPSW Best Paper Award for M.Phil/Ph.D Scholars of Social Work

Magico-religious Beliefs, Stigma and Help-seeking Behaviour among the Caregivers of Persons with Schizophrenia

Mrinal Basumatary[1], Arif Ali[2], Buli Nag Daimari [3]

ABSTRACT

Background: The cultural and traditional aspects of caregivers of people with mental illness have been seen widely, where the faith healers are the immediate source for treatment. Due to poor understanding of mental illness and stigma among caregivers, people often seek traditional help than modern medical treatment. **Aim**: To assess the Magico-religious beliefs, stigma and help seeking behaviour among the caregivers of persons with schizophrenia. **Methods and Materials:** Descriptive research design was used. Seventy caregivers of persons with schizophrenia attending the outpatient department of LGBRIMH, Tezpur, Assam were purposefully taken for the study. Socio-demographic datasheet, Family Interview Schedule (stigma section), Super Natural Attitude Questionnaire and General Help Seeking Questionnaire were administered. **Results:** Prevalence of the stigma was 100%. The majority (80%) of care giver's locality and community believe in *Jadu Tona*, 75.7% have performed *puja/ritual/jhad-phook*, 72.9% visited or consulted faith healer, 67.1% talk about or believe in *bhoot pret, Jadu Tona* (65.7%)*, Opari kasar* (64.3%), 68.6% believed that performing *puja/rituals/jhad-phook* can change patient's behaviour. Majority 57.6% care giver showed high help-seeking behaviour while 42.4% showed low help-seeking behaviour. Majority of the caregivers seek help from the parents (5.47±1.20). **Conclusion:** Supernatural beliefs and stigma found to be common among the caregivers of persons with schizophrenia. Caregivers have higher help-seeking behaviour from informal groups than formal groups.

Keywords: Magico-religious beliefs, stigma, help-seeking behaviour

INTRODUCTION

Schizophrenia is a major mental illness; it is devastating imposing significant costs on a person suffering from their family members and the society (Awad, 2008). The community beliefs and attitudes may influence many facets of mental health care. Mental illnesses in India are understood as being intricately related to spiritual and religious factors, and this belief often influences the patient's recognition of illness and their care-seeking behaviours. As a result, traditional magico-religious healers are an important source of health-care for a significant proportion of mentally ill patients in India (Chadda *et al.,* 2001). "Help-seeking behaviour within the community was influenced due to the factors such as beliefs about the causes of mental illness, the nature of service delivery, accessibility, cost and stigma" (Nsereko *et al*., 2011). "In India, with its cultural diversity and a mix of the rural and urban environment, the discriminating attitude towards mentally ill patients causes stigma to consult a psychiatric professional" (Srinivasan & Thara, 2000). The North-East region of India has been seen as rich ethnic diversity and well known for its cultural identity.

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The cultural and traditional aspects of caregivers of people with mental illness have been seen widely, where the faith healers are the immediate source for treatment. Due to poor understanding of mental illness and stigma among caregivers, people often seek traditional help than modern medical treatment hence, delaying the pathways to psychiatric care. Although various studies have been conducted in the other parts of India but there is a dearth of studies from the North-East region. Therefore, the present study is aimed to project how supernatural attitudes and beliefs, stigma and help-seeking behaviour of the caregiver have been influenced in the treatment of persons with schizophrenia.

To understand the broader area of the present study the researchers reviewed various existing studies. Kulhara, Avasthi and Sharma (2000) found that, "the majority of the patients had undergone magico-religious treatment (n = 23). Nearly 74% of the patients who had a delusional explanation in terms of paranormal phenomena had undergone magico-religious treatment". Natasha *et al.* (2012) in their study found that, "the community believed in sorcery and other magico-religious phenomena they also believed that only performance of prayers was sufficient to improve their mental status. About one-fourth admitted that during recent episodes either they or their caregivers performed magico-religious rituals". Ali and Jahan (2012) stated that, "There was a widespread belief in supernatural causation of mental illness in caregivers of persons with a mental disorder". Nidesh *et al.* (2016) in their study found that, "The belief and performing rituals can improve patient behaviour and local belief in supernatural influences". Nilamadhab Kar *et al.* (2008) hypothesize that, "A considerable proportion of patients and families found faith healing supportive, reassuring and more acceptable in the community".

Schnyder *et al.* (2018) found that, "participants' negative attitudes towards mental health help-seeking and their stigmatizing attitudes towards people with a mental illness were associated with less active help-seeking". Also, a significant association was seen with self-stigma while no association was found with perceived public stigma. Shibre *et al.* (2001) in the study found that, "75% of respondents perceived that they were stigmatized or had experienced some sort of stigma due to the presence of mental illness in the family". Koschorke *et al.* (2017) study indicated that, "High caregiver stigma by a significant minority of caregivers (21%) and 45% felt uncomfortable to disclose their family member's condition. Caregiver stigma was also independently associated with higher levels of positive symptoms of schizophrenia". Throughout the review of literature, it was evident that there is a lack of knowledge and understanding of beliefs, stigma and help-seeking behaviour among the caregivers of persons with mental illness in the context North-East.

Objectives

- To identify magico-religious beliefs among the caregivers of persons with schizophrenia,
- To study the stigma among the caregiver of the persons with schizophrenia,
- To describe the help seeking behaviour among the caregiver of persons with schizophrenia.

METHODS AND MATERIALS

The present study used a descriptive research design. The study was conducted at the outpatient department of LGB Regional Institute of Mental Health, Tezpur. The purposive sampling technique was used to take 70 samples of caregivers of a person with schizophrenia with their consent. Patients with the following inclusion criterion were

included: all who are above 18 years of age and educated up-to primary level and able to understand and comprehend having assisted living with patients from at least last 1 month. Caregivers with physical illness, which interferes with the assessment, psychiatric illness/intellectual disability (as per the informant's report) and those who score above the GHQ-12 cut off score were excluded. The following tools were used:

Socio-demographic Datasheet: It was prepared which includes age, sex, education, occupation, marital status, religion, caste, domicile, family income, duration of illness of the patient, etc.

Family Interview Schedule (stigma domain): It has been developed by Sartorius and Janca (1996), "Which consisted of 14 items rated on a four-point scale from 'not at all' rate 0, to 'a lot' rate 3, concerning stigma. A stigma sum score was computed by summarizing all positive responses (>0) for each of the 14 items to evaluate the distribution of stigma responses between groups".

Supernatural Attitude Questionnaire (SAQ): "It is a 28 items questionnaire focuses on the attitude and belief of the caregiver in various types of magico-religious and supernatural influences (4 items), the role of these factors causing mental illness or behavioural abnormalities in general (7 items), and their own patient (5 items) and help seeking behaviour based on such attitudes and beliefs (3 items). It explores the patient's attitude and belief towards these magico-religious and supernatural influences (7 items). It also explores the help seeking behaviour of patients based on these attitudes and beliefs (2 items)" (Kulhara *et al.,* 2000).

General Help Seeking Questionnaire: "It measures the future help seeking behavioural intentions. It measured through listing potential help sources and assisting participants to indicate how likely it is that they would seek help from that source for a specific problem on a 7-point scale which ranges from no intention to seek help to a very high likelihood of seeking help. Help-seeking intentions reported as three sub-scales: level of intention for seeking informal help; the level of intention for seeking formal help; the level of intention to seek help from no-one" (Rickwood *et al*. 2005).

The data was being used only for research purpose. Samples were selected voluntarily. Data was analysed with SPSS 25 for windows.

RESULTS

Socio-demographic Profile

The mean age of the caregivers was 41.5 ± 15.1 years and mean duration of the caregiving was about nearly 3 years (38.49 ± 81.95 months). The majority (74.3%) of caregivers were male. Majority of the caregiver were parents (38.6%) and completed primary schooling (44.3%), belonged to Hindu religion (74.3%), and general category (51.4%), Most of the caregivers were working as daily wage labourer (54.3%), belonged to rural area (82.95), and belonged to the upper-lower socio-economic background (52.9%).

Supernatural Attitude

Table 1 showed the majority (80%) of the caregivers' locality and community believed in *Jadu Tona* and such influences followed by 75.7% have performed *puja/ritual/jhad-phook*. The majority (72.9%) of the caregivers visited or consulted faith healers while 68.6% believed that performing *puja/rituals/jhad-phook* can change a patient's behaviour, while 68.6% of them visited faith healers with the patient's request. Majority i.e. 67.1% talked

about or believed in *bhootpret* and talked about it before falling ill. The majority (64.3%) of caregivers thought that mental illness can be caused due to the effect of dissatisfied or evil spirits. The majority (61.4%) of caregivers thought that a patient's behaviour or abnormal experience is due to *Grah-Nakchatra*.

Table 1: Item wise distribution of Supernatural Attitude Questionnaire

Variables	Yes	No
	N (%)	N (%)
Personal magico-religious beliefs		
Sorcery/Witchcraft *(Jaadu-Tona)*	34(48.6)	36(51.4)
Ghosts *(Bhoot-Pret)*	39(55.7)	31(44.3)
Spirit intrusion *(Opari Kasar)*	37(52.9)	33(47.1)
Aetiology of mental illness (Supernatural causes)		
Sorcery/Witchcraft *(Jaadu-Tona)*	41(58.6)	29(41.4)
Ghosts *(Bhoot-Pret)*	40(57.1)	30(42.9)
Spirit intrusion *(Opari Kasar)*	44(62.9)	26(37.1)
Divine wrath *(Devi Devta Prakop)*	41(58.6)	29(41.4)
Planetary influences *(Grah Nakchatra)*	43(61.4)	27(38.6)
Evil spirits *(Buri Atma)*	45(64.3)	25(35.7)
Bad deeds in a previous life *(Karma)*	40(57.1)	30(42.9)
Do you think the patient's behaviour is due to:		
Sorcery/Witchcraft *(Jaadu-Tona)*	41(58.6)	29(41.4)
Ghosts *(Bhoot-Pret)*	40(57.1)	30(42.9)
Spirit intrusion *(Opari Kasar)*	39(55.7)	31(44.3)
Divine wrath *(Devi Devta Prakop)*	39(55.7)	31(44.3)
Evil spirits *(Buri Atma)*	40(57.1)	30(42.9)
Planetary influences *(Grah Nakchatra)*	39(55.7)	31(44.3)
Treatment of mental illness		
Thought of Puja/rituals/Jhad-Phoonk	48(68.6)	22(31.4)
Visit or consult faith healer	51(72.9)	19(27.1)
Performed *puja/ritual/jhad-phoonk*	53(75.7)	17(24.3)
Does the patient believe in or talk about		
Jadu Tona	46(65.7)	24(34.3)
Bhoot Pret	47(67.1)	23(32.9)
Opari Kasar	45(64.3)	25(35.7)
Devi Devta Prakop	44(62.9)	26(37.1)
Grah-Nakchatra	44(62.9)	26(37.1)
Evil spirits	44(62.9)	26(37.1)
Talk about or believe in these things before falling ill	47(67.1)	23(32.9)
During illness, visit *a faith healer*	48(68.6)	22(31.4)
Magico-religious beliefs in the community	56(80.0)	14(20.0)
belong to any specific or special *tantric, spiritual or religious sect*	16(22.9)	54(77.1)

N (Number) =70; %= Percentage

Stigma Experienced

Table 2: The item wise distribution of stigma

Variables	Negative responses	Positive responses			
	Not at all	Sometimes	Often	A lot	Total
	N (%)	N	N	N	N (%)
Worry that neighbours would avoid	15(21.4)	36	13	6	55(78.6)
Spend time worrying	24(34.3)	35	10	1	46(65.7)
Need to hide the fact	31(44.3)	34	5	0	39(55.7)
Helped other people to understand	35(50.0)	32	3	0	35(50.0)
Effort to keep as a secret	33(47.1)	29	8	0	37(52.9)
Worry that neighbours would avoid	31(44.3)	30	8	1	39(55.7)
Explaining others that he/she is not crazy	39(55.7)	28	3	0	31(44.3)
Worry that you would be blamed	41(58.6)	27	1	1	29(41.4)
Worried marriage family members	0(0)	60	9	1	70(100)
Worried about taking him/her out	28(40.0)	38	4	0	42(60)
Ashamed / Embarrassed about it	28(40.0)	37	5	0	42(60)
Sought out families with a person with schizophrenia	34(48.6)	32	4	0	36(51.4)
Felt grief or depression	23(32.9)	41	5	1	47(67.1)
Felt it might be your fault	33(47.1)	35	2	0	37(52.9)

N (Number) =70; %= Percentage

Help-seeking Behaviour

Table 2 showed that at least one positive response to the items was regarded as having some sort of stigma. Distribution of positive response to stigma in the above diagram majority i.e 100% of caregivers worried that a person looking to marry would be reluctant to marry into a family which showed higher stigma among the caregiver, followed by 78.6% worried that neighbour would treat them differently followed by 67.1% felt grief or depression because they have a person with mental illness in their family. Subsequently, 65.7% used to spend time worrying about whether people would find out that they have a person with mental illness in their family.

Figure 1: Help-seeking Behaviour of the Caregivers

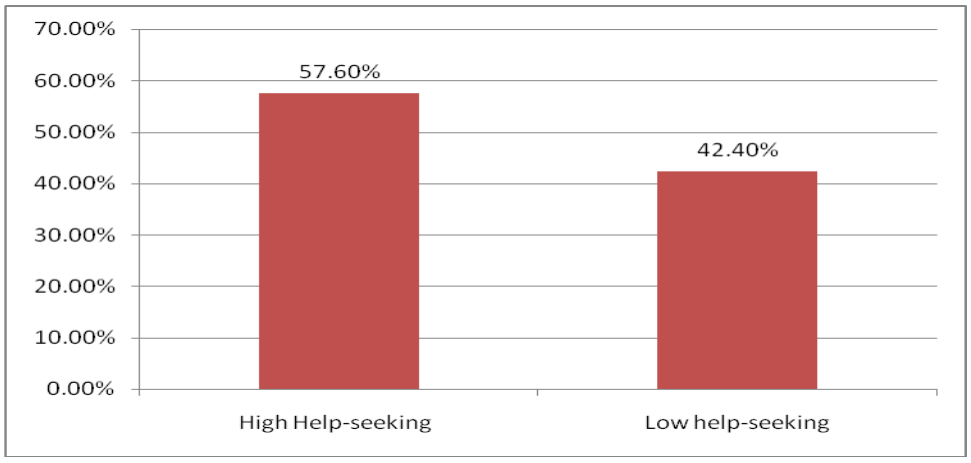

Figure 1 represents the help seeking behaviour of the caregivers. The present study showed that 57.6% of caregivers showed high help-seeking groups. The future help seeking behaviour was more towards parents.

DISCUSSION

The North-East region of India has been seen as a rich ethnic diversity with various cultural identities. Family members take most of the treatment decisions hence; understanding about their beliefs regarding the mental illness may be useful for planning management strategies. The present study evaluated beliefs of the caregivers of persons with mental illness and found the majority (80 %) believed in supernatural causation. The findings were consistent with the findings observed by Chakraborty *et al.* (2013) that nearly 96.8% of the family members of persons with schizophrenia had beliefs in supernatural causation. The beliefs extend to practices where the majority of caregiver had consulted *faith healer* (72.9 %) for the treatment of the patients and also performed *puja/ritual/jhad-phook (75.7)*. The findings were supported by Shefer *et al.* (2013) which reported that when someone had an episode of mental illness, they had critical beliefs of supernatural causes of mental illness and of religious rituals aimed at removing possession by evil spirits. A study by Sapkata *et al.* (2013) also supported that 76% of the primary Caretaker visited faith healer.

In the persent study, the prevalence of stigma was 100% which is somewhat similar to the findings of a study done by Ergetie *et al.* (2018) which suggested that the overall prevalence of perceived stigma was found to be 89.3% which showed higher stigma. The stigma found in the caregivers was that of marriage in the family, worried about how they would be treated by the neighbours. Same study line up with similar findings, Koschorke *et al.* (2017) suggested that 44% of caregivers worried a person looking to marry would be reluctant to marry into the family followed by 40% worried that neighbours would treat them differently. The study also shows of having a person with mental illness in the family developed grief or depression (67.1 %) among the caregivers. The findings are consistent with the similar findings by Thara and Srinivasan (2000) that highlighted 80% of the Caregivers felt grief or depression. However, how the caregivers' experience stigma are different from the other studies due to differences in cultural background.

High help seeking behaviour in our study was present towards the parents (mean of 5.47 & SD 1.20). Caregivers would prefer seeking help from the parents first then followed by family members, relatives, partner and friends. Similarly, 40% variation can be found in preference rates for parents with mental illness (Boldero & Fallon, 1995). A study by Umubyeyi, Morgen, Ntaganira and Krantz (2015) suggested that they sought help from the parents (8.0%), a partner (8.0%), a religious person (6.0%), a teacher (1.3%) or a traditional healer (6.7%). Kerebih *et al.* (2017) found that the most frequently visited source of Help was the Informal help sources (82.7%).

IMPLICATIONS

This study can be a primary source to understand the supernatural beliefs among caregivers of persons with schizophrenia in the north-east context. This study can encourage cultural formulation to understand the caregiver's beliefs, knowledge, and cultural manifestation of the mental illness and can help mental health professionals to formulate relevant interventions. The findings of the study will enable psychiatric social workers to develop intervention at the individual, family and community level such as awareness camp, prevention programs, etc., to deal with stigma, informal help seeking pathways and magico-religious beliefs.

