ISSN 2230 - 8768

Volume - 15, Issue 1-2, January - December 2014 NJPSW

NATIONAL JOURNAL OF PROFESSIONAL SOCIAL WORK

An Official Publication of the
INDIAN SOCIETY OF PROFESSIONAL SOCIAL WORK
Secretariat : DEPARTMENT OF PSYCHIATRIC SOCIAL WORK
NATIONAL INSTITUTE OF MENTAL HEALTH AND NEURO SCIENCES (NIMHANS)
BANGALORE - 560 029

ISBN 2230-8768

NATIONAL JOURNAL OF PROFESSIONAL SOCIAL WORK

(ESTD.1970)

Reg. No. 340/90-91

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NEURO SCIENCES (NIMHANS)

BANGALORE- 560029, INDIA

NATIONAL JOURNAL OF PROFESSIONAL SOCIAL WORK
Volume -15, Number 1-2, January – December- 2014

Subscription Rates

Individual

Single issue Rs. 100.00
Annual Rs. 175.00
Life Rs. 1,500.00
Single Back Issue Rs. 100.00

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Annual Rs. 100.00
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Published by
Dr. R. Parthasarathy, for the Indian Society of Professional Social Work

Secretariat
Department of Psychiatric Social Work
National Institute of Mental Health and Neuro Sciences (NIMHANS)
Bangalore- 560029, INDIA

Printed at
Akshara Printers
54/4, Police station road
Basavanagudi, Bangalore- 560 004
Ph: 080- 26624897

CONTENTS

EDITORIAL

PROFESSIONAL SOCIAL WORKER AS COUNSELLOR/PSYCHOTHERAPIST

In various settings, the professional social workers help the clients and their families to understand their problems and to enable them to solve these problems. Usually the helping process is called either counselling or psychotherapy. In non clinical settings it is referred to as counseling where as in clinical settings it is called Psychotherapy.

On the basis of both client and counselor ratings, approximately 22% of clients made significant gain 43% made moderate changes while 27% made some improvements (Sexton 1993, P.82).

In recent years, it has become increasingly evident that certain kinds of treatment methodologies work more effectively with certain kinds of presenting problems. In addition, it has also become clear that some qualities of the therapist seem to show efficacy regardless of the approach being employed. For instance, the ability to show empathy, the capacity to build the therapeutic alliance and adherence to a theoretical approach – all seem to be critical factors in positive client outcomes. Finally, the personal resources that the client brings with him or her are critical to successful outcomes.

In the recently held workshop on psychotherapy practice in Medical and Psychiatric Social Work settings at Department of Psychiatric Social Work, NIMHANS, Bangalore on 31st July to 2nd August 2014, following issues were focused: Psychotherapy in medical and psychiatry settings, Ethics in psychotherapy practice, working with individual in psychiatric settings, Group psychotherapy in Medical and Psychiatric Social Work settings, psychotherapy in medical settings, Psychotherapy practice in family interventions, psychotherapy training for mental health professionals, and skills in psychotherapy practice.

Trainees at MSW levels/M.Phil levels need to be exposed to Psychodynamic approaches, Existential – humanistic approaches, Cognitive – behavioural approaches, post modern approaches (Narrative therapy, Solution focused therapy) and couples and Family counseling/therapy.

By such training, the skills of social workers could be enriched so that they become effective counselors as Psychotherapists. The theoretical orientation when accompanied by supervised practical training will go a long way in making professional social workers effective individuals, group and family counselors or psychotherapists. Preparation at the early stages is vital for such transformation of professional social workers.

Reference: Sexton, T. (1993). A Review of the counseling outcome Research. In: G.R. Wale & J.C.Bleuer (Eds) Counsellor Efficacy. Assessing and using counseling outcome Research. Report No.ISBN-1-56109-056-5) Ann.Arbor.

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SPECTRUM OF PSYCHOSOCIAL INTERVENTIONS IN PSYCHIATRIC SOCIAL WORK SETTING- REVIEW OF CASE RECORDS AT NIMHANS, BANGALORE

Ashok S. Kori[1] Atiq Ahmed[2] Dr.Muralidhar D[3] Dharma Reddy[4] Dr.Ameer Hamza[5]

Abstract

New developments in the management of psychiatric disorders are crucial to understand and strengthen psychiatric social work interventions. The purpose of this review was to understand the broad range of psychosocial interventions carried out on persons with psychiatric disorders at NIMHANS. The researchers reviewed 209 cases from M. Phil case records submitted between 2008- 2012. Nearly 50.2% were female and 49.8% were male persons with psychiatric disorders. Majority 29.7% of the respondents educated up to graduation. Nearly forty types of psycho-social interventions were carried out by psychiatric social work trainees with persons diagnosed with various psychiatric disorders. The interventions were ranged from individual level, family level and community level. The results suggest that the interventions were comprehensive and directed at different levels in clients' milieu. Most of the trainees mentioned that there was improvement in the client.

Key Words: Persons with psychiatric illness, Psychosocial issues, Psychosocial assessment, Psychosocial interventions, Psychiatric Social Worker,

SPECTRUM OF PSYCHOSOCIAL INTERVENTIONS IN PSYCHIATRIC SOCIAL WORK SETTING- REVIEW OF CASE RECORDS AT NIMHANS, BANGALORE

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Introduction

Mental illnesses are treatable. Over a period of time clinical practice in psychiatric settings have developed various methodologies for the treatment of persons with mental illness. There is striking evidence to support that psychosocial intervention, as an adjunct to pharmacotherapy, has yielded good results in reducing the intensity, number of episodes, and frequency of hospitalization of psychiatric patients. The review shows that management of psychotic symptoms began with token economies in psychiatric hospitals using operant learning theories to modify behaviors through rewards and punishments in the early days (McCann, 2001). Family interventions are proposed as

adjuncts rather than alternatives to drug treatments and the purpose of these interventions are to decrease the stress within the family and also the rate of relapse (F. M. Pharoah, Rathbone, Mari, & Streiner, 2003).

Psychosocial interventions play crucial role at individual, family and community level in order to attain improvement of the mental health of individuals. Caring for the mentally ill in the family, mental illness weaves a web of doubt, confusion and chaos around the family (Cherkil, 2010). The literature suggests that closer the relationship of the carer with the patient, higher the levels of feelings of helplessness and guilt over not being able to do enough for the patient. (Bhatia S, 2003). However, utilization of social support and a sense of mastery over the situation are associated with lower levels of burden and distress.(Budd, Oles, & Hughes, 1998). This is possible through psychosocial interventions.

Aim and Objectives:

The aim of this study was to glance through broad range of psychosocial interventions carried out for the treatment of ICD- 10 mental disorders, undertaken to support the delivery of psycho social services at National Institute of Mental Health And Neuro Sciences, (NIMHANS), Bangalore, India.