LIMITATIONS

The study sample size was small hence; the results of the study cannot be generalized. The study used a quantitative approach where standardized scales/tools were used to collect data whereas; qualitative approaches such as in-depth interviews would have given more reliable and rich information. It was a hospital-based sample and the Help-seeking process, Stigma and Beliefs may be different in the community population. The role of various socio-demographic variables in Magico-religious Beliefs, Stigma and Help-seeking were not explored in a view of small sample size.

CONCLUSION

The present study assessed the magico-religious beliefs, stigma and help-seeking behaviour. Caregivers of persons with schizophrenia found to have beliefs in supernatural influences which can cause mental illness. In the magico-religious beliefs, majority of the caregivers believed in *Jadutona, Evil Spirits, Puja/ritual/jhad-phook, Oparik Asar, Devi/devata Prakop, bad deeds, Graha Nakshatra, etc., can cause mental illness.* The caregivers had a belief that *faith healing* can be taken as a treatment for people with schizophrenia. All the respondents reported the presence of stigma. Seeking help from Parents was high among Caregivers of people with Schizophrenia. Results showed that caregivers have higher help-seeking from the informal group than the formal group. Psychiatric social work professionals can take care of such supernatural beliefs, cultural diversities, stigma and pathways to help seeking while dealing with the caregivers.

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REFERENCES

Ali, A., & Jahan, M. (2012). Magico religious beliefs among caregivers of persons with psychiatric disorders as determinants for pathways to psychiatric care. *Journal of Pakistan Psychiatric Society*, *9*(2), 68-73.

Awad, A. G., & Voruganti, L. N. (2008). The burden of schizophrenia on caregivers. *Pharmacoeconomics*, *26*(2), 149-162.

Boldero, J., & Fallon, B. (1995). Adolescent help-seeking: What do they get help for and from whom. *Journal of Adolescence, 18(2*), 193-209.

Chadda, R. K., Agarwal, V., Singh, M. C., & Raheja, D. (2001). Help seeking behaviour of psychiatric patients before seeking care at a mental hospital. *International Journal of Social Psychiatry*, *47*(4), 71-78.

Chakraborty, K., Das, G., Dan, A., Bandyopadhyay, G., & Chatterjee, M. (2013). Perceptions about the cause of psychiatric disorders and subsequent help seeking patterns among psychiatric outpatients in a tertiary care centre in Eastern India (Abstract). *German Journal of Psychiatry*, *16*(1), 7-17.

Ergetie, T., Yohanes, Z., Asrat, B., Demeke, W., Abate, A., & Tareke, M. (2018). Perceived stigma among non-professional caregivers of people with severe mental illness, Bahir Dar, northwest Ethiopia. *Annals of General Psychiatry*, *17*(1), 42.

Goldberg, D., & Williams, P. (1988). General health questionnaire (GHQ). Swindon, Wiltshire, UK: nferNelson.

Kerebih, H., Abera, M., & Soboka, M. (2017). Pattern of Help Seeking Behaviour for Common Mental Disorders among Urban Residents in Southwest Ethiopia. *Quality in Primary Care*, *25*(4), 208-216.

Koschorke, M., Padmavati, R., Kumar, S., Cohen, A., Weiss, H. A., Chatterjee, S., & Balaji, M. (2017). Experiences of stigma and discrimination faced by family caregivers of people with schizophrenia in India. *Social Science & Medicine*, *178*, 66-77.

Kulhara P. · Avasthi A. & Sharma A. (2000). Magico-Religious Beliefs in Schizophrenia: A Study from North India, *Psychopathology*, 2000, March-April, 33(2), 62–68.

Sapkota, N., Shakya, D. R., Adhikari, B. R., Pandey, A. K., & Shyangwa, P. M. (2016). Magico-religious Beliefs in Schizophrenia: A study from Eastern part of Nepal. *Journal of College of Medical Sciences-Nepal*, *12*(4), 150-159.

Sartorius, N., & Janca, A. (1996). Psychiatric assessment instruments developed by the World Health Organization. *Social Psychiatry and Psychiatric Epidemiology*, *31*(2), 55-69.

Schnyder, N., Panczak, R., Groth, N., & Schultze-Lutter, F. (2017). Association between mental health-related stigma and active help-seeking: systematic review and meta-analysis. *The British Journal of Psychiatry*, *210*(4), 261-268.

Singh T, Sharma S, Nagesh S. Socio-economic status scales updated for 2017. *International Journal of Research in Medicine Sciences*. 5(7):3264-3267.

Thara, R., & Srinivasan, T. N. (2000). How stigmatising is schizophrenia in India? *International Journal of Social Psychiatry*, *46*(2), 135-141.

Umubyeyi, A., Mogren, I., Ntaganira, J., & Krantz, G. (2016). Help-seeking behaviours, barriers to care and self-efficacy for seeking mental health care: a population-based study in Rwanda. *Social Psychiatry and Psychiatric Epidemiology*, *51*(1), 81-92.

Wilson, C. J., Deane, F. P., Ciarrochi, J., & Rickwood, D. (2005). Measuring help-seeking intentions: Properties of the general help-seeking questionnaire. *Canadian Journal of Counselling*, *39*(1), 15-29.

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Research Paper: Dr. G. S. Udaya Kumar Memorial Award for Social Practitioner in the Field of Family Related Studies

Effectiveness of Family Therapy on Poor Communication and Family Relationship: An Intervention Study

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ABSTRACT

Background: A structured way of communication can bring clarity of expression between family members which help to maintain the homeostasis in the family. Like communication, there are various other aspects in the family that affects the entire familial relationship, such as cohesion between the members, their way of handling conflict situation and level of expressiveness amongst them. **Aim**: To evaluate and intervene poor communication and familial relationship through providing family therapy. **Methods and Materials:** This was an intervention study with a pre-post experimental design. Fifteen families those who had attended the OPD of the Institute of Psychiatry, Kolkata were selected in this study following clear inclusion and exclusion criteria and through purposive sampling technique. After assessing with FCS and BFRS, eclectic family therapy as provided, followed by post-assessment in the same parameters. Descriptive statistics and Wilcoxon signed-rank test were used for statistical analysis. **Results:** The findings reveal that an eclectic family therapeutic approach significantly improved communication level and overall family relationship among the members of the families. **Conclusion:** The study highlights the impact of communication in a familial relationship in the form of cohesion, expressiveness and conflict resolution through a practical implication of family therapy, which demonstrated to be highly effective.

Keywords: Family therapy, couples, communication, family relationship

INTRODUCTION

A family is a social unit characterized by interpersonal relationships, the common residence with individual cooperation who shares an emotional bond. It is part of a social system which is diverse in nature. Family is that entity which holds us to preserve harmony and brings balance into our life. Communication is that dominant force in a family that holds the key for a strong, healthy and lasting relationship among family members. Any relationship can be revamped by isolating detrimental, misunderstandings, problematic aspects of communication and enhancing interaction process that gets suppressed or changed through times. A family that stays together shares a common bond; maintain cohesion among its members through positive communication that helps members to maintain balance in a familial relationship.

A structured way of communication can bring clarity of expression between family members which help to maintain the homeostasis in the family. Like communication, there are various other aspects in the family that affect the entire familial relationship, such as cohesion between the members, their way of handling conflict situation and level of expressiveness between them. Cohesion is a strong emotional bonding that individual express towards each other to promote their support. Conflict arises when people living together have lack of cohesion that increases with other familial issues. "Family cohesion is the emotional bonding among family members and the feeling of closeness, acceptance within the family system" (McKeown et al., 1997). To develop emotional bonding family must regulate the emotional expressiveness between them.

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In the familial relationship, emotional expressiveness refers to the dominant pattern of both verbal and non-verbal expressions in the family. The study focuses on intricate relational patterns that exist in families and intervening them through imparting family therapy. Family therapy lies on the systems perspective, which proposes that change in one part of the system can bring out change in other parts, and the change can produce fruitful solutions. Family-based intervention can be described as a collection of techniques that focuses on family communication, cohesion, conflict resolution, emotional expressiveness and various other processes and dynamics. Some of the common evidence-based family therapeutic approaches are Brief Strategic Family Therapeutic Approach, Structural Family Therapeutic Approach, Family Behaviour Therapeutic Approach and Functional Family Therapeutic Approach. The goals of these interventions are to bring about systemic changes, enhancing positive family activities, improving communication pattern, equipping with problem-solving skills and enhancing overall family relationship.

Objectives

To evaluate and intervene poor communication and familial relationship through family therapy.

METHODS AND MATERIALS

The study was a cross-sectional, institution-based, pre-post intervention study which was conducted in Kolkata, West Bengal. Through purposive sampling 15 married couple, between 25-50 years of age with their children who have attended the Out-Patient Department of Institute of Psychiatry, Kolkata were included in the study. A person who has an acute psychiatric illness, any disability, chronic or neurological illness in the family and those who had more than 2 children were excluded from the study. After recruiting families, consent was obtained and pre and post-assessment were done after the stipulated number of therapy sessions. Statistical analysis was done using Statistical Package for Social Sciences, version 25 (SPSS-25), Descriptive statistics were used for Socio-demographic profile and Wilcoxon Signed Rank Test used for pre-post assessment. The following instruments were used:

Socio-demographic Datasheet

Family Communication Scale (Olson et. al., 2004): Which identify the pattern of communication present in the family.

Brief Family Relationship Scale (Fok et al., 1994): measures a person's perception of the quality of the family relationship and other dimensions, like cohesion, emotional expressiveness and family conflict.

RESULTS

Socio-demographic Profile

The age range of participants of families was found between 7-40 years. Among 15 families 60% hailed from the sub-urban background, 20% each from a rural and urban background. Majority of the families i.e., 80%, were Hindus whereas 20% were Muslim. A large majority of 86.7% of married couples with children belong to the nuclear family and 13.3% were from joint family. The range of the numbers of family members of the married couples with children was 3-7. Occupational background revealed that 46.7% each in the study were either unemployed or student, and 6.7% were full time employed. Almost 40% of the participant's monthly family income was less than 5,000 INR, 20% has between 10,001 -15,000 INR and 40% of them had 15,001 -20,000 INR.

Table 1 - Socio-demographic Profile

Variables	Categories	Frequency (%) Mean ± SD (N-15)
Age		22.53 ± 11.63
Domicile	Urban Sub-urban Rural	3 (20%) 9 (60%) 3(20%)
Education	Primary education Secondary education Graduation	7 (46.7%) 7 (46.7%) 1 (6.7%)
Religion	Hinduism Islam	12 (80%) 3 (20%)
Type of family	Nuclear Joint	13 (86.7%) 2 (13.3%)
Numbers of family members		3.93 ± 1.03
Occupation	Full time Employed Student House maker	1 (6.7%) 7 (46.7%) 7 (46.7%)
Current status of employment	Employed Unemployed	8 (53.3%) 7 (46.7%)
Family income (Per month)	Less than 5,000 10,001 – 15,000 15,001 – 20,000	6 (40%) 3 (20%) 6 (40%)

TABLE 2 Pre-post Intervention Comparative Profiles of Family Communication and Family Relationship

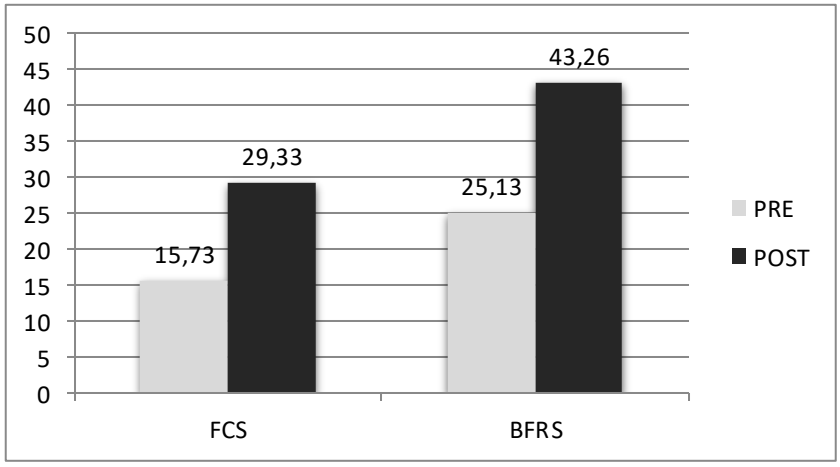
Variable	Negative Rank	Positive Rank	Tie	Z
Communication	0	15	0	-3.411***
Cohesion	0	15	0	-3.411***
Expressiveness	0	15	0	-3.441***
Conflict	0	15	0	-3.448***

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

The above Table2 indicated the comparative profile of communication and different areas of family relationships (like cohesion, expressiveness and conflict) on pre and post-intervention among married couples with children which was done by using Wilcoxon signed-rank test. Statistically, a significant difference has been found on family communication and family relationships on pre and post-intervention at 0.001 level.

Figure – 1 showed the mean score of pre-assessment of FCS was 15.73 and the post-assessment mean score of FCS was 29.33. The mean score of pre and post-intervention of BFRS were 25.13 and 43.26. In FCS higher score indicated a better level of communication and higher scoring of BFRS indicated improved level of family relationships; which evaluate that after the intervention scores were found to be more effective than previous.

Figure – 1 Mean score of pre-post Intervention of FCS and BFRS



DISCUSSION

In Indian context, families are described as a social institution with its responsibilities for child-rearing, child development, family member's emotional and economical support. After becoming a parent, both partners often focus on their parental role and consequently forgo the effort that is needed to put in other relationship including their marriage. A sudden involvement of a child between the married couple sometimes creates various communication dynamics which affect the family as a whole.

When pathological interaction and miscommunication can sabotage any familial relationships, healthy communication can strengthen the relationship and help to maintain homeostasis within the family. One supportive study by Smith et al., (2009) suggested that family communication has a crucial role in relation with various family domains. Another study by Miranda et al., (2016) suggested that communication has a significant impact on family relationship including cohesion between the family members, expressiveness of their inter-personal relationships and conflict.

In this present study a multi-faceted approach was taken to help the participatory families to bring a comprehensive change in various aspects of familial relationships by improving communication pattern, problem-solving abilities, engaging family in constructive activities, strengthening we feeling and enhancing the overall familial relationship. Through this eclectic approach, it was aimed to intervene intricaterelational patterns through family therapy and instil constructive changes.

While some of the problems were common and similar among the families other problems were polls apart. Some of the common problems were found to be criticizing each other, having excessive outburst of anger, neglecting each other's opinion, absence of sub-system, inappropriate adaptive pattern, higher expectation, and acting on impulse among family members.

Pre-assessment further suggested that there were towering problems in communication in families, which was affecting every familial relationship. As the child became the mediator between a married couple that affects family dynamics broadly, create marital conflict, bring a lack of cohesiveness, and inhibit emotional expressiveness. For managing those significant issues individual emphasis was given on their communication pattern. Some of the other issues that came out after the pre-assessment; were lack of communication between married couples, poor spousal sub-system, high negative expressed emotion, child's behavioural

problems like stubbornness, excessive anger outburst, demanding behaviour, rigid family boundary, family rituals, lack of adaptive pattern, cohesion and poor coping strategies.

All the dimensions of the family relationship were targeted in the eclectic approach of family therapy. Among many, common techniques some were specifically for the adults i.e., married couple or other family members and some were to intervene the child/children in the family. **Reframing** was a technique where the family members got the opportunity to perceive their interactions or situation from a different perspective, which found to have a positive outcome of that particular situation. **Prescriptions of rituals** were suggested to exaggerate or move against the rigid pattern of family rituals, so the couple can maintain their tasks and rituals according to their appropriate and suitable time. **First-order changes** were superficial behavioural changes that were not attempted to change the structure of the system but to bring some temporary changes in the family. These changes were little more than cosmetic change or perhaps simply a reflection of a couple's good intentions. Since some of the families were found to have too rigid or too flexible family boundaries, researcher attempted to create family boundaries that were autonomous and interdependent enough to allow for the growth of the family member.

The study also focused on the children and issues revolving around them. To intervene child's behavioural problem reinforcement-punishment, token economy, storied approach as part of family therapy were used. **Reinforcement** is the process of rewarding each other of family members for certain desire behaviour and **punishment** is a technique that weakens an undesired behaviour to reduce the chances that the behaviour will occur again. Another technique that mostly used as the **token economy**, where the target-based token was given in desired behaviour to modify a child's problem behaviour through reward.

Like the present study, various other studies found improvement through techniques of family therapeutic approach in similar domains. Some of the studies have supported that appropriate techniques of family therapeutic approach bring changes in different family dynamics (Robbins et al., 1996; Bressi et al., 2008).

After providing the intervention package, improvement in both the domains were evident in both the FCS and BFRS, where the higher score indicated the higher level of enhanced communication and family relationships. Similarly, a study by Roy, et al., (2017) revealed that appropriate use of family therapy techniques had a positive impact on parents of children and adolescents. Supporting the study, Bograd, M., (1992) suggested that family therapy had an essential role in conflict resolution. The present study findings suggested adequate use of eclectic family therapy techniques provided changes in family communication along with different familial relationships.

Limitation: A main shortcoming of the study was the small number of families recruited in the study and no control group was included in the study.

Future direction: The emerging evidence on this study allows further researchers to develop a detailed treatment modality, which can be more effective in solving the family problems based on current prospect.

CONCLUSION

Family is a complex unit and every family dynamic are entangled with each other. Ahealthy communication style enables the family to skilfully amend family cohesion and tackle situational and developmental demands when needed. The study highlights the importance of communication and familial relationship among persons suffering from mental illness. It

yields the practical implication of the eclectic approach of family therapy which found to be extremely beneficial for families with mental illness.