The Master of Philosophy trainees of Department of Psychiatric Social Work at NIMHANS play significant role in delivering a broad range of psychosocial interventions for persons with mental illness. It is essential to understand the spectrum of psycho social interventions which were carried out by PSW trainees at individual, family and community level. The other objective of the current study was to assess socio-demographic variables of persons with mental illness availing the psychosocial services.

Materials and Method

For the present study, available Case Records of five years (2008, 2009, 2010, 2011 and 2012), submitted by M. Phil. Scholars of Psychiatric Social Work, NIMHANS were reviewed. Each case record consists of five psychiatric cases, for which a comprehensive assessment of patient and subsequent psychosocial interventions provided are recorded in detail. Fourty two case records were selected for this study, totally 209 cases were reviewed for current study. A case record is comprehensive work done by the scholar in the first year of the programme wherein the trainee records the psychosocial assessment, interventions and outcome of each case. Thus a trainees needs to submit a compilation of five case reports under the guidance of Psychiatric Social Work faculties of a multidisciplinary unit team as part fulfillment of M.Phil programme. Hence, reviewing these records and presenting the results necessarily requires us to adopt a retrospective study approach.

A retrospective study uses existing data that have been recorded primarily for reasons other than research. In health care these are often called "chart reviews" because the data source is the medical record.

A *case report* is a report of one unusual and/or instructive case (eg, symptoms not previously observed with a given medical condition, or an unexpected or new combination of medical conditions in one case), whereas a *case series* is a report of multiple similar unusual or instructive cases. A retrospective case series can be used to study a disease that occurs infrequently or to generate a hypothesis that can be tested more rigorously in a prospective study (Hess, 2004). In Social Sciences, retrospective study involves collecting data about past events. This design is mainly employed to measure and understand change and to include a time dimension to the data that can be used to identify causal factors contributing to any observed change. Retrospective studies rely on recalling information about the past but vary in the extent to which they rely on such recall. Other retrospective studies involve collecting information about the past and comparing that with contemporary information collected from the same cases (Jupp, 2006). The current study follows this approach.

The data consisted of 209 cases from 42 Case Records of patients with mental illness; primary diagnosis of patients was ranging from F0 to F98 of ICD-10 *(Table-1)*. Out of the total patients, 104 patients were males and 105 patients were females. Mean age of the patient was found to be 32.37 (±10.83) years, median being 31 years. The educational status of the patients ranged from illiteracy to post graduation; nearly one third (29.7%) were graduates. Further details of the patients are depicted in *Table-2*.

Results:

The analysis of these Case Records revealed wide range of psycho social issues among the psychiatric patients and subsequent various psychosocial interventions adopted by the trainees. The psychosocial issues, psychosocial interventions and the outcome of these interventions are discussed as follows.

Psychosocial Issues:

The specific psychosocial issues found were adjustmental problems in the family, medico-legal issues, misconceptions about the illness, management of unusual behaviors, employment issues, disability related issues, social stigma, human rights violations of psychiatric patients, property issues related to psychiatric patients, poor drug compliance, problem of caring psychiatric female patients after divorce, expressed emotions, poor social support, family disputes in caring for person with mental illness, caring psychiatric patients by elderly parents, domestic violence, financial

issues, sexual incompatibility, alcohol related issues, family interaction issues, child rearing, parenting and socialization issues, unwed mothers with psychiatric illness and various marital issues.

It was understood that Expressed Emotions were present in many families with psychiatric ill persons. The empirical data show that Expressed emotions is one of the major psychosocial stressor and it has direct association with recurrence of illness (Amaresha & Venkatasubramanian, 2012).

Psychosocial Interventions:

"Psychosocial interventions" were interpreted broadly to include any non-pharmacological intervention carried out in a therapeutic context at an individual, family or group level (Drummond, 2007). These psychosocial family interventions may have a number of different strategies which include construction of an alliance with relatives who care for the person with severe mental illness, reduction of adverse family atmosphere, enhancement of the capacity of relatives to anticipate and solve problems, reduction of expressions of anger and guilt by the family, maintenance of reasonable expectations for patient performance, encouragement of relatives to set and keep to appropriate limits while maintaining some degree of separation when needed, attainment of desirable change in relatives' behavior and belief systems (F. Pharoah, Mari, Rathbone, & Wong, 2010). The main purpose of psychosocial interventions carried out at NIMHANS by psychiatric social work trainees were to prevent relapse of illness, psycho-education, reduce rehospitalisation, enable person with mental illness, to promote socio-occupational functioning and rehabilitation of persons with psychiatric illness. This study helps psychiatric social workers and mental health professionals to understand the spectrum of psychosocial interventions.

In the present analysis of Case Records, forty different psychosocial interventions have been identified. These interventions ranged from simple to complex. Many a times the therapists used these interventions in combination with other psychosocial interventions for each case. The adoption of psychosocial interventions depended upon the complexity of psychosocial issues and psychopathology. These psychosocial interventions included engagement and outcome-orientated assessment, the family's assessment, management of severity of illness. Whereas psychosocial interventions are cognitive behaviour therapies, coping strategy enhancement, self- monitoring approaches and training in problem-solving, medication management, via motivational interviewing techniques, group therapy and certain social work techniques like collateral contacts, environmental modification, mental health advocacy and multi sectorial networking with other services for resource mobilization and addressing welfare measures.

The basic observation was that all the trainees had combined two or more of the psychosocial interventions in order to attempt to increase the effectiveness of the intervention. For example, a course of family intervention was combined with a module of social skills training along with supportive psychotherapy and psycho-education.

The combinations are varied and thus these multi-modal interventions do not form a homogenous group of interventions which cannot be analysed together, further the psychiatric illness was also different. A comprehensive list of psychosocial interventions which were used by trainees to provide treatment for patients is listed in *Table-3.*

Outcome of the Psychosocial Interventions:

Psychosocial assessment at the individual level and family level were the core areas adopted by psychiatric social work trainees. Outcome assessment revealed that after the psychosocial interventions, there was a better understanding of mental illness scientifically, positive changes in family dynamics, reduced expressed emotions, increased social support and appropriate behavior of patient towards family and vice-versa was found in most of the patients. There was also an improvement in social skills and better understanding of the illness among family members of psychiatric patients. A reduction of expressed emotions in the family was seen which paved way to returning to normal social and occupational functioning, oriented to illness, drug adherence among person with psychiatric illness. The therapeutic interventions also helped in marital adjustment, reducing distress and rehospitalization, insight about the illness by patients with mood disorders and also their family members. Improvement was seen with the help of problem solving interventions and strengthening the support system for those psychiatric patients who were neglected or does not have relatives nearby. Vocational rehabilitation and coping skills development helped for job placement, improving coping pattern, reduction in suicidal ideas and change in eating patterns helped the performance of patients with depression and anxiety. The interventions also helped the families of patients with dementia by reducing the burden of caregivers, increased self-esteem in patients and also improved their social skills. Among the patient with alcohol and substance dependence understanding by the family members about causative factors for the illness and how to manage the harmful intake were the core areas of improvement. However, it differed among patients based on their condition of the illness and intervention. When used these psychosocial interventions in conjunction with pharmacotherapy, these interventions may reduce symptom severity, prolong time to relapse, and increase treatment adherence.

Psychosocial interventions were applied predominantly by PSW trainees which are efficacious as adjunctive treatments for mental disorders classified under ICD-10;Mental and behavioral disorders due to psychoactive substance use (F10-F19), Schizophrenia, schizotypal and delusional disorders (F20-F29), Mood Disorders (F30-F39), Neurotic, stress-related and somatoform disorders (F40-F49), Disorders of adult personality and behavior (F60-69), Mental Retardation (F70-F79), Behavioral and emotional disorders with onset usually occurring in childhood and adolescence (F90-98). More psychosocial interventions were applied for Schizophrenia, schizotypal and delusional disorders (F20-29) and least interventions were Behavioral and emotional disorders with onset usually occurring in childhood and adolescence (F91).

Discussion

Psychiatric Social Worker plays an important role as a team member along multidisciplinary psychiatric team. PSWs analyses patient's social situation in relation to present difficulty; such analysis is based on condition his present difficulties, family dynamics, environment, his attitude towards it. As an educator, psychiatric social worker educates the family members about mental illness scientifically, as an advocate; advocacy is adopted when patient faces legal issues in psychiatric setting, as a therapist; modifying his behavior through behavioral techniques, improves relationship among family members, works out programme for caregivers of patient for adequate readjustment. Thus, psychiatric social worker plays roles such as counselor, adviser, enabler, expert problem solver, troubleshooter, referrer, expeditor, arbitrator, discussion leader, resource person coordinator, administrator, work manager and consultant (Siporin, 1975).

Psychiatric Social Worker has to work with individuals and families in clinical setting when cases are referred for psychosocial interventions. Common psychosocial issues were at the time of referral were misconceptions about mental illness, poor drug compliance, expressed emotions, poor social support, negative coping mechanisms, religious practices along with medication and lack of awareness regarding management of the person with mental illness.

Psychoeducation has been given to patients with bipolar disorder in both individual and group formats. One study (Perry, Tarrier, Morriss, McCarthy, & Limb, 1999) shows that combination with individual psychoeducation and medication in comparison with usual care and medication. Results came after 7 to 12 sessions, patients learned how to identify warning sign of relapse and obtain emergency medical treatment. And who received psychoeducation and pharmacotherapy had a 30% reduction in manic relapse, longer intervals of relapses, longer intervals prior to manic relapses, and better social functioning over 18 months. Psychoeducation did not affect time to depressive relapses. Various forms of psychosocial interventions have been found efficacious as

adjunctive treatments for bipolar disorders, including family-focused therapy, Interpersonal Social Rhythm therapy (IPSRT), CBT and individual and group psychoeducation for Bipolar Affective Disorder (BPAD) patients (Malkoff-Schwartz et al., 2000).

In the current Case Records psychiatric social work trainees used IPSRT for BPAD patients which was an evidence based therapy. PSW trainees applied Motivational Enhancement Therapy (MET) for substance use disorders.

MET is a systematic intervention approach for evoking change. It is based on principles of motivational psychology, and is designed to produce rapid, internally-motivated change. This treatment strategy does not attempt to guide and train the client, step by step, through recovery, but instead employs motivational strategies to mobilize the client's own change resources. (Miller, 1995). Alcohol dependents but also their wives and children need professional clinical help and Family Therapy appears to be idea choice, in addition to pharmacological or behavioral treatment of the alcoholics (Kumari E., 2009). Motivational interviewing has been found to be effective for various forms of behavior change (Burke, Arkowitz, & Menchola, 2003; Dunn, Deroo, & Rivara, 2001). Most of the patients underwent group therapy and family members were educated about their role in recovery process and rehabilitation.

Problem Solving Therapy (PST) involves teaching a client how to use a step-by-step process to solve life problems. Rational problem-solving skills include attempting to identify a problem when it occurs, defining a problem, attempting to understand the problem, setting goals related to the problem, generating alternative solutions, evaluating and choosing the best alternatives, implementing the chosen alternatives, and evaluating the efficacy of the effort at problem solving (Malouff, Thorsteinsson, & Schutte, 2007). Many patients and caregivers took advantages of this approach.

Intervention at teaching coping skills to the members of family is important in clinical setting. Families caring for a member with a chronic severe mental illness like schizophrenia have to cope with a lot of burden and stress(Chandrasekaran, Sivaprakash, & Jayestri, 2002). In the current case records it was observed that many patients and caregivers were benefited through this approach. In a study by Nirmala et all, (Nirmala, Vranda, & Reddy, 2011) shows that its results regarding expressed emotions and caregiver burden in Schizophrenia that there is need for addressing expressed emotion in comprehensive psychosocial intervention plan and attentions should be paid to the needs of the caregivers in order to alleviate their burden in mentally ill patients.

Mental health professionals have to understand the cost of illness from different angles and this can help in formulation of comprehensive strategies dealing with psychological, social, cultural and economic issues at the micro- and macro levels (Parthasarathy, 2005).

Conclusion

Psychosocial assessments and interventions are essential part of psychiatric social work practice. Preventive and promotive family interventions may perhaps enable the formation of healthy families with members who are able to cope and solve problems adequately within the context of their homes. Curative psychosocial interventions at tertiary agencies like NIMHANS, Family Psychiatry center, Family counseling centers, Free Legal Aid centers and Dept. of Psychiatric and Neuro Rehabilitation center (DPNR) provide required care to caregivers of persons with psychiatric illness. Contribution of psychosocial interventions along with drugs can reduce the burden for psychiatrists in prevention of hospitalization and cost effectiveness. It also helps the caregivers to reduce burden and in functioning of family in a healthy way. Hence Psychiatric social work interventions play crucial role in mental health setting; these interventions are great contributions in preventive and promotion of mental health. Thus, integrating service and research has been reflected in reviewing the M.Phil Case Records of psychiatric social work trainees.