Source of Support: The First Author received a scholarship for pursuing a Master of Philosophy in Psychiatric Social Work degree (2017-19); the present study was done in partial fulfilment of the course from the Institute of Psychiatry, Kolkata, West Bengal. This study was completed under the guidance of the second author.

Conflict of Interest: None.

Ethical Clearance: Institutional ethics committee approved the protocol of the study.

REFERENCE

Bograd, M., (1992). Values in conflict: challenges to family therapists' thinking. *Journal of Marital & Family Therapy,* 18(3), 245-256.

Bressi, C., Manenti, S., Frongia, P., Porcellana, M., Invernizzi, G., (2008). Systemic Family Therapy in Schizophrenia: A Randomized Clinical Trial of Effectiveness. *Psychother Psychosom*, (77), 43-49.

Fok, C. C. T., Allen, J., Henry, D., & Team, P. A. (2014). The Brief Family Relationship Scale: A Brief Measure of the Relationship Dimension in Family Functioning. *Assessment*, *21*(1), 67–72.

Halberstadt, A. G., Cassidy, J., Stifter, C. A., Parke, R. D. & Fox, N. A. (1995). Self-expressiveness within the family context: Psychometric support for a new measure. *Psychological Assessment*, 7, 93–103.

Hogue, A., Liddle, H. A., (2009). Family based treatment for adolescent substance abuse: controlled trials and new horizons in services research. *Journal of Family Therapy*. 31 (2), 126-154.

Jackson, S., Goossens, L., Eds. (2006), Psychology Press: New York, NY, USA, 1–10

Jaworska, N., & MacQueen, G. (2015). Adolescence as a unique developmental period. *Journal of psychiatry & neuroscience: JPN*, *40*(5), 291.

Jiménez, L., Hidalgo, V., Baena, S., León, A., &Lorence, B., (2019). Effectiveness of Structural–Strategic Family Therapy in the Treatment of Adolescents with Mental Health Problems and Their Families. *International Journal of Environmental Research and Public Health*, 16(7), 1255.

Lubenko, J., Sebre, S., (2010). Longitudinal associations between adolescent behaviour problems and perceived family relationship. *Procedia-Social and Behavioral Sciences*, 5, 785–790.

MacCracken, M. (1998). Social Cohesion and Macroeconomic Performance. Ottawa, Canada

McKeown, R. E., Garrison, C. Z., Jackson, K. L., Cuffe, S. P., Addy, C. L., & Waller, J. L. (1997). Family structure and cohesion, and depressive symptoms in adolescents.*Journal of Research on Adolescence*, 7, 267-282.

Miranda, A. O., Estrada, D., & Firpo-Jimenez, M., (2000). Differences in Family Cohesion, Adaptability, and Environment among Latino Families in Dissimilar Stages of Acculturation. *The Family Journal*, 8(4), 341–350.

Olson, D. H., Gorall, D. M., &Tiesel, J. W. (2004). Faces IV package. *Minneapolis, MN: Life Innovations*, (39), 12-13.

Robbins, M. S., Alexander, J. F., Newell, R. M., & Turner, C. W., (1996). The immediate effect of reframing on client attitude in family therapy.*Journal of Family Psychology,* 10(1), 28–34.

Roy, T., Thirumoorthy, A., & Parthasarathy, R. (2017). Culturally Relevant Family Therapy Practice with Parents of Children and Adolescents. *Indian Journal of Psychological Medicine,* 39(2), 137-142.

Rowe, C. L., (2012). Family therapy for drug abuse. *Journal of Marital and Family Therapy*, 38 (1), 59-81.

Smith, M. K., Freeman, A. P., & Zabriski, B. R., (2009). An Examination of Family communication within the core and balance model of family leisure functioning. *Family Relations,* 58, 79-90.

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Research Paper: Dr. M. Chandrasekhar Rao Memorial Best Paper Award, for M.Phil/Ph.D. Scholars in the Field of Social Work Research

A Study on Social Media Addiction and Phubbing among Health Trainees

Neha Das Gupta[1], Soma Saha[2]

ABSTRACT

Background: When an individual looking at his or her mobile phone during a conversation with other individuals and escaping from interpersonal communication, it is called phubbing. Health trainees can be defined as doctors, nursing staffs and other professionals (such as psychologists, psychiatric social workers, physiotherapists, etc.) studying a postgraduate course in the medical field. **Methods and Materials:** The researcher collected data from 30 health trainees of the Institute of Psychiatry (COE) and Institute of Post-Graduate Medical Education and Research (IPGME& R &SSKM Hospital), Kolkata to assess social media addiction and phubbing among health trainees in the age range of 18 to 35 years who had an active social media account. After screening, the socio-demographic details of the participants were collected and the social media addiction and phubbing scale were administered. **Results:** Theresults indicated that the levels of social media addiction were more in other health trainees and nursing trainees than others. The level of phubbing was found to be significant among other health trainees. **Conclusion:** Social media addiction has affected the trainees' lives despite their knowledge about it.

Keywords: Social media addiction, phubbing, health trainees

INTRODUCTION

In our modern life the preoccupation with our cell phones has irrevocably changed how we interact with others. "The use of internet and social media has increased with time. Social media can be defined as an environment in which a group of people come together to share data, relationships and content, using internet communication channels. The most common social media tools are Facebook, Twitter, Instagram, Snapchat, WhatsApp, Google+, LinkedIn and Reddit" (Aksoy, 2018). Individuals use social media to be aware of what their friends were doing, stay up to date with news and events, evaluate leisure time, find entertaining and funny content, share ideas, share videos and pictures, share information with people and meet new people. It makes it easier to stay connected (Wersm, 2016).

The easy access to the internet and the social media platforms bring about the potential for social media addiction, "specifically the irrational and excessive use of social media to the extent that it interferes with other aspects of daily life" (Griffiths, 2012). "Individuals who have social media addiction are often found to be overly concerned about social media and are driven or forced by an uncontrollable urge to log on to and use social media" (Andreassen & Pallesen, 2014).

"Phubbing can be described as an individual looking at his or her mobile phone during a conversation with other individuals, by dealing with the mobile phone and escaping from interpersonal communication. The word phubbing is derived by merging the words phone and snubbing (which means ignoring or insulting someone).It can be considered as a disrespectful behaviour towards others and can damage real-life social relationships with others" (Karadag et al., 2015). In the Indian scenario, smart phone's addiction and

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problematic internet use among adolescents are on the increase, which indicates the possibility of phubbing among adolescents and youth.

The relation between social media addiction and phubbing explained in a study by Leary (1990), focused on the explanation of the reasons behind people turning to social media, rather than engaging into additional in-person interactions, and in his study, he concluded that it was simply an attention seeking behaviour with a sense of gregariousness.

Health trainees can be defined as the doctors, nursing staff and other professionals (such as psychologists, psychiatric social workers, physiotherapists, etc.) who are studying a postgraduate course in the medical field.

In one of the studies by Meredith E. David and James A. Roberts (2017) it was found that phubbing has a significant indirect effect on social media intensity via feelings of exclusion during time spent in person with others and need for attention. The overall result indicated that being phubbed was associated with individuals feeling excluded during their time spent with others and that those feelings of exclusion created a need for attention from others.

Aim: The aim of the present study is to find out the social media addiction and phubbing among health trainees and to see the association between them.

METHODS AND MATERIALS

Research Design: Cross sectional institution based study.

Sampling Method: Criterion based purposive sampling.

Inclusion Criteria: Participants in the age range of 18 to 35 years, spending more than one hour daily at social media sites with a frequency of being active in social media account of at least 6 months and having at least 2 social media accounts; were considered for the research.

Exclusion Criteria: Participants with a score of 4 and above in the General Health Questionnaire-28, with any substance abuse except nicotine or tobacco were excluded.

Ethical Consideration: Permission was taken from the health trainees' Head of the Departments for data collection, written consent was taken and an information brochure was provided to them. They were free to withdraw their consent during the study and all the queries and clarification were addressed before and after the study. Confidentiality was strictly maintained. Ethical clearance was taken from the Ethical Committee of the Institute prior to conducting the study.

Method of Data Collection: After the permission from the ethical committee of IPGME & R, the data collection process was started. The researcher collected data from 30 health trainees (10doctors, 10nursing trainees and10 other health professionals such as M.Phil. in Psychiatric Social Work, PhD in Microbiology, etc.) of the Institute of Psychiatry (COE), and the Institute of Postgraduate Medical Education and Research (SSKM & IPGME&R Hospital), Kolkata, who had an active social media account. They were selected based on the inclusion and exclusion criteria. The General Heath Questionnaire (GHQ-28) was administered and the socio-demographic details of the participants were collected. The social media addiction and phubbing scale were administered.

Tools of Data Collection: Semi-structured socio-demographic details form, General Heath Questionnaire (GHQ-28) (Goldberg & Hillier, 1979), Social Media Addiction Scale - Student Form (Cengiz Şahin, 2018), Phubbing scale (Engin Karadağ, 2015), were utilised as the tools of data collection.

Statistical Analysis: Descriptive statistics, mean, standard deviation and percentage has been used. Pearson's correlation has been used to compute the correlation among variables. Collected data has been coded and analysed with the help of Statistical Package for Social Sciences (SPSS) version 25.

RESULTS

Data inserted in Table 1 reveals, the comparative picture of the socio-demographic details of the health trainees (doctors, nurses and other health trainees). The below data shows that 23.33% of the health trainees fall in the age range of 18-25 years and the rest of the 76.66% falls in the age range of 25-35 years. The overall mean was found to be 28.47 and the standard deviation was 3.381.

73.3% of all the health trainees were females which is higher than the male trainees which are 26.7% only. Among all the health trainees, maximum of them 83.3% were Hindus, 10% Muslim, 3.3% Christian and 3.3% were of other religion.

86.7% of all the health trainees were Bengali speaking, 6.7% Hindi and 6.7% other languages.66.7% of the health trainees belonged to nuclear family, 23.3% were from joint family and 10% had an extended family.

13.3% of the health trainees were hailing from a rural background, 30% from sub-urban domicile, and 50% from urban and 6.7% were coming from an urban metro domicile. So, it can be said that most of the trainees came from urban background.

Among all the health trainees only 33.3% were not receiving scholarship and the rest of 66.7% were getting scholarship. 90% of all the trainees were using one mobile phone and only 10 of them were using two mobile phones.

The table also shows the details of the social media usage and accounts of the health trainees. The table indicates that 63.33% of the health trainees were using 2-3 accounts and 36.66% were using 4-5 accounts. So, it indicates that more of the trainees have 2-3 accounts. The table shows that 43.3% of the trainees prefer using Facebook, 43.3% WhatsApp, 6.7% Instagram and 6.7% YouTube. It was also observed that 83.33% trainees spend 1-3 hours on social media and only 16.66% spend 4-6 hours. It was also found that 90% of the health trainees were more active on social media as their last update was 1-4 hours before the data collection than the only 10% trainees who had last updated their social media 5-10 hours ago.

The data analysis shows that the mean score for health trainees in terms of social media addiction was 70.60 and the S.D. was found out be 20.612. From the data it can be said that the mean score for social media addiction is higher than the mean score for phubbing. The mean score for phubbing-communication disturbance was found out be 10.17 and the S.D. was 3.239. The mean score for phubbing-phone obsession was 15.50 and S.D. was 4.066. So, it can be said that the mean score for phone obsession is higher than the mean score for communication disturbance. So, it indicated that the health trainees have higher levels of social media addiction than phubbing.

Table 2 shows the correlation between social media addiction and phubbing (communication disturbance and phone obsession) of the health trainees. The data indicates that there is a presence of positive correlation 0.507 at 0.01 level between social media addiction and phone obsession. Positive correlation is also present between the two factors of phubbing-communication disturbance and phone obsession at 0.01 level of 0.619.

Table1: Socio-demographic Details of the Subjects

Socio-demographic	Health Trainees	
	Frequency	**Percentage**
Age		
18-25 Years	7	23.33
25-35 Years	23	76.66
Total:	**Mean -** 28.47	**S.D.** - 3.381
Gender		
Female	22	73.3
Male	8	26.7
Religion		
Hindu	25	83.3
Muslim	3	10.0
Christian	1	3.3
Other Religion	1	3.3
Mother Tongue		
Bengali	26	86.7
Hindi	2	6.7
Others	2	6.7
Family Type		
Nuclear	20	66.7
Joint	7	23.3
Extended	3	10.0
Domicile		
Rural	4	13.3
Sub-Urban	9	30.0
Urban	15	50.0
Urban-Metro	2	6.7
Scholarship		
No	10	33.3
Yes	20	66.7
No. Of Phones		
1	27	90.0
2	3	10.0
Accounts		
2 to 3	19	63.33
4 to 5	11	36.66
Preference		
Facebook	13	43.3
Instagram	2	6.7
Whatsapp	13	43.3
Youtube	2	6.7
Last Update		
Within 1to 4 hours	27	90
Between 5 to 10 hours	3	10
Hours Spent		
Between 1 to 3 hours	25	83.33
Between 4 to 6 hours	5	16.66

Table 2: Correlations between Social Media Addiction and Phubbing

Correlations	Social Media Addiction	Phubbing	
		Communication Disturbance	Phone Obsession
Social Media Addiction	1	.287	.507**
Phubbing Communication Disturbance	.287	1	.619**
Phone Obsession	.507**	.619**	1

**Correlation is Significant at the 0.01 Level (2-Tailed)

DISCUSSION

Social media addiction is one of the growing concerns in recent times. One of the recent popular social media platforms is the social networking site (SNS). In a study by P. B. Brandtzaeg and J. Heim (2009) the reasons behind use of social media were investigated many motivational reasons were reported behind use of social media platforms. One of the most important reasons was to get in contact with new people (31%), second was to keep in touch with their friends (21%), and the rest (14%) was for general socializing. From this study it can be said that people are using social media more to get in contact with new people and this may be the reason behind the increasing use of it.

In a study by B. K. Sharma et al., (2015), where students perception towards social media – was observed with special reference to management students of Bhopal, Madhya Pradesh concludes that majority of respondents agreed that usage of social sites is not just limited to chatting with friends but also used for business networking, jobs and entertainment purpose. This makes social media important in our day-to-day life.

In favour to the above findings the study perception and attitude towards the use of social media network among Benue State University undergraduates by Patrick Saaondo and James Aondoakula Igbaakaa (2018) recommended that students' use of social media network should not be seen as a crime or social vice. Nevertheless, the use of social media during productive hours like lectures, exams, should be avoided.

The socio-demographic details of the present study shows that more of the trainees belong to the age range of 25 to35 years and there were more female trainees than male trainees. Facebook and WhatsApp were the most preferred social media platforms to the health trainees and the maximum trainees were found to spending more than 2hours on a regular basis on social media.

Survey data on social media and messaging app use by Aaron Smith and Monica Anderson (2018) indicates that half of social media users' aged 18 to 24 years (51%) find it hard to give up social media than the other half of the age groups.

It can be easily said that social exclusion is present with social media addiction. The study on Social Exclusion, Surveillance Use, and Facebook Addiction: The Moderating Role of Narcissistic Grandiosity found out that social exclusion was positively associated with Facebook addiction. The surveillance use of Facebook was found to be a significant mediator between the risk of social exclusion on Facebook and Facebook addiction.

Sometimes social media addiction may lead to phubbing as studied by Meredith E. David and James A. Roberts (2017), who wanted to find out the relation between phone-snubbing (phubbing), social exclusion and attachment to social media. This was done on 180 US adults.

Varoth Chotpitayasunondh and others in 2016 conducted a study to examine the contributing roles of internet addiction, fear of missing out, self-control, and smart phone addiction. They examined how the frequency of phubbing behaviour and of being phubbed may both lead to the perception that phubbing is normative. The result from the first study shows that phubbing had a significant effect on individuals' tendencies to feel excluded during their time spent in person with others. In the same way, the second study results revealed that internet addiction, fear of missing out, and self-control predicted smartphone addiction, which in turn predicted the extent to which people phubb.

The results in the present study indicates a positive correlation between phone obsession (phubbing) and social media addiction at 0.01 level for the health trainees which is supporting the above mentioned studies. The results of the present and the previous studies indicate that there is a positive relation between phubbing and social media addiction. It also reveals that social media addiction is present in health trainees as well, who are aware of the pros and cons of this addiction. Social media addiction and phubbing are positively related for the health trainees who mean that when social media addiction increases the phubbing behaviour of the individual also increases. The present study also reveals that phone obsession has a positive correlation with communication disturbance.

Limitations: The time for the study was limited due to which the intergroup correlation and the different types of trainees could not be divided for further statistical analysis. Different platforms of social media could not be separated and different analysis was not done. The gender was not separately taken under consideration and the number of participants was less.

IMPLICATIONS

The present study can be used to create awareness about the fact that social media addiction is present among the health trainees, among whom some are mental health trainees who are aware about the harmful effects of different addictions. Necessary measures should be taken to avoid the excessive use of social media or mobile phone in the working areas. The use of mobile phones should be restricted during working hours and some serious mental health care wards should have mobile free zones where mobile phones should not be allowed. For broader societies the access of mobile phones in workplaces should be limited. The amount of time spent on social media which is related to phone obsession can be harmful for the quality of work and service provided to the patients. Hence, the study can be used to create awareness amongst the health trainees about their growing social media addiction and phubbing and to take necessary steps against it.

FUTURE DIRECTIONS

In the near future, this study can be performed on a larger scale with a more large population, the trainees can be dived into different groups and further analysis can be done. This study can be used to focus on the gender difference in terms of social media addiction and phubbing. More variables can be analyzed related to social media addiction such as fear of missing out, self-esteem etc. The study can be further aimed at studying the impact of social media addiction and phubbing among the different trainees. It can also aim at assessing the impact of social media addiction on the professional empathy of the trainees. The study may also be extended to assess other professional groups as well.

CONCLUSION

Social media addiction has become a growing concern for not only the teenagers but also amongst the health trainees. The health trainees were found to be addicted to social media and had a high level of phone obsession. Necessary care and steps should be taken for avoiding use of social media at work places for health trainees.

Conflict of interest: Nil

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REFERENCES

Smith, A., & Anderson, M. (2018). Social media use in 2018. Retrieved from http://www.pewinternet.org/2018/03/01/social-media-use-in-2018/ Aksoy, M. E. (2018). A qualitative study on the reasons for social media addiction. *European Journal of Educational Research*, *7*(4), 861-865.

Andreassen, C. S., & Pallesen, S. (2014). Social network site addiction-an overview. *Current Pharmaceutical Design, 20*, 4053–4061. https://doi.org/10.2174/13816128113199990616

Brandtzaeg, P.B., & Heim, J. (2009). Why People Use Social Networking Sites, International Conference on Online Communities and Social Computing, *62,143*-152.

Chotpitayasunondh, V., & Douglas, K. M. (2016). How "phubbing" becomes the norm: The antecedents and consequences of snubbing via smart phone. *Computers in Human Behavior.* 63, 9-18

David, E., M., & Roberts, A., J. (2017). Phubbed and Alone: Phone Snubbing, Social Exclusion, and Attachment to Social Media. *Association for Consumer Research, 2* (2), 155-163.

Dr. Wilson, Lawrence. (2018). Social Media Addiction. Retrieved from https://drlwilson.com/ARTICLES/ADDICTION,%20SOCIAL%20M.htm

Goldberg, D. P. & Hillier, V. F. (1979). A scaled version of the General Health Questionnaire. *Psychological Medicine,* 9, 139–145.

Griffiths, M. D. (2012). Facebook addiction: Concerns, criticism, and recommendations: A response to Andreassen and colleagues. *Psychological Reports, 110*, 518–520.

doi: 10.2466/01.07.18.PR0.110.2.518-520

Hou, Y., Xiong, D., Jiang, T., Song, L., & Wang, Q. (2019). Social media addiction: Its impact, mediation, and intervention. Cyber psychology: *Journal of Psychosocial Research on Cyberspace*, *13*(1), article 4. doi. http://dx.doi.org/10.5817/CP2019-1-4

Karadagi, E., Betul, Ş., Tosuntas, E, E., Duru, P., Bostan, N., Mizrak, B, Ş., Culha, İ., & Babadag, B.,(2015). Determinants of phubbing, which is the sum of many virtual addictions: A structural equation model.*Journal of Behavioural Addictions, 4*(2), 60–74.

Leary, Mark R. (1990).Responses to Social Exclusion: Social Anxiety,Jealousy, Loneliness, Depression, and Low Self-Esteem. *Journal of Social and Clinical Psychology*, 9 (2), 221–29.

Saaondo, P., James, A, I., (2018). Perception and Attitude towards the Use of Social Media Network among Benue State University Undergraduates. *Journal of Humanities and Social Science, 23*(8), 69-75.

Şahin, C. (2018). Social Media Addiction Scale - Student Form: The Reliability and Validity Study. *The Turkish Online Journal of Educational Technology, 17* (1), 169-182.

Sharma, B., Jain, M., & Tiwari, D. (2015). Students perception towards social media – with special reference to Management Students of Bhopal Madhya Pradesh. *International Journal of Engineering and Applied Sciences, 2*(1), 30-34.

WERSM (2016). Retrieved from http://wersm.com/the-10-top-reasons-why-we-use-social-networks/ [accessed May 22 2020].

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Research Paper

Adolescent Humour and Its Relationship with Psychological Adjustment

Abhijeet Singh[1], Arif Ali[2], Maria Choudhary[3], Rini Gogoi[4], Nilesh Maruti Gujar[5]

ABSTRACT

Background: Adolescence is a transition phase towards adulthood. There is a correlation between humour and psychosocial adjustment. **Aim**: To assess the level of humour among adolescents and to see its relationships with their general psychological adjustment. **Methods and Materials:** The present study is a cross-sectional study. Convenience sampling was used to select the school and total enumeration method was used for the selection of the respondents (school-going adolescent). School going adolescents between the ages of 13-17 years were included. They were assessed with their consent using a Socio-demographic Datasheet, Richmond Humour Assessment Instrument, Beck Depression Inventory, Interaction Anxiousness Scale, Strength and Difficulty Questionnaire, Academic Expectation Stress Inventory and Rosenberg self-esteem scale. **Results:** Humour has a significant negative correlation with the emotional problems and significant positive correlation with pro-social behaviour and total difficulty score. Moreover, it was found that humour has a significant positive correlation with self-efficacy. In regression analysis, it was found that conduct problems and pro-social behaviour contribute significantly to the prediction of humour among adolescents; though, accounting only for 1.08% variance. Remaining 98.9% was attributed to a variable not included in the study. **Conclusion:** Humour can lead to an improvement in psychological adjustment among adolescent.

Keywords: Humour, depression, anxiety, emotional and behavioural problems, self-esteem, adolescent

INTRODUCTION

Adolescence is a transition phase towards adulthood with gradual changes in physical and psychological domains. This transitional phase comes with own emotional upheavals and societal pressure (Case and Daley, 2014; Erikson, 1963). Mental illness affects many adolescents, and they are at risk (Nair et al. 2017). Humour and laughter are frequently presumed to mean people can use to cope with life's difficulties in society (Ziv, 1988). Falkenberg et al. (2011) stated that humour and laughter can positively influence mood, promote optimism and lead to a change of perspective. Gupta, Mongia and Garg (2017) in a descriptive study of behavioural problems in school going children found that 22.7% of children showed the behavioural, cognitive, or emotional problem.

Humour plays an important role in interpersonal relationships, resolving interpersonal conflict (Zand et al., 1999); Humor can soften the relationship between two people and helps to establish and maintain social contact (Zand, Spreen and Lavalle, 1999). Elliot (2013) believes that humour is believed to have impact on psychological and social well-being. Mannell and McMahon (1982) reported that adolescents who engaged in humorous activities showed an elevation in positive emotions and decrease in negative emotions, such as anxiety and fatigability.

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There is evidence, which states that there is a strong correlation between humour and psychosocial adjustment (Martin et al., 2003). According to scholars, "Affiliative and self-enhancing humour is negatively correlated with anxiety, depression, and suicidal ideation, and positively correlated with self-esteem and life satisfaction among adults. In contrast, self-defeating humour is associated with high levels of anxiety, depression, and suicidal ideation, and lower self-esteem and lower life satisfaction" (Dyck and Holtzman, 2013; Kuiper, Grimshaw, Leite, and Kirsh, 2004; Martin et al., 2003; Tucker et al., 2013). Fox, Hunter and Jones (2016) found that, "Self-defeating humour was associated with an increase in both depressive symptoms and loneliness and with a decrease in self-esteem in adolescence. Also, depressive symptoms predicted an increase in the use of self-defeating humour over time, indicating that these may represent a problematic spiral of thoughts and behaviours". According to Gibson and Tantom (2017), "Adolescents are easily impacted by humour because it tends to increase social bonding with peers, and therefore, increase self-esteem". Social bonding prevents individuals from being vulnerable to negative environmental influences. Since research studies on humour among children and adolescents in India are relatively few. Therefore, the present study was conducted to assess the level of and see the relationships between humour and their general psychological adjustment among school-going adolescents.

Objectives

- To assess the level of humour among school-going adolescent.
- To study the Psychological adjustment among adolescents (emotional and behavioural problems, interaction anxiousness, academic stress and self-esteem).
- To see the relationships between humour and psychological adjustment.
- To determine the extent to which emotional and behavioural problems, interaction anxiousness, academic expectation stress, self-esteem predicts the variability in humour among school adolescent.

METHODS AND MATERIALS

The present study was a cross-sectional study. Convenience sampling was used to select the school from Guwahati, Assam and total enumeration method was be used for selection of school-going adolescents between the age range of 13 to 17 years willing to give consent along with parental consent were included. The participants were informed about the purpose of the study and confidentiality was assured; firstly parents' consent was taken and then from the adolescents. The following tools were used:

Socio-demographic Datasheet: A self-developed demographic profile was used in the present study. It includes basic information on the student's background. Information like age, gender, family type, socio-economic status, etc. were asked to the participants.

Richmond Humor Assessment Instrument (RHAI): "It is a 5-point Likert scale consisting of 16 self-report items. It was designed to be a self-report measure of an individual's use of humour in communication. The score should be between 16 and 80. Scores of 60 and above indicate high degrees of humour usage; scores of 30 and below indicate low of humour usage; scores between 30 and 60 indicate moderate degrees of humour usage. Alpha reliability estimates for this measure have been near .90" (Richmond, (2013).

Strength and Difficulty Questionnaire (SDQ): "It is used for screening the child and adolescent emotional and behavioural problems and contains 25 questions that consists 5 subscales including emotional problem, hyperactivity, peer problem, conduct problems, and

prosocial behaviours with 5 items in each. The sum of the first four subscales consists of the total difficulty score. The questionnaire has three forms: parent report, teacher report, and self-report" (Goodman, Meltzer and Bailey, 1998). For the present study, the self-report version of the questionnaire was used.

Interaction Anxiousness Scale (IAS): A self-report inventory with a paper-and-pencil format. It consists of 15 items. The IAS is composed of items describing subjective responses of anxiety a higher score indicates a higher tendency to experience subjective anxiety in social situations. "Psychometric data show the scale to possess high internal consistency and test-retest reliability, as well as strong evidence of construct and criterion validity" (Leary 1983).

Rosenberg Self-esteem Scale: "It is a 10-item scale that measures global self-worth by measuring both positive and negative feelings about the self. All items are answered using a 4-point Likert scale ranging from strongly agree to strongly disagree" (Rosenberg, 1965).

General Self Efficacy Scale: This scale measures e general sense of perceived self-efficacy along with predicting coping with day to day problems as well as adapting after facing various types of stressful situations. Self-efficacy is considered a positive resistance resource factor. In this scale, 10 items are included to analyse this construct of self-efficacy. The Cronbach's alpha ranged from point 0.76 to 0.90. The scores were calculated by totalling the scores of all the 10 items which range from 10 to 40 (Schwarzer and Jerusalem, 1995).

Academic Expectation Stress Inventory: It is a self-report questionnaire designed for students. This Scale measures the stress of students regarding their academics. The scale contains 9 items. The Cronbach's alpha of 9 items score was 0.89. The internal consistency of expectations of parents/teachers (5 items, alpha = 0.85) and internal consistency of expectations of self (4 items, alpha = 0.84). For the scoring purpose, the responses were taken on the five-point scale. Scoring was done by summing up scores of all the items. There was no reverse scoring (Ang and Huan, 2006).

Samples were selected voluntarily and the data was analysed with SPSS 23.0 for Windows.

RESULTS

Socio-demographic Profile

The study was conducted on 194 adolescent residing in and around Guwahati city. In the study, there were an equal number of male and female respondents, studying in standard 9^{th} (44.3%), followed by standard 10^{th} (25.3%), standard 12^{th} (15.5%), standard 8^{th} (13.4%) and standard 11^{th} (1.5%). Majority of respondents were Hindu (85.6%), with non-tribal ethnicity (49.5%), followed by tribal ethnicity (8.8%), hailing from the urban sector (88.7%) with a nuclear family type (82.5%). The mean age of the respondents was 14.94 and the standard deviation was 1.205.

Humour and Psychological Adjustment

Table no. 1 reflects that majority of school-going of adolescent were having moderate (84.5%) and high (15.5%) level of humour. In the domain of SDQ it was seen that majority of adolescent were in abnormal range in total difficulty score (35.6%), and experienced conduct problems (34.0%), followed by peer problems (29.9%), hyperactivity problems (23.2%), emotional problems (21.1%) and prosocial behaviour (6.2%). The table also reveals the mean and standard deviation of self-esteem (mean=18.02, standard deviation=2.83), self-efficacy (mean=28.66, standard deviation=5.37), anxious (mean=38.4, standard deviation=7.75), academic stress (mean =31.3, standard deviation=7.00).

Table 1: Humour and Psychological Adjustment among School Going Adolescents (N=194)

Variables		Frequency	Percentage (%)	
Humour	Moderate	164	84.5	
	High	30	15.5	
-		**Mean**	**Standard Deviation**	
Self-esteem		18.02	2.83	
Self-efficacy		28.66	5.37	
Interaction Anxiousness		38.4	7.75	
Academic stress		31.1	7.00	
Strength and Difficulty Questionnaire	**Domains**	**Normal N (%)**	**Borderline N (%)**	**Abnormal N (%)**
	Emotional Problems	133 (68.6%)	20 (10.3%)	41 (21.1%)
	Conduct Problems	91 (46.9%)	37 (19.1%)	66 (34.0%)
	Hyperactivity Problem	104 (53.6%)	45 (23.2%)	45 (23.2%)
	Peer Problem	49 (25.3%)	87 (44.8%)	58 (29.9%)
	Total Difficulty Score	61 (31.4%)	64 (33.0)	69 (35.6%)
	Pro-social Behaviour	160 (82.5%)	22 (11.3%)	12 (6.2%)

SDQ=Strength and Difficulty Questionnaire

Correlations

Table 2: Correlation between Humour and Domains of Strength and Difficulties Questionnaire (N=194)

Variables	Conduct	Hyperactivity	Emotional problems	Peer problems	Pro-social behaviour	Total difficulty score
Humour	0.106	0.108	-0.164*	0.010	0.214**	0.000**

*p<.05; **p<.01

Above table (2) shows that the humour has significant negative correlation with the emotional problems (r= -0.164, p<0.05) and significant positive correlation with pro-social behaviour (r=0.214; p<0.01) and total difficulty score (r=0.000, p<0.01). Humour has a positive correlation with conduct disorder (r=0.106), hyperactivity (r=0.108), and peer problems (r=0.010).

Table 3: Correlation of Humour, Self-efficacy, Anxiety and Academic Stress (N=194)

Variables	Self-esteem	Self-efficacy	Interaction Anxious	Academic stress
Humour	0 .015	0.184*	-0.043	0.004

*p<.05

The above table (3) shows that humour has a significant positive correlation with self-efficacy (r= 0.184; p<0.05) and positive correlation with self-esteem (r= 0.015) and academic stress (r=0.004), and negative correlation was found with interaction anxiousness (r=-0.043).

Regression Analysis

Table 4: Regression analysis of SDQ Domains and Humour

Multiple R	R square	Adjusted R square	Std. Error of the Estimate
.319	.108	.065	6.465

ANOVA Table

	df	Sum of square	Mean of square	F	Significant
Regression	9	933.035	103.671	2.408	.001
Residual	184	7691.872	41.804		

Variables in the equation

Variables	B	Std Error	Beta	t	Significance
Emotional problems	-0.575	0.244	-0.212	-2.353	0.020
Conduct problems	0.447	.261	0.135	1.716	0.004**
Hyperactivity problems	0.361	0.325	0.087	1.111	0.268
Peer problems	-0.255	0.313	-0.061	-0.814	0.417
Pro-social behaviour	0.661	0.277	0.179	2.388	0.018**
Total difficulty score	0.024	0.105	0.019	0.233	0.816
Self-efficacy	0.089	0.096	0.072	0.927	0.355
Self-esteem	0.069	0.171	0.029	0.402	0.688
Academic Stress	0.023	0.071	0.024	0.318	0.751
Interaction Anxiousness	0.033	0.071	0.038	0.469	0.640
Constant	43.189	5.143	-	8.398	.000

As shown in Table (4) conduct problems (Beta=0.135, t=1.716, p=0.001) and pro-social behaviour (Beta=0.179, t=2.388, p=0.001) contribute significantly to the prediction of humour among adolescents [F (5,188) =4.426, p=0.001]; though, accounting only for 1.08% variance. Remaining 98.9% was attributed to variable not included in the study.

DISCUSSION

Humour has manifold influence on overall well-being of an individual (Berk, 1994; Elliot, 2013). It has been observed that humour can be positive factor of forming strong therapeutic alliances in the society (Bachelor, 1995; Beck et al., 2006; Gelkopf et al., 1994).

In the present study it is seen that humour is negatively correlated with emotional problems, which means if the level of humour is high, there is a decrease in emotional problems. A similar finding was noted in other studies, where it was highlighted that humour helps in getting rid of emotional problems like tension, alteration in self-image, aggression (Galloway, Cropley and Cropley, 2001; Mathews, 2016). Mathews (2016) explained, "Deficits in emotion regulation skills, including coping deficits lead to difficulties in the monitoring, evaluation, and modification of emotional reactions that may foil the success of one's goals. Here, humour can be used as an important emotional regulation skill in distancing oneself

from an emotional situation and facilitate the acceptance of negative emotions that cannot be immediately modified. Thus, humour may serve both as a means of initially minimizing aversive situations as well as coping with consequences of the event". Moreover, in the present study, humour was positively correlated with prosocial behaviour. Falanga, De Caroli and Sagone, (2014) also commented that the adolescents expressed prosocial behaviours, with the help of humour in emotionally critical and dire situations, and develops a good interpersonal relationship with others. Bergin, Talley and Hamer (2003) in their study found that adolescent who often uses humour are pro-social in nature and help others in dire situation encourages others and facilitates emotional regulations.