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Appendix

Table – 1: Breakup of year wise case report and diagnosis

Brief Profile of Patient	Description	Frequency (n=209)	Percent
Case Record (Year)	2008	19	9.1
	2009	45	21.5
	2010	65	31.1
	2011	5	2.4
	2012	75	35.9
Primary Diagnosis (ICD-10 code)	F0-09	8	3.8
	F10-19	21	10.0
	F20-29	79	37.8
	F30-39	59	28.2
	F40-49	21	10.0
	F60-69	9	4.3
	F70-79	10	4.8
	F90-98	2	1.0

Table – 2: Brief profile of the patient

Brief Profile of Patient	Description	Frequency (n=209)	Percent
Sex of Patient	Male	104	49.8
	Female	105	50.2
		Total- 209	100%
Education of Patients	Illiterate	19	9.1
	Primary	25	12.0
	High School	45	21.5
	PUC	37	17.7
	Diploma	12	5.7
	Graduate	62	29.7
	PG	9	4.3
		Total- 209	100%
Marital Status	Married	77	36.8
	Unmarried	100	47.8
	Separated	8	2.9
	Widowed	17	8.1
	Not Mentioned	7	2.9
		Total- 209	100%
Religion of the Patients	Hindu	170	81.3
	Muslim	19	9.1
	Christian	11	5.3
	Not Mentioned	9	4.3
		Total- 209	100%
Socio-Economic Status of the Patients	MSES	113	54.1
	LSES	62	29.7
	HSES	14	6.7
	Not mentioned	20	9.1
		Total- 209	100%
Domicile	Urban	97	46.4
	Rural	65	31.1
	Semi Urban	18	8.6
	Other	1	.5
	Not mentioned	28	13.4
		Total- 209	100%
State	Karnataka	101	48.3
	Kerala	29	13.9
	Tamil Nadu	22	10.5
	Andhra Pradesh	13	6.2
	West Bengal	11	5.3
	Chhattisgarh	2	1.0
	Assam	3	1.4
	Madhya Pradesh	2	1.0
	Bihar	1	.5

	Orissa	1	.5
	Jharkhand	1	.5
	Mizoram	1	.5
	Not Mentioned	22	10.5
		Total- 209	100%

***Table-3: A comprehensive list of psychosocial interventions* used by trainees**

Sl. No.	Psychosocial Interventions
1	Psycho-Education
2	Social Skill Training
3	Supportive Psychotherapy
4	Cognitive Behaviour Therapy
5	Cognitive Reorientation and Reality Orientation
6	Insight Oriented Therapy
7	Sleep Hygiene Techniques, Activity Scheduling and Time Management
8	Interpersonal Social Rhythm Therapy(IPSRT)
9	ABC Model of Rational Emotive Behaviour Therapy
10	Techniques of Mindfulness Based Therapy
11	Counselling aiming at Reducing Expressed Emotions
12	Anger Management
13	Relaxation Techniques
14	Problem Solving Therapy
15	Strengthening Support System
16	Enhancing Problem Solving Skills
17	Contingency Management Techniques
18	Motivational Enhancement Therapy
19	Coping Skills Training
20	Assertiveness Skills Training
21	Recreational Therapy
22	Exposure Response Prevention Therapy (ERP)
23	Resource Mobilization
24	Group Therapy
25	Grief Therapy
26	Craving Management
27	Sex Education
28	Crisis Intervention
29	Family Therapy
30	Attachment Therapy
31	Bibliotherapy
32	Referral and Collateral Interventions
33	Medico Legal Interventions
34	Mental Health Advocacy and Networking
35	Environment Modification
36	Case Management

37	Relapse Prevention Strategies and Motivational Interviewing
38	Welfare Measures
39	Rehabilitation
40	Pre Discharge Counselling

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A STUDY ON ISSUES AND PROBLEMS OF WOMEN IN RURAL RAJASTHAN

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ABSTRACT

Introduction: Rajasthan is India's largest state in geographical area and it prides itself on a rich cultural heritage, the people here are known to value long-held beliefs, customs and traditions. The state has a population of about 68 million people; almost 48% of the population are female (Census 2011). The National Commission For Women (NCW) received the third highest number of cases of crime against woman from Rajasthan in 2010-11., out of 1,350 cases, maximum cases of child marriage are received from Rajasthan followed by cases of dowry and domestic violence. This research paper discusses the various issues and problems faced by rural women in Rajasthan.

Aim and Objectives: The aim of the present study was to empirically understand the issues and problems faced by women in rural areas of Rajasthan.

Materials and Method: Descriptive Research study was undertaken to study the problems of rural women in Rajasthan. Married women above 18 years living in Kalyanipura and Parasia villages of Ajmer District, Rajasthan were interviewed with the help of semi structured interview schedule prepared by the researchers.

Results and Discussion: Nearly half of the women in the present study were illiterate (41.2%), the mean age of marriage for women were found to be 14.63±6.19 years and for men were 17.57±6.19 years. As reported in the present study, less than two third of women (60.8%) were satisfied with their married life. A vast majority of women (>90%) revealed that, they cannot easily and freely talk with their husband. Majority (88.2%) of women reported that due to social structure of society, they had hesitation to sleep with their husband. When it comes to reproductive rights, a vast majority (85%) of women felt that they are treated as a slave for reproducing children. Two third of women (66.7%) had no freedom to take decisions in family planning. Further, nearly three fourth (70.6%) of the women reported that they are not allowed to participate in decision making at home, 86.5% of women reported that they are not allowed to take part in expenditure or financial matters related to home.

Conclusion: If the state wants to bring a change, they need to change the ideology and thinking of children by making changes in syllabus and education system. Further, educating the women and children about their rights can bring in the required changes. The greatest need of the hour is change of social attitude towards women.

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A STUDY ON ISSUES AND PROBLEMS OF WOMEN IN RURAL RAJASTHAN

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Introduction

Rajasthan is India's largest state in geographical area and it prides itself on a rich cultural heritage, the people here are known to value long-held beliefs, customs and traditions. The state has a population of about 68 million people; almost 48% of the population is female (Census 2011). Many factors coalesce dramatically to make the position of women in Rajasthan, a desperate one. Child marriage and dowry system are age-old customs in Rajasthan. Gender based discrimination, wages based discrimination, and health and malnutrition are the other issues which rural women face in Rajasthan. Incidences of Female foeticide, sexual abuse and domestic violence are high; many incidents never get reported to neither authorities nor the media. The state also has one of the lowest rates for female literacy in India. Rajasthan state has made policy document for empowerment of women, however, it has failed to enable the participation and decision making of women themselves.

Women of Rajasthan want to live in dignity; they do not want to be reduced to a state of helplessness where there is no respect for them as a human being (Ramachandran, V, 1999). This was explained further by Ramachandran (1999), that dignity means meeting the basic needs such as clean water, toilets, fuel, food and a roof over head; freedom from violence; justice - a society where right and wrong is recognised; equity between men and women and between people; not be dependent for essentials on the outside world; opportunity to know the world outside - mobility, exposure and information; society where every girl and women experiences good health; a clean environment and a say in decisions which affect their lives.

Kumari, S., Kaushik, V., & Lodha, N. (2010) in their research article state that a different orientation is required in rural sector and an altogether different outlook is required for developing women and that should be based on understanding of the dynamics of rural behaviour. The life and lifestyle of women living in Rajasthan is more complicated than the surface level problems reported by media or crime department. Some of age old customs which complicate the problems of women are Naata system, Aata-Saata, and Feudalistic Patriarchal system, which are still practiced, besides the abolished systems, viz., Sati, Dowry and child marriages.