A study by Vaughan, Zeigler-Hill and Arnau (2014) shown that, "Individuals with stable high self-esteem reported the highest levels of affiliative humour as well as the lowest levels of aggressive and self-defeating humour. The study concluded that individuals with stable and unstable forms of self-esteem employ different styles of humour", which was concerning the present study. Fox, Hunter and Jones (2016) seen associations between psychosocial adjustment and humour styles and found that, "Self-defeating humour was associated with an increase in both depressive symptoms and loneliness, and with a decrease in self-esteem. In addition, depressive symptoms predicted an increase in the use of self-defeating humour over time, indicating that these may represent a problematic spiral of thoughts and behaviour. Self-esteem was associated with an increase in the use of affiliative humour over the school year but not vice-versa". A study by Falanga, De Caroli and Sagone (2014) showed that humour is positively correlated with self-efficacy. The study highlighted that adolescents cope up positively with emotionally critical and dire situations with affiliative humour, which was in line with the present study.

Studies have shown that humour can be an important tool in dealing with depression, anxiety and stress. It is seen that depression can be reduced by participating in different humour interventions. Humour also found to be an effective strategy in dealing with clinical anxiety and is associated with positive well-being (Tagalidou, Distlberger, Loderer and Laireiter, 2019). Studies have shown that humour may enhance immune functioning, helps in stress reduction, facilitates tension relief, promote better general health and may allow patients to open to new interpretations of events, which can lower down their depressive symptom (Bokarius et al., 2011; Adams and McGuire, 1986). Freiheit, Overholser, and Lehnert (1998) have stated that humour may be an important coping skill for dealing with emotional difficulties during adolescence.

Studies have discussed the relationship between humour and academic stress. In the present study, humour was negatively correlated with academic stress. Similar studies have shown that students who had more affiliative humour and self-enhancing humour were high achievers whereas students with more aggressive humour and self-defensive humour were low achievers (Berk, 1996; Liu, Katy, 2012).

These results inform our understanding of the ways in which humour is associated with psychosocial adjustment in adolescence. Humour accelerates social bonding and positively effects interpersonal relationships (Garrick, 2006; Wanzer, Booth-Butterfield, and Booth-Butterfield, 1996). Wanzer et al., (1996) found that individual with a higher level of humour exhibited less loneliness and found to be more socially accepted resulting in an increased sense of inclusivity. In a study by Erickson and Feldstein (2007) found that, "On adolescent humour and its relationship to coping, defence strategies, psychological distress, and well-being found that humour was demonstrated by its unique contribution in predicting both depressive symptoms and adjustment above and beyond contributions from coping and

defence composites". Crawford and Caltabiano (2011) concluded that humour aids in the development of healthy coping strategies and emotional well-being. Study commented that using humour focussed program would enhance increase the levels "positive affect, optimism, self-efficacy and perceptions of control" and will lower perceived stress, depression, negative affect, stress, and anxiety.

Implication and future direction

- Humour based intervention can be planned to combat distress among adolescents. Mental health professionals in dealing with adolescent mental health can use this kind of intervention in their future researches. As research on humorous intervention is scare, future studies may assess its efficacy.
- Experimental, longitudinal, and qualitative research designs are recommended for future research in the field enable a better understanding of how contextual factors interact with humour styles and psychological health.

Limitation

- Small sample size.
- Self-reported measure for humour styles and psychosocial adjustment, which raises the possibility that associations were biased by shared method variance. For future study gathering data from different sources, such as peers, teachers or parents will be useful.
- The study is purely quantitative in nature; however, an in-depth understanding of the lived experiences of the participants using qualitative approach would have given a broader perspective.

CONCLUSION

In the present study it was found that if level of humour is high, there is a decrease in emotional problems and increase in pro social behaviour. Adolescents often use humour in order to come out from stressful and dire situation. The present study found that individual's self-esteem employed different styles of humour. The study also talked about relationship between humour and academic stress, as adolescents who had more affiliative humour and self-enhancing humour were high achievers whereas adolescent with more aggressive humour and self-defensive humour were low achievers. Humour plays an important role in initiating and enhancing communication in adolescents with difficult temperament. Thus, use of humour creates a positive environment and helps in emotion regulation for a better well-being.

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REFERENCE

Adams, E. R., and McGuire, F. A. (1986). Is laughter the best medicine? A study of the effects of humor on perceived pain and effect of humor on perceived pain and affect. *Activities, Adaptation and Aging*, *8*(3-4), 157-175.

Bachelor, A. (1995). Clients' perception of the therapeutic alliance: A qualitative analysis. Journal of Counseling Psychology, 42(3), 323-327.

Barrera, M., and Garrison-Jones, C. V. (1988). Properties of the Beck Depression Inventory as a screening instrument for adolescent depression. *Journal of abnormal child psychology*, *16*(3), 263-273.

Beck, A. T., Epstein, N., Brown, G., and Steer, R. A. (1988). An inventory for measuring clinical anxiety: psychometric properties. *Journal of consulting and clinical psychology*, *56*(6), 893.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., and Erbaugh, J. (1961) An inventory for measuring depression. *Archives of General Psychiatry,* 4, 561-571.

Beck, M., Friedlander, M. L., and Escudero, V. (2006). Three perspectives on clients' experiences of the therapeutic alliance: a discovery-oriented investigation. Journal of Marital and Family Therapy, 32(3), 355-368.

Bergin, C., Talley, S., and Hamer, L. (2003). Prosocial behaviours of young adolescents: a focus group study. *Journal of adolescence*, *26*(1), 13-32.

Berk, L. S. (1994). New discoveries in psychoneuroimmunology. Humor and Health Letter, 3(6), 1-8.

Berk, R. A. (1996). Student ratings of 10 strategies for using humor in college teaching. *Journal on Excellence in College Teaching*, *7*(3), 71-92.

Bokarius, A., Ha, K., Poland, R., Bokarius, V., Rapaport, M. H., and IsHak, W. W. (2011). Attitude toward humor in patients experiencing depressive symptoms. *Innovations in clinical neuroscience*, *8*(9), 20.

Chan, Y. C., Chou, T. L., Chen, H. C., Liang, K. C., 2012. Segregating the comprehension and elaboration processing of verbal jokes: an fMRI study. Neuro Image 61, 899–906.

Chen, S. T., and Martin, R. A. (2007). A comparison of humor styles, coping humor and mental health between Chinese and Canadian university students. HUMOR: International Journal of Humor Research, 20, 215–234.

Conway, J. M., and Lance, C. E. (2010). What reviewers should expect from authors regarding common method bias in organizational research. Journal of Business and Psychology, 25, 325–334.

Dyck, K. T. H., and Holtzman, S. (2013). Understanding humor styles and well-being: The importance of social relationships and gender. Personality and Individual Differences, 55, 53–58.

Elliot, M. L. (2013).Finding the fun in daily occupation: An investigation of humor. Occupational Therapy in Mental Health, 29(3), 201-214.

Erickson S. J., Feldstein S. W. (2007). Adolescent humor and its relationships to coping, defense strategies, psychological distress and well-being. Child Psychiatry and Human Development, 37, 255–271. 10.1007/s10578-006-0034-5

Erickson, S. J., and Feldstein, S. W. (2007). Adolescent humor and its relationship to coping, defence strategies, psychological distress, and well-being. *Child psychiatry and human development*, *37*(3), 255.

Falanga, R., De Caroli, M. E., and Sagone, E. (2014). Humor styles, self-efficacy and prosocial tendencies in middle adolescents. *Procedia-Social and Behavioral Sciences*, *127*, 214-218.

Falkenberg, I., Buchkremer, G., Bartels, M., and Wild, B. (2011). Implementation of a manual-based training of humor abilities in patients with depression: A pilot study. *Psychiatry Research*, *186*(2-3), 454-457.

Fox, C. L., Dean, S., and Lyford, K. (2013). Development of a humor styles questionnaire for children and young people. Humor: International Journal of Humor Research, 26, 295–319.

Fox, C. L., Hunter, S. C., and Jones, S. E. (2015). Reciprocity between humor styles and psychosocial adjustment in children. Unpublished manuscript.

Fox, C. L., Hunter, S. C., and Jones, S. E. (2016). Longitudinal Associations Between Humor Styles and Psychosocial Adjustment in adolescence. *Europe's Journal of Psychology*, *12*(3), 377–389.

Freiheit, S. R., Overholser, J. C., and Lehnert, K. L. (1998). The association between humor and depression in adolescent psychiatric inpatients and high school students. *Journal of Adolescent Research*, *13*(1), 32-48.

Führ, M. (2002). Coping humor in early adolescence. Humor: International Journal of Humor Research, 15, 283–304. Galloway, G. (2010). Individual differences in personal humor styles: Identification of prominent patterns and their associates. Personality and Individual Differences, 48, 563–567.

Galloway, G., Cropley, A., and Cropley, A. J. (2001). Humour and mental health: implications for psychotherapy. *Journal of Baltic Psychology*, *2*, 5-14.

Gelkopf, M., Sigal, M., and Kramer, R. (1994). Therapeutic use of humor to improve social support in an institutionalized schizophrenic inpatient community. The Journal of Social Psychology, 134(2), 175-182.

Goodman, R., Meltzer, H., and Bailey, V. (1998). The Strengths and Difficulties Questionnaire: A pilot study on the validity of the self-report version. *European Child and Adolescent Psychiatry*, *7*(3), 125-130.

Groth-Marnat G. (1990). *The Handbook of Psychological Assessment* (2nd ed.). New York: John Wiley and Sons.

Gupta, A. K., Mongia, M., and Garg, A. K. (2017). A descriptive study of behavioral problems in school going children. *Industrial Psychiatry Journal*, *26*(1), 91–94.

Rotenberg, K. J., Boulton, M. J., and Fox, C. L. (2005). Cross-sectional and longitudinal relations among children's trust beliefs, psychological maladjustment and social relationships: are very high as well as very low trusting children at risk?. *Journal of Abnormal Child Psychology*, *33*(5), 595-610.

Kazarian, S. S., and Martin, R. A. (2004). Humor styles, personality and well-being among Lebanese university students. European Journal of Personality, 18, 209–219.

Kovacs, M., and Beck, A. T. (1977). An empirical clinical approach toward a definition of childhood depression. In J. G. Schulterbrandt, and A. Raskin (Eds.), Depression in childhood: Diagnosis, treatment and conceptual models. New York: Raven.

Kuiper, N. A., Grimshaw, M., Leite, C., and Kirsh, G. A. (2004). Humor is not always the best medicine: Specific components of sense of humor and psychological well-being. Humor: International Journal of Humor Research, 17, 135–168.

Kuiper, N., Kirsh, G., and Leite, C. (2010). Reactions to humorous comments and implicit theories of humor styles. Europe's Journal of Psychology, 6, 149–173.

Leary, M. R., and Kowalski, R. M. (1993). The interaction anxiousness scale: Construct and criterion-related validity. *Journal of Personality Assessment*, *61*(1), 136-146.

Leist, A. K., and Müller, D. (2013). Humor types show different patterns of self-regulation, self-esteem and well-being. Journal of Happiness Studies, 14, 551–569

Liu, Katy W.Y. (2012). Humor Styles, Self-Esteem and Subjective Happiness. Discovery SS Student EJournal 1, (21) 21-41

Martin, R. A. (2007). The psychology of humor: An integrative approach. Burlington, MA: Elsevier Academic Press.

Martin, R. A., Puhlik-Doris, P., Larsen, G., Gray, J., and Weir, K. (2003). Individual differences in use of humor and their relation to psychological well-being: Development of the humor styles questionnaire. Journal of Research in Personality, 37, 48–75.

Mathews, L. (2016). Role of Humor in Emotion Regulation: Differential Effects of Adaptive and Maladaptive Forms of Humor.

Nair, S., Ganjiwale, J., Kharod, N., Varma, J., and Nimbalkar, S. M. (2017). Epidemiological survey of mental health in adolescent school children of Gujarat, India. *BMJ Paediatrics Open*, *1*(1).

Richmond, V. P. (2013). Richmond Humour Assessment Instrument (RHAI). Measurement Instrument Database for the Social Science. Retrieved from www.midss.ie

Rosenberg, M. (1965). Society and the adolescent self-image. Princeton: NJ: Princeton University Press. Rotenberg,

Rosenberg, M. (1965). Rosenberg self-esteem scale (RSE). *Acceptance and commitment therapy. Measures package*, *61*, 52.

Russell, D. W. (1996). UCLA Loneliness Scale (Version 3): Reliability, validity, and factor structure. *Journal of Personality Assessment*, *66*(1), 20-40.

Tagalidou, N., Distlberger, E., Loderer, V., and Laireiter, A. R. (2019). Efficacy and feasibility of a humor training for people suffering from depression, anxiety, and adjustment disorder: a randomized controlled trial. *BMC Psychiatry*, *19*(1), 93.

Vaughan, J., Zeigler-Hill, V., and Arnau, R. C. (2014). Self-esteem instability and humor styles: Does the stability of self-esteem influence how people use humor?. *The Journal of Social Psychology*, *154*(4), 299-310

Zand, J., Spreen, A., and Lavalle, J. B. (1999). Smart medicine for healthier living: A practical a-to-z reference to natural and conventional treatments for adults. Garden City Park, New York: Avery Pub Group.

Ziv, A. (1988). Teaching and learning with humor: Experiment and replication. *The Journal of Experimental Education*, *57*(1), 4-15.

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Research Paper

Quality of Life and Life Satisfaction among Persons with Alcohol DependenceSyndrome

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ABSTRACT

Background: Quality of life plays a vital role to improve the life satisfaction of an individual. The increase in quality of life is related to the increase of subjective life satisfaction. There is an existing relationship between quality of life and life satisfaction for persons with alcohol dependence (Frisch et al., 2000). **Aim:** The aims of the present study was to assess and examine the relationship between Quality of life and life satisfaction among persons with alcohol dependence. **Methodology:** A total number 30 respondents with alcohol dependence syndrome were taken by using a purposive sampling technique. The samples were collected from MHI (COE), SCBMCH, Cuttack IPD and OPD. The scales such as WHOQOL-BREF questionnaire and Life Satisfaction were administered. **Result:** In this present study it was found that the persons with alcohol dependence scored the poor quality of life in all domains of WHO QOL, as well as life satisfaction scale and also statistically positive significant co-relationbetween quality of life and life satisfaction among persons with alcoholdependence.

Keywords: Quality of life, life satisfaction, alcohol dependencesyndrome

INTRODUCTION

Quality of life plays an important role to enhance the life satisfaction of the individual. The increase in quality of life is related to the increase of subjective life satisfaction. There is an existing relationship between Quality of Life and Life Satisfaction for persons with alcohol dependence (Frisch et al., 2000). Quality of life is an important parameter that providesaninsight into how a disorder influences the life of those affected. World Health Organization defined quality of life as "an individual's perception of their position in life and in the context of culture and value systems in which they live and also to their goals, expectations, standards, and concerns." Among various psychiatric disorders,alcohol-related disorders drastically affect Quality of Life, but this area has not been expansively studied (Srivastava et al., 2013). Quality of life refers to the psychological well-being, social and emotional functioning, functional performance and social support whereas life satisfaction denotes the subjective satisfaction of a person towards his health, personal, economic, marital, social and occupational aspects of life (Kaushik et al.,2014).

Satisfaction is in general considered as the reflectionof broader aspirations, achievements, and perceived reality in comparison to peers and societal norms. “Life satisfaction is a subjective quality-of-life index that reflects the extent to which individuals find aspects of their lives to be satisfying or fulfilling. It can be assessed globally or divided into various domains, including satisfaction with self, job, family, school, relationships, leisure, and so forth” (Fischer et al.,2015).

Dependence syndrome is a “cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A vital descriptive characteristic of the dependence is the desire (often strong, sometimes overpowering) to

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take psychoactive drugs (which may or may not have been medically prescribed), alcohol, or tobacco. There may be evidence that return to substance use after a period of abstinence leads to a more hasty reappearance of other features of the syndrome than occurs with nondependent individuals" (W.H.O., 1992).

Alcohol Dependence and Quality of Life

A study to assess the quality of life of 100 clients with alcohol dependence either attendingorattending alcoholic anonymous group meeting (equal number) by using WHOQOL-BREF scale from rural areas form Mysorefound that alcohol dependency deteriorates the QOL among dependent clients(Srivastava et al., 2013).Srivastava et al., (2013) has studied quality of life of 56 patients as an outcome measure in the treatment of alcohol dependence. QOL was assessed using WHOQOL-BREF and the study confirms the poor quality of life in patients with alcohol dependence.Shareef et al., (2013) has studied on the burden of care and quality of life (QOL) in opioid and alcohol-abusing, it was a cross-sectional hospital-based study where the sample consisted of 37 patients. The result shows poor QOL.

Life satisfaction and Alcohol Dependence

Fergusson et al. (2015) has studied life satisfaction and mental health problems. The purpose was to examine the associations between mental health problems and life satisfaction in a birth cohort studied from 18 to 35 years. The sample size was 1265. The study found significant associations between life satisfaction and the psychiatric disorders major depression, anxiety disorder, suicidality, alcohol dependence and substancedependence.Murphy et al., (2005) have studied the impact of alcohol use and alcohol-related problems on several domains of life satisfaction with a sample of 353 college students. The study revealed that alcohol use was associated with lower general satisfaction among adolescents' alcohol dependants.Clifford et al, (1991) have studied the relationship between drug use and life satisfaction among college student, using the modified versions of the National Institute on Drug Abuse (NIDA) Monitoring the Future Survey and it was administered to 683 students. The study examined the impact of alcohol consumption on LS with college students found that increased alcohol use causes decreased life satisfaction.

METHODS AND MATERIALS

Aim: The aims of the present study is to asses and examine the relationship between Quality of life and life satisfaction among persons with alcoholdependence.

Hypothesis: There isno relationship between quality of life and life satisfaction among persons with alcoholdependence

Research Design: This study was a cross-sectional, hospital-based, time-bound study.

Sample: A total number of 30 patients being diagnosed as a mental and behavioural disorder due to use of Alcohol (dependence) as per ICD-10 were selected from the OPD and IPD, of M.H.I., C.O.E., SCBMCH, Cuttack, Odisha.

Inclusion criteria for the persons with Alcohol dependence: Male patients diagnosed with mental and behavioural disorder due to use of alcohol (dependence) as per the ICD-10at least 2yearshistory of illness.The persons should have studied minimum 5thstandard between 20 to 50years of age and given consent for being part of thestudy

Exclusion criteria for the persons with Alcohol Dependence: History of any chronic physical illnesses, organic brain syndromes and co-morbid psychiatric illness or mentalretardation.

Tools used:

1. **Socio-demographic datasheet:** All clinical details will be made for the study & obtained from patients, caregivers, or case record file, with the help of structuredforms.
2. **WHOQOL-BREF:** World Health Organization Quality of Life Short Form (WHO, 1996) is a 26-items questionnaire which is formulated to measure the quality of life in physical health (7 items), psychological health (6 items), social relationships (3 items), and environmental health (8 items). The four domain scores denote an individual's perception of the quality of life in each particular domain. Domain scores were scaled in a positive direction (i.e. higher score denote the higher quality of life). In this scale, the validity coefficient for physical health, psychological health, social relationships and environmental health was equal to 0.70, 0.73, 0.55 and 0.84 respectively and Cronbach's Alpha 0.70 viatest-retest.
3. **Life Satisfaction Scale:** This was developed by Q.G.Alam and Ramji Shrivastava in the year 1971. It has 5 domains like Health, Personal, Economic, Marital and Job. In scoring the scale has 60 items. Every item was responded either in yes or no. There was no other alternative. Every 'yes' response was assigned 1 mark. The sum of marks is obtained for the entire scale and the interpretation was done in a 3 point scale i.e. High, Average and Low, where higher score shows higher satisfaction. Reliability score was 0.84 and this scale had face validity and content validity were 0.74 and 0.82respectively.

Procedure: Those patients who fulfilled the inclusion and exclusion criteria for the study they were included in the study process. The researcherswerer elaborate in detail about the purpose of the study to the respondent. After that informed consent was taken from the participant and subsequently socio-demographic and clinical details were collected from the participant. After that WHOQOL-BREF and Life Satisfaction Scales was administered on theparticipant.After completion of data, collection data were coded and decoded and data analysis was done by using Statistical Package for Social Sciences (SPSS) version 16.0.

RESULTS

Table 1 shows that the mean age of the persons with alcohol dependence was 35.3 ± 7.07 years. The majority of the respondent belongs to the Hindu religion i.e. 80% whereas, 20% belong to other religion. The majority of respondents were above metric i.e. 43.33% whereas 30% had acquired education up to matriculation whereas 26.67% had studied under matriculation. The majority of participants were married i.e. 60 % whereas 16.67% were unmarried and 23.33% were separated. The majority of the study population belongs to a nuclear family i.e. 46.67 % whereas, 33.33% belongs to extended family and only 20% belong to Joint family. The majority of respondents belong to rural area i.e. 40 % whereas, 36.67% belonged to semi-urban and the rest 23.33 % were from the urban area. The majority of participants were self-employed i.e. 50% whereas 26.67% were daily wage earners and 23.33% were service holders. The majority i.e. 50% were earning above Rs. 30000 per month, 26.7 % of respondents monthly earning were between 5000-15000 and 23.33% were earning between 16000-30000.

Table 2 shows that the persons with alcohol dependence were scored (48.93 ± 6.5) in Physical health domain, (42.2 ± 8.66) in Psychological wellbeing domain, (37.9 ± 9.23) Social relationship domain and (45.16 ± 8.03) in Environmental domain. The table also reveals that the persons with alcohol dependence were scored (38.78±3.78) in Life satisfactionscale.

Table. 1Socio-demographic Profile(N=30)

Variable		M±SD *f*(%)
Age		35.3 ± 7.07
Religion	Hindu	24(80)
	Others	6(20)
Education	Under Matric	8(26.67)
	Matriculate	9(30)
	Above Matric	13(43.33)
Marital status	Married	18(60)
	Unmarried	5(16.67)
	Separated	7(23.33)
Typeof family	Nuclear	14(46.67)
	Joint	6(20)
	Extended	10(33.33)
Domicile	Rural	12(40)
	Semi-urban	11(36.67)
	Urban	7(23.33)
Occupation	Daily wage earner	8(26.67)
	Service	7(23.33)
	Self-employed	15(50)
Monthly income	5000-15000	7(23.33)
	16000-30000	8(26.67)
	Above30000	15(50)

Table2QOL and life satisfaction among persons with Alcohol dependence(N=30)

Variables	M ± SD
Physical health	48.93 ± 6.5
Psychological wellbeing	42.2 ± 8.66
Social relationship	37.9 ± 9.23
Environmental	45.16 ± 8.03
Life Satisfaction	38.78 ± 3.78

Table.3: Co-relation between QOL & Life Satisfaction among the person with alcohol dependence

Scale	Physical health	Psychological Wellbeing	Social relationship	Environ mental
Life Satisfaction	.514 **	.541 **	.402*	.475**

**. significant at the 0.01 level (2-tailed).*. significant at the 0.05 level (2-tailed).

Table 3 shows a significant correlation between life satisfaction and all the domains of WHOQOL-BREF among persons with alcohol dependence. The table shows significant co-relation with sub-domains i.e. Physical health (P=.514 P>0.01), Psychological wellbeing (P=.541 P>0.01), Social relationship (P=.402 P>0.05), with Environmental domain (P=.475 P>0.01) of WHOQOL-BREF scale.

DISCUSSION

*Socio-demographic Variables:*In the present study it was found that the majority (80%) of the respondent belongs to the Hindu religion whereas, nearly half (43.33%) of the respondents were above metric. More than half (60%) of participants were married. The majority of the study population belongs to a nuclear family i.e. 46.67 %. Half (40%) of respondents belong to rural area and were self-employed. Half (50%) of the respondents were earning above Rs. 30000 per month. Similar study findings were reported by Srivastava et al., (2013) they reported that the mean age of the sample was (M±SD 35.94 ±7.32) years. The mean year of education was (M±SD 8.17 ±5.13). The majority were married (89.8%). The regular duration of treatment was (M±SD 12.85 ±8.13). Majority of patients had a monthly income of Rs. 5,000 or below (41%), followed by those between Rs. 5000 to Rs. 10,000 (28.6%) and above Rs. 10.000 (30.4%). In this present study as the researcher has only included the male gender and excluded the female. These limitations can be explained based on the socio-cultural diversity of the universe as well as most of the time due to the cultural belief the females are under-reported. Alcohol dependence is more common in males and has an onset in the late second or early third decade. The course is usually insidious. There is often an associated abuse or dependence of other drugs if the onset occurs late in life, especially after 40 years of age (Ahuja,2006).

*The correlation between QOL & Life Satisfaction among the persons with Alcohol dependence:*Present study revealed that there was a significant positive correlation between the total score of Life Satisfaction Score (LSS) with all domains of Quality of Life (QOL). Persons with alcohol dependence scored (P=.514, P<0.01) in physical health domain of QOL, psychological wellbeing domain (P=.541, P<0.01), social relationship (P=.402, P<0.05), environmental domain (P=.475, P<0.01) and total score of QOL (P=.855, P<0.01) respectively. Similar study findings by Srivastava et al., (2013) concluded poor quality of life in patients of alcohol dependence. Swain et al., (2012) the study reported that there were significant associations between alcohol abuse/dependence and life satisfaction. Murphy et al., (2005) revealed that alcohol use was associated with lower general satisfaction and anticipated future satisfaction among adolescents. Clifford et al, (1991) reported that illicit drug use and LS and the study concluded with an increased alcohol causes decreased lifesatisfaction.

CONCLUSION

In this present study the researcher found that in all the domain of quality of life scale the person with alcohol dependence scored the poorer quality of life, the inverse relationship seems much more silent in the domains of subjective health and wellbeing rather than behavioural dysfunction. Although the relationship between alcohol intake pattern and mental health isn't to study, the findings suggested that the people who are taking the substance for a longer period might be a possible target group to intervene and help them to improve their quality of life. Further clarification of the complex relationship between quality of life and life satisfaction of alcohol dependence person is needed to be studied more inclusively particularly in the mental health domain. It was also found that life satisfaction is positively correlated with all the domains of Quality of lifescale.

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REFERENCES

Alam, O.G. and Srivastava, R. (1971). A manual for Life Satisfaction Scale (L-S Scale). National Psychological Corporation Kacheri Ghat, AGRA (UP).

Clifford, P. R., Edmundson, E. W., Koch, W. R., & Dodd, B. G. (1991). Drug use and life satisfaction among college students. International Journal of the Addictions, 26(1), 45-53. Cloninger, C. R., Sigvardsson, S., & Bohman, M. (1996). Type I and type II alcoholism: An update. *Alcohol Health & Research World*, 20(1), 18-23.

Fergusson, D. M., McLeod, G. F. H., Horwood, L. J., Swain, N. R., Chapple, S., & Poulton,R. (2015). Life satisfaction and mental health problems (18 to 35 years). *Psychological Medicine*, 45(11),2427-2436.

Fischer, J. A., Clavarino, A. M., Plotnikova, M., & Najman, J. M. (2015). Cannabis use and quality of life of adolescents and young adults: Findings from an Australian birth cohort. *Journal of Psychoactive Drugs*, 47(2), 107-116.

Frisch, M. B. (2000). Improving mental and physical health care through quality of life therapy and assessment. In Advances in quality of life theory and research (pp. 207-241). Springer, Dordrecht.

Kaushik, S. B., Cerci, F. B., Miracle, J., Pokharel, A., Chen, S. C., Chan, Y. H., & Yosipovitch, G. (2014). Chronic pruritus in HIV-positive patients in the Southeastern United States: its prevalence and effect on quality of life. *Journal of the American Academy of Dermatology*, 70(4), 659-664.

Saraswathi, K. N., & Williams, S. (2014). A Study to Assess the Quality of life of clients with Alcohol dependence syndrome attending and not attending Alcoholic Anonymous group meeting in selected Alcoholic Anonymous group and in rural areas of Mysore and with a view to develop self instructional module. *Asian Journal of Nursing Education and Research*, 4(3), 298-303.

Shareef, N., Srivastava, M., & Tiwari, R. (2013). Burden of care and quality of life (QOL) in opioid and alcohol abusing subjects. *International Journal of Medical Science and Public Health*, 2(4), 880-885.

Srivastava, S., & Bhatia, M. S. (2013). Quality of life as an outcome measure in the treatment of alcohol dependence. *Industrial Psychiatry Journal*, 22(1), 41-46.

Whoqol Group. (1998). Development of the World Health Organization WHOQOL-BREF quality of life assessment. *Psychological Medicine*, 28(3), 551-558.

World Health Organization. (1992). The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization.

World Health Organization. (2004). The world health organization quality of life (WHO QOL)-BREF (No. WHO/HIS/HSI Rev. 2012.02). World Health Organization.

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Research Paper

Impact of Empowerment Intervention on Recovery and Symptoms Reduction in People with Schizophrenia

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ABSTRACT

Background: Around one percent population is affected with Schizophrenia which is a severe mental illness. Typically onset is in late adolescence and remains for a lifetime. **Objectives:** The current study examined the impact of Empowerment intervention in Schizophrenia. **Methods and Materials:** This was a quasi-experimental, hospital-based intervention study, used purposive sampling to select 15 patients diagnosed with schizophrenia and admitted in Central Institute of Psychiatry, Ranchi.. Recovery Assessment Scale (RAS), Positive and Negative Syndrome Scale (PANSS) were administered. The study group received 6 sessions of empowerment intervention over a period of one month. Pre-post measurements were taken. Data were analysed using SPSS. **Results:** Findings suggested significant improvement in personal confidence, willingness, goal, reliance, and positive and negative syndrome than treatment as usual over a period of one month therapy. **Conclusion:** Empowerment intervention found to be effective in the management of schizophrenia. Findings indicate viable resource and pathways for future development are suggested.

Keywords: Schizophrenia, empowerment intervention, recovery

INTRODUCTION

Schizophrenia imposes a significant disability on people with suffering from and very often unable to achieve life various goals (Corrigan, 2012). In about three-fourth of cases, the course of schizophrenia has various phases including a remission phase which with relapses and despite giving effective pharmacological treatments and psychosocial interventions, less than 15% recovery rate is found (Zipursky & Agid, 2015). In India, the prevalence of schizophrenia and other psychoses is about 0.64%and was nearly 2-3 times more in urban metros (NIMH, 2016). "It is more common in men, and in terms of age of onset, men tend to be younger by an average of about five years than women when they develop schizophrenia" (Leung & Chue, 2000).

The concept of empowerment as a process which accesses to information, knowledge and developed skills, the ability to make decisions, developed individual strength, participation in society and real control, hope, share decision making, community approaches and stigma. Empowerment intervention is a core component of the recovery framework, together with connectedness, hope and optimism about the future identity and meaning of life. The intervention has 2 levels- individual and connective level. During this intervention, person rediscovers his identity and self-esteem and 'takes his life in his own hands" at the individual' level. At the collective level, it is about the contribution of people with lived experience to the organization and practice of mental health care and society. The empowerment intervention and the activities embraces have been receiving growing attention in mental health care in several European countries in recent years. The literature shows that empowerment is an appropriate treatment goal for psychosis (Berry et al., 2014; Kurtz, 2015; Boevink et al., 2016).

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It has been found in previous studies that lack of awareness were major challenges for a patient with Schizophrenia to manage their psychiatric symptoms and preventing relapses. Empowerment intervention which aims to strengthen the individual's competence, natural helping systems and proactive behaviours found to be effective in promoting recovery and overcoming their illness-related disability (Zimmerman & Rappaport, 1988). However, there are only a few studies which have investigated the efficacy of such interventions to empower patients, improve their prognoses, and reduce the risk of relapse. Such areas have not been actively studied in India. The aim was to examine the efficacy of empowerment intervention in improving positive and negative symptoms of schizophrenia, empowerment and recovery in patients with schizophrenia. In the present study, outcome variables were positive and negative symptoms, empowerment, and recovery.

METHODS AND MATERIALS

The study was conducted at the in-patient unit of Central Institute of Psychiatry, Ranchi. It was a quasi-experimental hospital-based intervention study for which a purposive sampling technique was done based on certain inclusion and exclusion criteria. Inclusion criteria were meeting the criteria for Schizophrenia according to ICD-10, DCR, aged between 18 to 60 years, both male and female were included with their informed consent for the study. Exclusion criteria were patients having a history of Co-morbid psychiatric diagnosis, organic psychiatric diagnosis, substance dependence, chronic or significant general medical or neurological conditions, physical/sensory disability and patients who were under any psychological intervention. Fifteen participants were selected for the final analysis in the present study. Following tools were used for the study:

1. **Socio-demographic and Clinical Datasheet:** A semi-structured proforma, especially drafted which contained all the socio-demographic and clinical details of the participants relevant to the study.
2. **Empowerment Scale in patients with schizophrenia**: This scale includes "self-efficacy, external control, interpersonal communication skills, interpersonal assertiveness, social assertiveness, social-political resource, social-political power and social-political action domains" (Li, C.P., & Chiu. 2017).
3. **Recovery Assessment Scale**: It has 22 items which "measured life goal, coping ability, hope and knowledge of support systems" (Giffort, Schmook, Woody, Vollendorf, & Gervain. 1995).
4. **Positive and Negative Syndrome Scale (PANSS) for Schizophrenia**: **"**It consists of a semi-structured clinical interview and any available supporting clinical information from family members or hospital staff. It includes positive syndrome, negative syndrome and general psychopathology" (Kay et al. 1987).