Sharma, M. and Jha, S. (2011) report that 'Nata Pratha' is a traditional practice whereby a man can refuse to stay in his present marriage and can seek antoher woman by paying a specified monetary price for her, 'Jhagada'. The sum may range from a few thousands to even a few lakhs. The reasons for divorcing a woman may range from her character being suspect to calling her a witch and subsequently abandoning her. As nata is traditional practice which is socially sanctioned and acknowledged, most men have the freedom to leave one women and get another without actually giving any reason for it. Nata Pratha has always been practiced in rural Rajasthan. It has many repercussions on women and society. The women are left to live on their own, and children out of this wedlock survive as orphans.

Marriage by exchange or negotiation is known as ata-sata system (Singh, K.S., 2008), wherein, the daughter of a family is married in the same family as the son. Once upon a time it was the tradition of Kamad and Gavarias community, however, at present it is quiet prevalent in Rajasthan. Many people in Rajasthan sort to this tradition to evade dowry issues and there is more security, generally the couples are married during the same occasion. The present situation is that many brides wait for the suitable match for themselves and their brothers, if any conflicts start in one family, the repercussions are reflected in other too.

Patriarchal feudalism could be described as a set of implicit exchanges in which the subordinated parties (women or children) received protection and security in return for working long hours in the service of their superiors (lords or men). But these exchanges were enforced by threat of violence as well as weight of political and military power. In the past, a variety of collective interests were at work: lords benefited from the extraction of labor dues from serfs; men benefited from a division of labor that assigned women the least remunerative forms of work; and parents benefited from their children's labor and support. The internal organization of the lowest level of society, the peasant family, replicated the hierarchical organization of the whole. Religious precepts also reinforced the authority of men over their wives and children, enhancing incentives to high fertility within

marriage. The exclusion of women from access to education or to apprenticeships in trade or commerce constricted their alternatives to marriage. Within marriage, women had no right to refuse intercourse or to avert conception. But patriarchal religious doctrines also played a role, encouraging high birth rates and sanctions against infanticide that probably contributed to demographic expansion. The brutal repression of women through witchcraft trials may have been intensified by economic insecurities, but it served patriarchal interests more directly than the interests of any nascent capitalist class (Nelson, 2011).

The problems of women folk in Rajasthan become much more complicated when we look very closely. More than the problems the life and lifestyle of these women is more complicated than the surface level problems reported by media or crime department. Starting with the problems of rural women, The National Commission For Women (NCW) received the third highest number of cases of crime against woman from Rajasthan in 2010-11., out of 1,350 cases, maximum cases of child marriage are received from Rajasthan followed by cases of dowry and domestic violence. This research paper discusses the various issues and problems faced by rural women in Rajasthan.

Aim and Objectives

The aim of the present study was to empirically understand the issues and problems faced by women in rural areas of Rajasthan. The specific objectives of the study were to analyze general living conditions of women, understanding issues related to marital life and reproductive health, studying about their feelings and thoughts and social experiences.

Materials and Method

Need for the study: An observation made by Wells of India organization (Grey, 2007), a NGO addressing the issues of women reports that Rajasthan is the second poorest state in India and many of the opportunities for women do not penetrate to the remote interior villages because of ancient traditions, religion, discriminatory customs and values in addition to the caste-based patriarchy. The status of women in Rajasthan has become an international issue. Despite all efforts towards social justice, women continue to be perceived as burdens.

It has been observed personally, by the researchers that the rural women in Rajasthan are still facing problems and patriarchy has continued to be there to have a control over women. Domestic violence, gender based discrimination in wages, work and education, women rights violation, matrimonial trends of Naata and Aata Saata system, preference for boy child and child marriages

were the problems rampant as depicted in the media and local dailies. All these observations made the researcher to study the frequently missed issues faced by rural women of Rajasthan.

Study design selection: A review of literature related to various issues of women in Rajasthan revealed that most of the studies were generally carried on gender inequality on economic marginalisation (Agarwal, 1989 & Moore, 1993); studies on microcredit, nature and the extent of rural poverty (Grillo & Stirrat, 1981 and Moodie, 2008); women and illiteracy, (Stromquist, 1990); marital violence, human development and women's property status (Panda, 2005); community-based prevalence studies of gynaecological morbidity (Koenig, Jejeebhoy, Singh, & Sridhar, 1998); health and economic status, as well as the public and private provision of health care (Banerjee, Deaton, and Duflo, 2009); antenatal care, provision and inequality in rural north India (Pallikadavath, Foss and Stones, 2005); and childbirth practices in rural Rajasthan, (Iyengar et al., 2008). A comprehensive review on women issues was not possible due to paucity of time and accessibility of journal articles for the researchers. The researchers felt that many issues related to women were not yet described properly and Descriptive Research study was undertaken to study the problems of rural women in Rajasthan.

Field of study: The sample was selected from Kalyanipura and Parasia villages of Ajmer District, Rajasthan. These villages were chosen due to accessibility of researchers by road and personal vehicle. Further, the village panchayat leaders were known to the researchers who helped in providing permission to collect the data. These villages are located in plain demographic area; the basic income source of the residents of the village is agricultural activities and cattle rearing. The main water source for agricultural and day to day use is from borewell, wells and village ponds, wherein rain water is harvested.

Sampling frame: Married women above 18 years living in Kalyanipura and Parasia villages were considered to be involved in the study.

Universe of the sample: In Kalyanipura a total of 17 women were found to satisfy the sampling frame as decided. Parasia village was a larger community when compared to Kalyanipura, in total 134 women were found to satisfy the sampling frame. It was intended to interview atleast 100 women.

Method of sampling: Since Kalyanipura had a total of 17 women, all the women were included in the study, hence survey method was followed. In Parasia village the selection of sample was made by judgement sampling. Judgement sampling is one of the deliberate sampling or non probability method. In this researcher's judgement is used for selecting items which he considers as representative of the population (Kothari, C.R., 2004). This type of sampling was considered due

to various reasons. The main reason being, (1) the villagers have strong caste feelings, they socialize with only their own caste people, reception of researcher as an outsider and from different caste (2) socialization and interaction of women with any strangers, especially people from city is considered as a taboo, and (3) being the availability of women and feasibility of interviewing them. As these women are engaged in house hold chores and working in their own fields. A sample of 51 women was interviewed personally at their homes in the month of December, 2013. Each interview lasted upto 20 to 30 minutes. However, due to lack of time and saturation of availability of women in village the sample 17 women from Kalyanipura and 34 Women from Parasia Village were included in this study. The mean age of the women was found to be 36.47(±10.75) years; age range was between 19 to 60 years. Nearly two fifth (41.2%) of women were illiterate and one fifth (19.6%) were educated upto 5 standard.