INTERVENTION

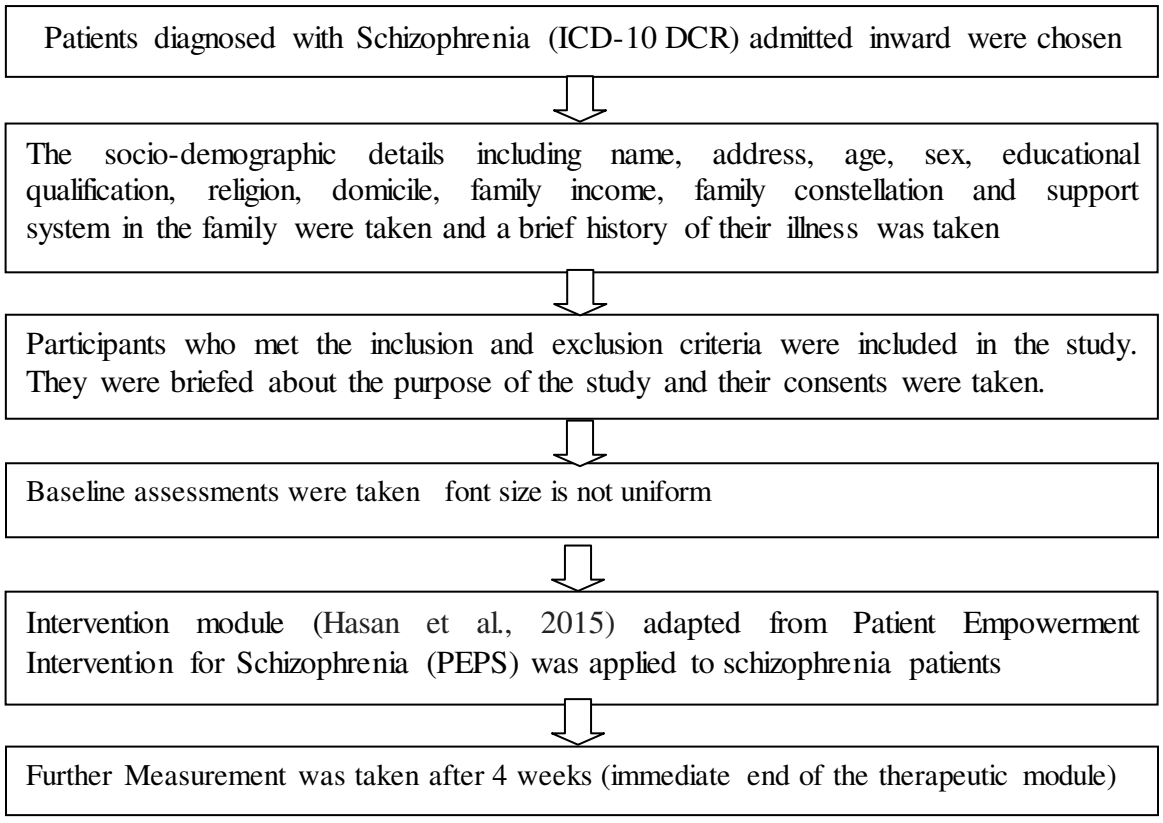
Session	Topic	Broad area
One	Nature and disease of schizophrenia; stigma	• Diagnosis of schizophrenia according to ICD- 10. • Truths and myths about schizophrenia. • Symptoms of schizophrenia • How to free oneself from stigma as schizophrenia.
Two	Weakness and strength of ability to pursue recovery	• Discussing obstacles to recovery in everyday life. • Finding individual strength to achieve recovery. • Searching for a helpful support system.

Three	Challenges to one's life and things to do with family members	• Plan a daily activity schedule for enhancing individual strengths. • Seeking support from family members. • Learning how to do housework. • Learning how to share experiences with family members.
Four	Enhancing communication skills and managing self care	• Practising verbal and nonverbal communication in a situation. • Maintaining general hygiene
Five	Drugs treatment to improve long term outcomes and improve drug adherence and prevent worsening of the illness	• Understanding the importance of continuing with one's medication. • Listing therapeutic effects and side effects of medication. • Learning medication adherence strategies. • Sharing experiences with different side effects of various antipsychotic drugs.
Six	Crisis management	• Understanding the risks and benefits of every medication. • Asking the help of family members and health providers. • Stress management skills and strategies. • Being aware of serious or life-threatening side effects. • Correcting problematic situations.

Adopted from: Park, S. A., & Sung, K. M. (2013).

Statistical Analysis: Data was analyzed using Statistical Packages for Social Sciences version 23.0 (SPSS 23.0). Paired sample t-test was used for pre-post measurement.

PROCEDURE



RESULTS

Table 1: Social Demographic Variables (N = 15)

VARIABLE	CATEGORY	*f*(%)
Sex	Male	8 (53.3)
	Female	7 (46.7)
Education	Up to 10th STD	4 (26.7)
	11th and 12th STD	6 (40)
	Graduation and above	5 (33.3)
Employment status	Employed	6 (40)
	Unemployed	9 (60)
Monthly income	<Rs 5000	4 (26.7)
	Rs. 5000–Rs. 20,000	7 (46.6)
	Rs>20,000	4 (26.7)
Socioeconomic status	Low	11 (73.4)
	Middle	3 (20)
	High	1 (6.6)
Family type	Joint	2 (13.4)
	Nuclear	13 (86.6)
Domicile	Rural	9 (60)
	Urban	6 (40)
Religion	Hindu	13 (86.6)
	Other	2 (13.4)
Caste	General	3 (20)
	OBC	6 (40)
	SC/ST	6 (40)
Marital status	Unmarried	7 (46.7)
	Married	8 (53.3)
Family mental illness	Present	3 (20)
	Absent	12 (80)

In the study group, 53.3% were male and 46.7% were female, 53.3% were married, educated up to 10th STD. Majority of patients belongs from the Hindu religion (86.6%) came from a rural background and nuclear family (86.6%).

Table 2: Paired Sample t-test (N=15)

Psychopathology		Pre Mean ± SD	Post Mean ± SD	t (df=14)	P
Empowerment	Self-Efficacy	19.40±1.72	23.00±2.07	-7.901	.000**
	External control	11.33±1.11	14.25±.70	-11.000	.000**
	Interpersonal communication skills	7.53±.63	8.80±.41	-6.141	.000**
	Social assertiveness	7.26±.70	8.66±.48	-6.548	.000**
	Social political	11.86±.99	14.26±1.03	-7.483	.000**
Recovery	Willingness	7.00±2.50	13.20±1.37	-9.898	.000**
	Personal confidence	18.13±3.88	29.80±3.32	-11.364	.000**
	Goal	14.00±3.35	22.20±2.80	-6.518	.000**
	Reliance	10.46±3.58	16.46±2.13	-6.088	.000**
	Not dominated	7.06±1.72	12.20±1.89	-9.280	.000**
PANSS	Positive syndrome	25.06±7.95	14.06±5.68	6.785	.000**
	Negative syndrome	23.06±5.47	13.00±4.27	7.474	.000**
	General psychopathology	46.80±13.89	26.33±8,80	7.156	.000**

P<0.001**

In the empowerment scale, the areas of self-efficacy, external control, social-political and interpersonal communication skills have shown significant improvement with treatment as usual at 0.001 level. And social assertiveness has shown significant improvement with treatment as usual at 0.001 level. There was no significant improvement on any of the other domains with treatment as usual.

In recovery scale, the domains of willingness, personal confidence, goal, reliance, not dominated have shown significant improvement at the 0.001 level in the study group.

In PANSS, Positive syndrome, negative syndrome and general psychopathology domains have significant improvement with treatment as usual at the 0.001 level.

DISCUSSION

In the present study, the experimental group consisted of 53.3% male and 46.7% female, 53.3% were married, educated up to 10^{th} STD that corresponds to age 14-17 yrs. Majority of patients belongs from the Hindu religion (86.6%) came from a rural background and nuclear family (86.6%) and the majority were unemployed.

In this present study, general psychopathology including positive and negative symptoms has shown significant improvement after therapy which indicates that the patient had better understanding his/her illness and its behaviour. Furthermore, findings supported that active treatment for negative symptoms, psychological discomfort, and resistance can improve quality of life among inpatients with Schizophrenia (Fujimaki et al., 2012).

Overall empowerment scale has shown significant improvement after intervention. Among all subscales of empowerment scales, self-efficacy, external control, interpersonal communication skills, social assertiveness, and social-political domains have shown significant improvement after therapy. Studies have shown that, "Empowering is associated

with a reduction in psychiatric symptoms, improving empowerment levels and improvement in recovery rate. It indicates that internalized stigma moderates the effect of awareness of schizophrenia on the hope and self-esteem of Schizophrenia patients. This is consistent with the findings, suggesting that benefits from the psychiatric treatment and rehabilitation interventions are related to the meanings people assign to both their illness and the treatment itself" (Pijnenborg et al., 2013). The empowerment intervention in this study has helped patients with schizophrenia to learn some strategies that enhance recovery from schizophrenia. Furthermore, this study's findings support the conclusion that conducting empowerment intervention in 6 sessions provides enough time for patients to demonstrate positive changes in the direction of recovery from mental illness. "This intervention module gave accurate information about the illness, which might enhance their insight of the illness and help People with Schizophrenia develop coping strategies as well as change their attitudes towards antipsychotic medication" (Mui & Huiting, 2015).

Recovery scale has shown significant improvement after intervention. Studies have shown that, "The empowerment was an effective group intervention supporting the recovery of people with schizophrenia. Intervention program can be useful in this population to facilitate change in personal feelings of strength and hopes of recovery. The empowerment of people with schizophrenia continues with their drug treatment after discharge" (San et al., 2013). Studies also have shown that, "Empowerment intervention can aid recovery from mental illness and patients learn practical strategies regarding communication skill, management of self-care, medication adherence, crisis management, management of sexual dysfunction and preparation for employment" (Park & Sung, 2013). These areas were also focused on the current intervention, which has supported this finding.

A major limitation of the current study was its small sample size. The second limitation was follow-up assessment could not be done. The third limitation was the duration of intervention was short.

Future studies may include larger sample size along with family members for better generalizability. Longer follow-up studies may be done, to see whether the results obtained are maintained in long term.

Major implications are the improvement of recovery and decreasing psychiatric symptoms. Such interventions can be utilized in both inpatient and outpatient setups. As limited sessions are able to produce significant results it would be easy to adapt and follow in existing clinical setups. Imparting empowerment-related domains in the group and individual therapy can help in regular clinical practice while working with patients with schizophrenia.

CONCLUSION

Empowerment intervention has shown to be an important intervention for patients with schizophrenia. It helps in enhancing recovery from a chronic and disabling condition. It also involves a supportive relationship, social inclusion, coping skills and developing a new meaning towards life despite the limitations caused by the mental illness. Empowering an individual with schizophrenia to walk in the path of recovery and providing opportunity and a supportive environment is what enhances the journey of recovery.

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Conflict of interest: None declared

Ethical Clearance: The study was approved by the Institutional Ethics Committee, Central Institute of Psychiatry, Ranchi.

REFERENCES

Berry, K., Allott, R., Emsley, R., Ennion, S., & Barrowclough, C. (2014). Perceived empowerment in people with a dual diagnosis of schizophrenia spectrum disorder and substance misuse. *Social psychiatry and psychiatric epidemiology*,*49*(3), 377-384.

Boevink, W., Kroon, H., Delespaul, P., & Van Os, J. (2016). Empowerment according to persons with severe mental illness: development of the Netherlands empowerment list and its psychometric properties. *Open Journal of Psychiatry*, *7*(1), 18-30.

Corrigan, P. W., Mueser, K. T., Bond, G. R., Drake, R. E., & Solomon, P. (2012). *Principles and practice of psychiatric rehabilitation: An empirical approach*. Guilford Press.

Fujimaki, K., Morinobu, S., Yamashita, H., Takahashi, T., & Yamawaki, S. (2012). Predictors of quality of life in inpatients with schizophrenia. *Psychiatry Research*, *197*(3), 199-205.

Giffort, D., Schmook, A., Woody, C., Vollendorf, C., & Gervain, M. (1995). Construction of a scale to measure consumer recovery. *Springfield, IL: Illinois Office of Mental Health*.

Hasan, A. A., Callaghan, P., & Lymn, J. S. (2015). Evaluation of the impact of a psycho-educational intervention for people diagnosed with schizophrenia and their primary caregivers in Jordan: a randomized controlled trial. *BMC Psychiatry*,*15*(1).

Kay, S. R., Fiszbein, A., & Opler, L. A. (1987). The positive and negative syndrome scale (PANSS) for schizophrenia. *Schizophrenia Bulletin*, *13*(2), 261-276.

Kozak, M. J., & Cuthbert, B. N. (2016). The NIMH research domain criteria initiative: background, issues, and pragmatics. *Psychophysiology*, *53*(3), 286-297.

Kurtz, M. M., Mueser, K. T., Thime, W. R., Corbera, S., & Wexler, B. E. (2015). Social skills training and computer-assisted cognitive remediation in schizophrenia.*Schizophrenia Research*, *162*(1-3), 35-41.

Li, C. P., & Chiu, E. C. (2017). Construct validity of the Empowerment Scale in patients with schizophrenia. *Neuropsychiatry*, *7*(5), 501-508.

Leung, A., & Chue, P. (2000). Sex differences in schizophrenia, a review of the literature. *Acta Psychiatrica Scandinavica*, *101*(401), 3-38.

Mui, L. E., Huiting, X. (2015). The effects of psychoeducational on patients with schizophrenia and their families: An integrative review. *Singapore Nursing Journal,*41, 3–16.

Park, S. A., & Sung, K. M. (2013). The effects on helplessness and recovery of an empowerment program for hospitalized persons with schizophrenia. *Perspectives in Psychiatric Care*, *49*(2), 110-117.

Pijnenborg, G. H., van Donkersgoed, R. J., David, A. S., & Aleman, A. (2013). Changes in insight during treatment for psychotic disorders: a meta-analysis. *Schizophrenia Research*, *144*(1-3), 109-117.

San, L., Bernardo, M., Gómez, A., Martínez, P., González, B., & Peña, M. (2013). Socio-demographic, clinical and treatment characteristics of relapsing schizophrenic patients. *Nordic Journal of Psychiatry*, *67*(1), 22-29.

Zimmerman, M. A. & Rappaport, J. (1988). Citizen participation, perceived control and psychological empowerment. *American Journal of Community Psychology*,*16*(5), 725-750.

Zipursky, R. B., & Agid, O. (2015). Recovery, not progressive deterioration, should be the expectation in schizophrenia. *World Psychiatry*, *14*(1), 94-96.

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Effectiveness of Social Skills Training in Person with Schizophrenia: A Case Study

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ABSTRACT

Background: Schizophrenia imposes problems in day to day living, community functioning, interpersonal relationships, problem-solving strategies or new skills acquisition. Psychosocial intervention like social skills training helps in the improvement of social skills of the person with schizophrenia. The applicability of social skills training for the patient with poor social skills has been well evidenced in social work practice. **Aim:** The present case study aimed to improve the social skills of the person with schizophrenia by using social skills training. **Methodology:** This case study was a single subject case study done in the inpatient department of LGBRIMH, Tezpur. A case diagnosed with schizophrenia according to ICD-10 criteria was selected. Psychiatric social work assessment was done using clinical and social history proforma, Work Behaviour Inventory, Social Adaptive Functioning Evaluation (SAFE), Positive and Negative Syndrome Scale (PANSS), Social Skills Checklist was administered before and after the intervention. Based on the assessment social skill training was provided to improve the social skills of the client. **Results:** There were changes observed in pre and post scores of social functioning, social skills, positive and negative symptoms. Significant changes were noticed in social skills and work functioning. **Conclusion:** Social skills training is effective and can be provided for improving social skills, for enhancing work behaviour and social functioning.

Keywords: Schizophrenia, social skills training, psychoeducation, social work intervention

INTRODUCTION

According to World Health Organization (2014) "Schizophrenia can be described as a severe mental disorder characterized by profound deficits in thinking, perception, affect, and social behaviour. The disorder has been imposes problems in everyday work functioning, community functioning, interpersonal relationships, problem-solving skills or in obtaining new skills (Addington & Addington, 1999; Bellack, Gold, & Buchanan, 1999; Bellack, et al., 2004; Green, et al., 2000; Perlick et al., 2008). The psychosocial intervention like social skills training (SST) is needed for the improvement of social skills of the person with schizophrenia. "Social skills training can be focused on one of the components social cognition and social competence or both in combination (Green et al., 2008). The most important elements when training social skills are expressive behaviour i.e. speech content and paralinguistic elements: volume of voice, rhythm, body movements and gestures, interpersonal distance, etc.; responsive behaviours like social perception, attention, emotion recognition and interpretation; interactive behaviours such as response and reaction times, conversational turns and use of social reinforcements; and situational factors like knowledge of cultural factors and specific contextual demands" (Rus-Calafell, M., 2014). The psychiatric social worker can provide social skills training to the person with schizophrenia with poor social skills. Various studies have shown the effectiveness of SST in schizophrenia

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in reducing negative symptoms and enhancing social functioning (Tsang & Lak, 2010; Bustillo, Lauriello, Horan, Keith, 2001; Liberman et al, 1998; Granholm, & Harvey, 2018). The present case study is an attempt to enhance social skills, work behaviour and social functioning by using social work principle, techniques for the intervention in the person with schizophrenia.

Client presenting problems and diagnosis

An adult man found to be roaming around in the area of Diphu police station. As reported by local people he was found to be showing inappropriate behaviour, he used to visit shops and homes in search of food. People found him unhygienic; he was wearing dirty clothes and smell, he was wandering in the locality. Therefore, local people file a complaint in Diphu police station. Police took him to the custody and presented before judicial magistrate of Karbi Anglong district of Assam. After inquiry, he was found to have disturbances in mental functions. Hence, he was referred to LGB Regional Institute of Mental Health, Tezpur for treatment under section 102 of Mental Healthcare Act, 2017. He was admitted with the chief complaints of wonder some behaviour, self-smiling, poor self-hygiene & inappropriate behaviour with an unknown period of illness. He was diagnosed as schizophrenia (F20). After in-patient treatment he gave information about himself, that he was Mr. X, 27 years old, male, Hindu, unmarried, studied up to class IX. He was unable to give adequate information about his family. Later hospital staff found that after improvement in symptoms he was not mingling with other people instead he used to sit alone, did not participate in ward activities, did not take part in communication with others such as supporting staff, a medical staff of the hospital. Therefore, treating team referred him to the centre for rehabilitation sciences for vocational and social skills training.