Tool of study: A semi structured interview schedule was prepared by the researchers to explore the issues and problems of rural women. The interview schedule had questions related to basic demographic details of women, facilities available within the house, specific problems at home, issues related to privacy, marital life and reproductive health. Further, few more items were related to personal feelings and thoughts and social experiences and issues related to work and occupation.

Results and Discussion

The data was analysed with the help of simple frequency distribution and observations made by researchers during the interviews are discussed below.

Education of women: Nearly half of the women in the present study were illiterate (41.2%), and one fifth (19.6%) of them had studied upto 5^{th} Standard, whereas, one sixth (17.6%) had studied upto Middle School. Only 11.8% women had studied till secondary school and very few (9.8%) of them were educated above 11^{th} Standard. There were many reasons for illiteracy and less education in women. Child Marriage and undesired behaviour of parents had been the reason for being illiterate and less educated for very few (5.9%) of the women. Similarly, caste based discrimination and non availability of schools in villages has acted as an obstacle for few (9.8%) of them. Domestic Work was a cause for about 2% women. Some (5.9%) of them had faced financial problem, whereas, 3.9 % women themselves been not interested in taking education and for a little more than one fifth (21.6%) of the women, tradition become the barrier in taking education. The exclusion of women from access to education or to apprenticeships in trade or commerce constricted their alternatives to marriage this is paved way through the patriarchal feudalistic system (Nelson, 2011).

Marital Status and Marital Life: A little more than two third (70.6%) had been married. A little more than one seventh (15.7%) had been widowed and few (9.8%) had been separated, whereas very few (3.9%) of them had been divorced in the present study. Rajasthan is famous for its age old cultural tradition of child marriage. In the present study the mean age of marriage for women was found to be 14.63±6.19 years and for men were 17.57±6.19 years. Rajasthan remains as single most state in India wherein the boys and girls are married away before attaining Legal age of 18 Years. The data from Annual Health Survey (AHS) indicates that nearly one-fourth of girls are married before reaching 18 years whereas the average age for boys stand at 20.7 years. The female mean age at marriage in Rajasthan is 17.7 years, every fourth girl in rural areas are married before attaining 18 years.

In this study, vast majority is of arranged marriage, whereas, cultural trend 'naata' and 'aata-saata' hold 9.8 % and only 2% had indulged in love marriage. Vast majority (98 %) of marriage had been of non- consanguineous nature and only 2% had been done under consanguineous. As reported in the present study, less than two third of women (60.8%) were satisfied with their married life, whereas, 39.2% of them were not satisfied with their married life. Nearly three fourth (74.3%) of women had good emotional bonding in their marriage. Only 39.6% of women felt safety and security in their marital life, whereas, 60.0% do not feel safe and secure in their family life. A vast majority of women (>90%) revealed that, they cannot easily and freely talk with their husband. Majority (88.2%) of women reported that due to social structure of society, they had hesitation to sleep with their husband.

Family Type: A little more than half (51%) of the population had been living in nuclear type of family whereas, a little less than half of the population i.e. 49% had been living in joint family. Rural villages of Rajasthan are known for joint family system with large number of members in a family. In the present study 54.9% of family consists upto 5 members, whereas, 45% of the families consist more than 5 members in a family.

Annual Income of the Family: A little less than one seventh (13.7%) of the population had been earning annual income below 1Lakh, whereas a little less than half had been earning 1 to 2Lakh annually. Similarly, a little more than one sixth (17.6%) had been earning more than 3Lakhs but a little more than one fifth (21.6%) had been earning 2 to 3lakhs annually. More than two third (70.6%) families were not facing poverty whereas for 29.4% of them had poverty as a problem.

More than half of the women (62.7%) in the present study were economically dependent over their in-laws and on husbands. More than half (56.9%) women stated that whatever money they earn, they had to give it to their husband or to in-laws, whereas, only 35.3% had been allowed to keep it for themselves. Out of the total sample, 70.6% of women cannot save money by their own but very few (29.4%) of them are allowed to save money.

Women had been contributing to the family income by doing labour work. Out of the total number from the present study vast majority of the women (98%) had been supplementing family income; 88.2% of women had been regularly working in their own fields, whereas 9.8% engage in cattle rearing for income purpose, only 2% of them had been doing tailoring work, labour work as another alternative in family income.

Housing and facilities at home: In the present study, it was observed that, 49% of the houses were having RCC and another 49% were tiled houses, whereas, only 2% were thatched houses. Considerably a good number (60.8%) of people had *Pakka* toilets within the houses and more than one forth (29.4%) were having *Kaccha* toilets in house, very few (9.8%) of them had been going to open space for toilet. Availability of potable water was not a problem, since; a considerably good (84.3%) number of respondents had piped water at home. Less than one seventh (13.7%) people had been using hand-pump, boring or well as water source. Only 2% had been procuring it from outside. Vast majority of people (86.3%) were using pipeline for drinking water whereas more than one eighths (13.7%) had been dependent upon other source of drinking water. More than half of the women had not had their own personal vehicle, nearly 40% of women had been dependent upon public vehicle and 39.2% walk to commute. All the houses (100%) had metered electricity connection. Almost vast majority of people had television as a source of recreational facility and only 2% of them had radio and very few (3.9%) of them had not had any source of recreational facility.

Status at Home

Nearly three forth of women felt that they are treated as an individual at home, whereas, 28.6% of them did not feel treated as individual at their home. Nearly more than three forth of women had felt that they had their own value in their house. Majority of women (80%) reported that their status was not merely of a house maid at their home. Whereas, when it comes to reproductive rights, a vast majority (85%) of women felt that they are treated as a slave for reproducing children. Two third of women (66.7%) had no freedom to take decisions in family planning. Further, nearly three fourth (70.6%) of the women reported that they are not allowed to participate in decision making at

home, 86.5% of women reported that they are not allowed to take part in expenditure or financial matters related to home.

A quarter of sample (25.4%) feels that their family members do not understand their feelings and they also feel rejection for love and affection from family members. A little more than one fifth (21.6 %) reported that they receive unresponsive behaviour from family members ignoring the expressed needs. Majority (>80%) responded that they cannot travel alone anywhere, they cannot join self help groups; they are frequently expected to adjust with others by sacrificing their comfort and peace of mind. However, majority (>80%) of respondents reported that they can easily interact with women folk of their neighbours, easily interact with other men in the family, had freedom to make friends of women in their age group. Vast majority (88.2%) of women cannot go out of the house without permission.

Problems experienced by women

In the present study, majority (86.3%) of people did not report any health problem but less than one seventh (13.7%) had faced general health problems. Majority of women had not had any sanitation problem but more than one seventh of them had problems related with sanitation. Vast majority (94.1%) of women reported that they were overburdened with domestic work, whereas; very few (5.9%) had not felt any burden of domestic work.

Majority (86.3%) of women from the present study reported that they had faced some or the other kind of domestic violence, more than one eighths (13.7%) of them had not faced any kind of domestic violence. The commonest form of domestic violence was verbal abuse and forced indulgence in domestic work. A vast majority of women (>90%) reported that they had privacy in sleeping, changing clothes, keeping their personal things separately, privacy to change sanitary pads, bathing and defecation etc. However, still 10% of women have problems in privacy.

Only one forth (31.7%) of them had easy access to the doctor during problem with menstrual cycle. Similarly, more than half of them (54.9%) were facing problem in access to doctor when required for general health conditions. More than half of the women (52.9%) had reported that they have difficulty to access pre natal and also post natal facilities.

Vast majority (97%) women reported that they had faced cast based discrimination in various matters. Three fourth (75.4%) of the women reported that they have been discriminated on gender basis, 86.3% had faced discrimination at work in terms of wages but less than one seventh (13.7%) of women had not. Vast majority (92.2%) of women in the present study had also experienced discrimination at work in terms of type of work allotted to them.

Those women engaged in labour work frequently reported discrimination in wages fixation. Similarly, more than one seventh (15.7%) of them had not been facing discrimination at work field. There were multiple reasons for discrimination on wages fixation, majority (82.4%) of them reported that discrimination was based on caste and gender of the women.

Frequency Distribution Depicting Brief Profile and Issues of Women in Rajasthan

	Variable	Description	Frequency (N=51)	Percent
Brief Profile of Respondents	Village	Kalyanipura	17	33.3
		Parasiya	34	66.7
	Education	Illiterate	21	41.2
		Upto 5th	10	19.6
		Upto 8th	9	17.6
		Upto 10th	6	11.8
		11th and above	5	9.8
	Marital Status	Married	36	70.6
		Separated	5	9.8
		Divorced	2	3.9
		Widowed	8	15.7
	Family Type	Nuclear	26	51
		Joint	25	49
	Annual Income (INR)	Below 1 lakh	7	13.7
		1 to 2 Lakhs	24	47.1
		2 to 3 Lakhs	11	21.6
		3 Lakhs and Above	9	17.6
	Marriage type	Arranged	45	88.2
		Love	1	2
		Naata or Aata Saata	5	9.8
Issue of Women	Privacy-To speak to husband any time	Yes	5	9.8
		No	46	90.2
	Privacy-To sleep with husband without any hesitations	Yes	6	11.8
		No	45	88.2
	I can take decisions in family planning	Yes	17	33.3
		No	34	66.7
	Safety and security in marriage	Agree	20	39.6
		Somewhat Agree	8	15.4
		Disagree	23	45
	I do not have a say in decision making at home	Agree	23	45.1
		Mildly Agree	14	27.5
		Disagree	14	27.5
	I am not suppose to have any feelings or thoughts	Agree	8	15.7
		Mildly Agree	38	74.5
		Disagree	5	9.8
	I am not allowed to go out of house	Agree	34	66.7

	without permission	Mildly Agree	11	21.6
		Disagree	6	11.8
	I experience discrimination at work in terms of wages	Agree	44	86.3
		Disagree	7	13.7
	Whatever money I earn I have to give it to my husband/ in laws	Agree	29	56.9
		Mildly Agree	4	7.8
		Disagree	18	35.3
	I am not allowed to handle any money	Agree	31	60.8
		Mildly Agree	13	25.5
		Disagree	7	13.7

Conclusion

The field observations reveal that women still have problems, during the interview; the researcher observed that villages in Rajasthan still have old benchmark tradition of 'Aata–saata' system. A girl of 35 years had not yet married just because of this 'aata-saata system', the girl and her parents are waiting for a family where they can find an unmarried boy having three sisters, so that they can arrange the marriage of their daughter. The same had been reported in media and many studies also during survey, researcher found cases of child marriages, child marriage are still prevalent despite government interventions because village elders or leaders decide the marriages, it is because of holding on to old values and tradition.

Child marriage is an established social custom in Rajasthan. It is very common custom, little children, even infants, are married away on an auspicious day called 'aakha teej'. Child marriages contribute to virtually every social problem that keeps Rajasthan behind in women's rights. Despite several attempts of the state government, the evil practice is widely prevalent in the state.

The failure to improve the condition of women from poverty and suppression lies in the inability of proper implementation of government policies. Further, the tradition of feudalistic patriarchal system has also contributed to it. This can be overcome by education of women and the school going children. If the state wants to bring a change, they need to change the ideology and thinking of children by making changes in syllabus and education system. Further, educating the women and children about their rights can bring in the required changes.

The greatest need of the hour is change of social attitude towards women. The time has come when it becomes necessary that a woman is viewed as one person and all the programmes whether it is in health sector or in education sector or in economic sector or are meant for providing protection from adverse situations is planned and executed in integrated and holistic manner. Empowerment of women, respect of women in society, treating them as not merely house maids and income generation source, reduction of corruption, proper education of children can make Rajasthan state no longer the second poorest state.

It is true that we may never be able to eliminate all social and economic injustices or to provide equality of opportunity to all people. But we certainly can take a few practical steps to make our society a little more compassionate, a little more humane (PAIRVI & DCNC).

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EMPOWERMENT OF WOMEN IN DISASTER MANAGEMENT

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Abstract

Disasters are natural unforeseen circumstances resulting in multi dimensional impact. Women are significantly vulnerable owing to socially determined differences in roles and responsibilities and inequalities in terms of accessing resources and decision making power. Research and International recommendations on Disaster Mental Health emphasize the need for the psychosocial care to facilitate the normalization of the emotional reactions. Considering women's socio-political position in the developing economy and their increased vulnerability to disaster it is felt necessary by the International Organizations/Communities like World Bank, HFA, HLP to develop policies and frameworks on Disaster response and Risk reduction which essentially involves empowerment of women as a crucial agenda. Current study shows that Uttarakhand Flood disaster June 2013, created immense impact in terms of Loss of life and Loss of materials and that subsequently led to major psychological impact among the survivors. Women outnumbered men in reporting loss and psychological distress. In terms of dealing with psychological impact on women a capacity building program was conducted for 36 female health volunteers directly working with the affected community for provision of psychosocial care. To understand change in knowledge of the trainees pre and post assessment was done and results indicate that mean post assessment is significantly higher than mean pre assessment (16.75 vs. 12.39) thus leading to a significant difference ($t=12.544$, $df=35$, $p<0.001$) in knowledge level of the trainees/FHVs. This study indicates that women community level workers were empowered in developing capacity to provide PSS and taking initiative in active community participation post disaster.

Key Words: Disaster, Women, Empowerment.