METHODOLOGY

The single-subject case study design was used for the study in which assessment was done and psychiatric social work intervention was provided. Single-case designs permit the evaluation of treatments as they are applied clinically. A case diagnosed with schizophrenia according to ICD-10 criteria was selected. Psychiatric social work assessment was done using clinical and social history proforma, Work Behaviour Inventory, Social Adaptive Functioning Evaluation (SAFE); Positive and Negative Syndrome Scale (PANSS), was administered before the intervention. Based on the assessment psychiatric social work intervention was provided to improve the social skills of the client. Post-test was done after one month of the intervention.

Tools description

Social Adaptive Functioning Evaluation (SAFE): It is developed by Harvey et al. (1997) "which consist of 17 items, including bathing and grooming, clothing and dressing, eating feeding and diet, money management, neatness and maintenance activities, orientation/ mobility, impulse control, respect for property, communication skills, conversational skills, instrumental social skills, social engagement friendship, recreation and leisure, participation in a hospital programme, cooperation with treatment".

Positive and Negative Syndrome Scale (PANSS): It is a scale for measuring the severity of the symptoms of patients with schizophrenia developed by Stanley Kay et al. (1987). It composed of 30 items 7 constitutes a positive scale, 7 negative scales, and the remaining 16 are general pathology scale. The scoring for the scale is arrived at by summation of rating across component items. The score ranges 7-49 for the positive and negative scale and 16 to 113 for the general psychopathology scale.

Work Behaviour Inventory: It is developed by Bryson et al. (1997) used with the client to assess the work behaviour of the patient. "It consists of 5 areas which include social skills, cooperation, work habits, quality of work, personal presentation, each comprising 7 items, plus a global item reflecting the overall assessment. Each item must be scored from one to five: 5 = area of superior performance in the majority of cases, 4 = area of superior performance in some cases, 3 = adequate performance in this area, 2 = area for improvement in some cases, 1 = area for improvement in the majority of cases" (Bryson et al., 1997).

RESULTS

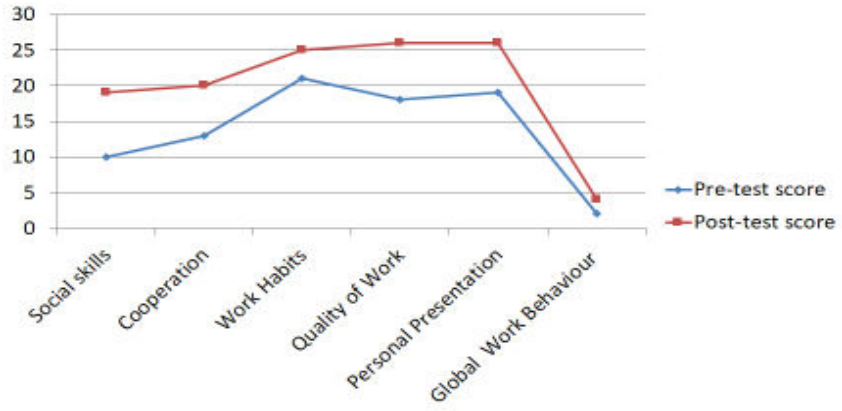
Table 1: Social Adoptive Functioning

Social Adoptive Functions	Pre-intervention		Post-intervention	
	Scores	Impairment	Score	Impairment
Bathing and grooming	1	Mild	1	Mild
Clothing and dressing	1	Mild	1	Mild
Eating feeding and diet	1	Mild	0	No
Neatness and maintenance activities	2	Moderate	1	Mild
Orientation/mobility	1	Mild	1	Mild
Impulse control	1	Mild	0	No
Respect for property	2	Moderate	1	Mild
Communication skills	3	Severe	**2**	Moderate
Conversational skills	4	Extreme	**2**	Moderate
Instrumental social skills	4	Extreme	**2**	Moderate
Social appropriateness/politeness	2	Moderate	1	Mild
Social engagement	3	Severe	**2**	Moderate
Friendship	3	Severe	**1**	Mild
Recreation / leisure	4	Extreme	1	Mild
Participation in hospital programme	3	Severe	**1**	Mild
Cooperation with treatment	2	Moderate	0	No

As shown in table 1, pre and post scores on social adaptive functioning of the client based on Social Adaptive Functioning Evaluation (SAFE) scale. It was found that there were no changes in the pre and post scores in the domain of bathing and grooming, clothing and dressing, orientation/mobility. The pre scores in the domain of eating feeding and diet have a mild impairment but post score shows no impairment. In the domain of impulse control, there was mild impairment in pre score and post scores show there was no impairment. In the domain of Neatness and maintenance activities pre score shows moderate impairment and post score shows mild impairment. In the domain of Respect for property, there was a moderate level of impairment in pre score and post score showed mild impairment. The pre score showed severe level impairment in the domain of communication skills but post score is moderate level impairment. The patient has an extreme level of impairment in the pre score of conversational skills, instrumental social skills and post score shows a moderate level of impairment. In the domain of social adaptiveness/politeness, the pre score was moderate impairment and post score showed mild impairment. In the domain of social engagement, it shows severe impairment in pre score and post score shows moderate impairment. In the friendship domain, pre score shows severe impairment and post score shows mild impairment. In the recreational/leisure domain pre score shows extreme impairment and post

score showed mild impairment. In the domain of participation in a hospital programme, pre score shows severe impairment and post score shows mild impairment. In the domain of cooperation with treatment, pre score shows moderate impairment post score shows no impairment.

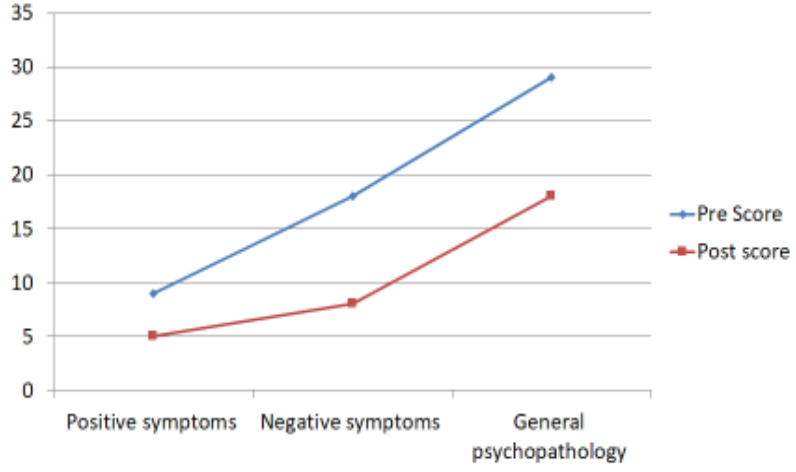
Figure 1 Pre and Post Score of Work Behaviours Inventory



As shown in figure 1, the pre and post score of Work Behaviour of the client based on Work Behaviours Inventory it was found that there was an improvement in the client's behaviour. In the domain of social skill, the pre score was 10 and post score is 19. In the domain of work habit, the pre score was 21 and post score is 25. The pre score of quality of work was 18 and post score was 26. In the domain of personal presentation, pre score was 19 and post score was 26. In the domain of global assessment of behaviour, it was 2 in pre score and 4 in post score. Thus, the score indicates that there was an improvement in work behaviour of the client.

As shown in figure 2 pre and post score on Severity of Positive and Negative Symptoms of the client based on Positive and Negative Syndrome Scale (PANSS) it was found that there were changes in both positive and negative symptoms. In the domain of positive symptoms, pre score was 9 and post score was 5. In the domain of negative symptoms, pre score was 18 and post score was 8. In the domain of general psychopathology, it was 29 in pre score and 18 in post score.

Figure 2 Pre and Post Score on Severity of Positive and Negative Symptoms



Psychiatric Social Work Intervention

In this case study, psychiatric social work interventions focused on social skills training where the individual as well as group therapy to enhance the social skills of the client.

Process of Interventions

Rapport establishment and therapeutic alliance: Rapport establishment is important to maintain a good relationship with the patient and to assess the level of co-operation and participation of the client. This can promote open communication, develops trust between the client and therapist. In this case study, it was crucial to establish rapport with the client as he was not involving himself in any kind of interactions. A trustworthy relationship was required to proceed further. The therapist took ways to engage patient in communication with asking opinions about hospital food, facilities, etc. and then turned the conversation towards his personal life. Rapport was established by an empathic and shared understanding of the issues between a therapist and a client. Once the patient started interactions he was informed about common goals of working together. The client was informed about the therapy and the benefit that he would get. It was also explained to the client that confidentiality will be maintained.

Activity schedule: The engagement of the individual in activities of daily living helps to improve productivity. The present case was also encouraged to maintain his activities of daily living (ADL) and it was also monitored by the therapist. His day was structured in different activities which were planned according to the mastery and pleasure of the patient. It helped to regulate day to day activities of ADL, vocational training, group activities and SST sessions. This helped to enhance his functioning in a positive direction.

Social skills training: Social skills training comprises of learning activities using different behavioural techniques that enable persons with schizophrenia and other mental disorder to obtain independent living and functional skills to improve their functioning in their communities. Social skills training is needed for improvement of social skills of the person with schizophrenia with poor social skills, So in the intervention process, the four basic social skills i.e. listening to others, making the request, expressing positive feelings and expressing unpleasant feelings skills were provided to the client to develop his social skills based on Bellack et al. (2004). The therapist taught the steps of the skills through interaction, role play, proving feedback, suggestions and also gave him to do homework for practice. Further, social group work was planned to enhance social skills and work functioning of the client for the group work in the rehabilitation centre. Trainee involved the client in group activities with the other patient so that he communicates with others, build rapport with the other client, to learn how to engage in work in a group setting. The purpose of group therapy also focused on enhancing the attention and concentration of the clients to enhance work functioning. In one of the session, psychoeducation was also provided to the group members. Psychoeducation was provided to the participants to enhance the knowledge regarding the illness. The main emphasis was given to inform him about the signs and symptoms and nature of the illness, causal factors, importance of treatment and medication, early signs and symptoms, the importance of engage in work, the ill effect of substance use during medication, the importance of physical exercise and importance of regular follow up.

DISCUSSION

From the pre-test and post-test of Social Adaptive functioning of the client based on Social Adaptive Functioning Evaluation (SAFE), it was found that there was an improvement in eating feeding and diet, impulse control, cooperation with treatment, Neatness and maintenance activities, Respect for property, Social appropriateness/politeness, friendship,

recreation and participation in hospital programme, Communication skills, conversational skills, instrumental skills and in Social engagement. Thus, it can be said that social skill training is found to be effective in enhancing social skills in person with schizophrenia. A similar finding has been reported by various researchers. Koujalgi, et al. (2014) in the study on the efficacy of social skills training in a patient with chronic schizophrenia found that there was a significant difference between the pre and post-intervention SAFE scores in the experimental group. They also concluded that SST is effective in improving the social skills of patients with schizophrenia. The meta-analysis by Turner and colleagues (2018) reported that social skills training (SST) can improve social skills and can reduce negative symptoms in people with schizophrenia. Similarly, in another meta-analysis of 19 clinical trials by Pfammatter and colleagues (2006) found large significant benefits for skills acquisition and medium effects for social functioning and general psychopathology. In the present case study, the post-score of work behaviour inventory showed that there were significant changes in Social skills, Cooperation, work habits; quality of work, personal presentation, and global assessment of work behaviour. There was also a change in pre and post-assessment of PANSS. It was shown that there was an improvement in positive symptoms, negative symptoms and general psychopathology. Another meta-analysis of 22 clinical trials by Kurtz and Mueser (2008) found that SST can reduce negative symptoms and can enhance community functioning. Thus, it can be said that SST can improve social skills, negative symptoms and functioning for the person with schizophrenia. In a study conducted by Mahanta & Ali (2018) in persons with Schizophrenia having poor social, communication and work functioning, found that psychiatric social work intervention can enhance client social skills and overall quality of life. They also found that after psychiatric social work interventions, there was a difference in pre and post-test score in social adaptive functioning evaluation scale (SAFE.) which is similar to our findings.

Outcome: There was a change in pre and post scores in SAFE, PANSS, and Work Behaviour Inventory. From the present case study, it was found that the client has an improvement in social skills and work functioning

CONCLUSION

Psychiatric social work interventions for the treatment of schizophrenia cover different areas of treatment interventions. In this case study, the interventions mainly focussed on enhancing the level of social skills, work behaviour and functioning of the client through proving social skills training and it was found that SST is effective in the improvement of social skills of a person with poor social skills.

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Declaration of interest: None.

REFERENCES

Addington, J., & Addington, D. (1999). Neurocognitive and social functioning in schizophrenia. *Schizophrenia Bulletin*, *25*(1), 173-182.

Bellack, A. S. (2004). Skills training for people with severe mental illness. *Psychiatric rehabilitation journal*, *27*(4), 375.

Bellack, A. S., Gold, J. M., & Buchanan, R. W. (1999). Cognitive rehabilitation for schizophrenia: problems, prospects, and strategies. *Schizophrenia Bulletin*, *25*(2), 257-274.

Bellack, A. S., Mueser, K. T., Gingerich, S., & Agresta, J. (2013). *Social skills training for schizophrenia: A step-by-step guide*. Guilford Publications

Bryson, G., Bell, M. D., Lysaker, P., & Zito, W. (1997). The Work Behavior Inventory: A scale for the assessment of work behavior for people with severe mental illness. *Psychiatric Rehabilitation Journal*, *20*(4), 47–55.

Bustillo, J. R., Lauriello, J., Horan, W. P., & Keith, S. J. (2001). The psychosocial treatment of schizophrenia: an update. *American Journal of Psychiatry*, *158*(2), 163-175.

Granholm, E., & Harvey, P. D. (2018). Social skills training for negative symptoms of schizophrenia. *Schizophrenia Bulletin*, *44*(3), 472-474.

Green, M. F., Kern, R. S., Braff, D. L., &Mintz, J. (2000). Neurocognitive deficits and functional outcome in schizophrenia: are we measuring the "right stuff"?. *Schizophrenia Bulletin*, *26*(1), 119-136.

Harvey, P. D., Davidson, M., Mueser, K. T., Parrella, M., White, L., &Powchik, P. (1997). Social-Adaptive Functioning Evaluation (SAFE): A rating scale for geriatric psychiatric patients. *Schizophrenia Bulletin*, *23*(1), 131-145.

Horan, W. P., Kern, R. S., Green, M. F., & Penn, D. L. (2008). Social cognition training for individuals with schizophrenia: emerging evidence. *American Journal of Psychiatric Rehabilitation*, *11*(3), 205-252.

Kay, S. R., Fiszbein, A., & Opler, L. A. (1987). The positive and negative syndrome scale (PANSS) for schizophrenia. *Schizophrenia Bulletin*, *13*(2), 261-276.

Koujalgi, S. R., Patil, S. R., Nayak, R. B., Chate, S. S., & Patil, N. M. (2014). Efficacy of social skill training in patient with chronic schizophrenia: An interventional study. *Journal of the Scientific Society*, *41*(3), 156.

Kurtz, M. M., &Mueser, K. T. (2008). A meta-analysis of controlled research on social skills training for schizophrenia. *Journal of consulting and clinical psychology*, *76*(3), 491–504.

Lak, D. C., Tsang, H. W., Kopelowicz, A., & Liberman, R. P. (2010). Outcomes of the Chinese basic conversation skill module (CBCSM) for people with schizophrenia having mild to moderate symptoms and dysfunction in Hong Kong. *International Journal of Psychiatry in Clinical Practice*, *14*(2), 137-144.

Liberman, R. P., Wallace, C. J., Blackwell, G., Kopelowicz, A., Vaccaro, J. V., &Mintz, J. (1998). Skills training versus psychosocial occupational therapy for persons with persistent schizophrenia. *American Journal of Psychiatry*, *155*(8), 1087-1091.

Mahanta, P., & Ali, A. (2018). Psychiatric Social Work Intervention in Person with Schizophrenia Having Poor Social, Communication and Work Functioning. *Indian Journal of Psychiatric Social Work*, *9*(1), 47-53.

Rus-Calafell, M., Gutiérrez-Maldonado, J., Ribas-Sabaté, J., & Lemos-Giráldez, S. (2014). Social skills training for people with schizophrenia: What do we train?. *Psicología Conductual*, *22*(3), 461-471

Perlick, D. A., Rosenheck, R. A., Kaczynski, R., Bingham, S., & Collins, J. (2008). Association of symptomatology and cognitive deficits to functional capacity in schizophrenia. *Schizophrenia Research*, *99*(1-3), 192-199.

Perlick, D. A., Rosenheck, R. A., Kaczynski, R., Bingham, S., & Collins, J. (2008). Association of symptomatology and cognitive deficits to functional capacity in schizophrenia. *Schizophrenia Research*, *99*(1-3), 192-199.

Pfammatter M, Junghan UM, Brenner HD. Efficacy of psychological therapy in schizophrenia: conclusions from meta-analyses. *Schizophrenia Bulletin*, 2006;32 (Suppl 1): S64–S80.

World Health Organization (2014). *Schizophrenia.* Retrieved from http://www.who.int/mental_health/management/schizophrenia/en.

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