EMPOWERMENT OF WOMEN IN DISASTER MANAGEMENT

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Introduction

Disasters are very complex, a multidimensional phenomenon and they affect the health of the people, especially their mental health whether it is manmade or natural disaster (Srilatha and Rajendran, 2000). The risk of the community depends on the vulnerability in the community (Sekar et al, 2005). The World Health Organization (2002) document on 'Gender in Disasters' reported that since the mid-1990s there has been an increase in the occurrence of both natural and manmade disasters and among the population at risk in the aftermath of any disaster Female-headed households that are more vulnerable to poverty to begin with, more likely to have limited assets, have a slower rate of return to 'normal' and have limited security of land tenure, (Delaney and Shrader 2000; Enarson 2002).

Disasters affect men and women in different ways, with greater impacts on women and children (Dasgupta, Siriner, & Partha, 2010). There are research evidences showing greater psychosocial impact of disaster on women and given the socio-cultural context in developing countries like India, women fall into one of the most vulnerable groups owing to socially determined differences in terms of roles and responsibilities and inequalities between men and women in access to resources and decision making power, (WHO 2002). It was stated in a study on 'Psychosocial Consequences of Natural Disasters in Developing countries' that gender is one of the most important risk factors for adverse outcomes like PTSD, major depressive disorders, depressive symptoms, anxiety or generalized anxiety disorders. Gender influenced post disaster outcomes were strongest for PTSD for which women's rate often exceeded men's by a ratio of 2:1 (Fran H. Norris, 2005).

Mental health aspects of relief and rehabilitation are increasingly recognized as an integral part of disaster response (Satcher D, Friel S, Bell R., 2007). The above literature on the psychosocial problems of the women emphasizes the need for the psychosocial care to facilitate the normalization of the emotional reactions after the disaster with the objective of making individuals and communities more resilient. The Inter-Agency Standing Committee (2007) published international guidelines for the provision of mental health services and psychosocial support during emergencies. These guidelines recommend community-centric activities that assist in the

reestablishment of a sense of place and improve the quality of life of disaster survivors. In India, disaster mental health response has evolved from identifying and treating psychiatric cases with individual treatments to preventing psychiatric morbidity by strengthening the coping abilities of survivors in community-based self-help groups, with community-level workers as providers of psychological care and facilitators of recovery for affected communities. (Prewitt Diaz J, Murthy S, 2004). In 2003, the International Federation of the Red Cross established a policy that encourages integration of psychological support into existing disaster infrastructures, with training programs for lay counselors to address the overwhelming mental health needs of affected populations in resource-poor settings. (Prewitt Diaz J, Lakshminarayana R, Bordoloi S., 2004). Thus literature and evidence research shows the importance of involvement of women in disaster management and preparedness and their empowerment as crucial in community mobilization post disaster. Current study is emphasizing on women empowerment through capacity building program post disaster in terms of their acquiring proficiency in knowledge and skill in provision of psychosocial support for disaster survivors.

Context

In June 2013, Uttarakhand 27th State of the Union of India and adjoining Himalayan region experienced devastating floods leading to death of more than about 5000 and many more missing. The worst affected areas include Rudraprayag, Chamoli, Uttarkashi and Pithoragarh districts. The main cause of the flood was heavy rainfall for 3 consecutive days and a huge cloudburst leading to massive devastation. In context of this disaster Relief Commissioner of Rudraprayag District, Govt. of Uttarakhand & NGO HelpAge India State Head, Uttarakhand who were working in collaboration in the worst flood affected regions of Rudraprayag district requested NIMHANS (National Institute of Mental Health and Neurosciences, Bangalore, India declared as the Nodal Centre and Centre of Excellence in Psychosocial Support and Mental Health Services by the Ministry of Health and Family Welfare, Govt. of India, in 2005) to provide PSSMHS for survivors of those areas. NIMHANS Team visited Guptakashi and associated villages, 30kms from Kedarnath Temple in Rudraprayag district where the magnitude of flood was highest. From NIMHANS's visit in Guptakashi area and associated villages in Rudraprayag district certain recommendations were given like: 1. Psychological Impact assessment of the affected survivors. 2. Training/capacity building program for Female Health Volunteers (ASHA, ANMs, and Anganwadi workers) in order to empower them to provide PSS to the affected community.

Methodology

This study attempts to understand the scope of provision of psychosocial support to the flood affected survivors by empowering the community-level-workers (ASHA, ANMs and Anganwadi workers) through a Capacity Building program. Objectives: 1. To assess the impact of the floods on women in Guptakashi and associated villages of Rudraprayag district. 2. To conduct a capacity building program on 'Women health volunteers' for empowering them to provide Psychosocial Care & Support among the disaster affected community in Guptakashi and associated villages.

A Sample Survey was conducted to find out Impact of disaster among the affected villagers. A Purposive sampling was done in choosing 36 Female Health volunteers from the same affected villages to conduct a capacity building training program in order to empower them in providing psychosocial support to the affected villagers. Population to be studied includes people from worst flood-hit villages, 30kms from Kedarnath Temple, Rudraprayag District. A sample of 133 people from 6 worst affected villages was assessed for Psychological Impact and 36 Female Health Volunteers-ASHA, ANMs, and Anganwadi were chosen for Capacity Building Program on provision of Psychosocial Care.

Tools of Data collection involved: 1. Structured Questionnaire on 'Domains of Impact' (Intrusion, Hyper-arousal & Avoidance) based on the items of IES-R (Daniel Weiss & Charles Marmar, 1997) for Impact assessment. 2. Disaster Opinion Questionnaire (DOQ) with Items on Psychosocial Factors in Disaster & Psychosocial First-Aid during and Post Disaster for Pre-Training & Post-Training assessment**.**

Process of Data collection: Structured Interview in the form of door-to-door personal interview for assessing Impact of the disaster was conducted in all the six worst affected villages. For the Capacity Building Program on provision of psychosocial care a Pre-Intervention Assessment on DOQ was done following which Intervention (3 days Essential Module Training on Provision of PSC for FHV) was given and following that a Post-Intervention Assessment on DOQ was done. The trainees/Female Health Volunteers were chosen from different affected villages in and around Guptakashi and associated villages.

The Capacity Building program on 3 days Essential Model of PSC was conducted using training methodology based on a participatory model including group discussions, group presentations, role plays, sharing of experiences, flash cards, card sorting, group activities using analogies etc. The intervention package for the Female Health Volunteers was developed based on the Standardized Tool kits available in NIMHANS- 1. Psychosocial Care in Disaster Management - My Workbook; 2. Facilitation Manual for Trainers of Trainees in Natural Disasters, (Sekar et al., 2006). The

theoretical framework for the intervention followed a model of psychosocial care towards normalization of psychological reactions of both adult and children and principles and techniques of psychosocial care for survivors affected by Uttarakhand Flood disaster. Verbal ethical consent was taken from the interviewees regarding collecting information about their mental health status assured that their identity would be kept confidential throughout the process. The data acquired was entered and processed using SPSS software. Descriptive measures, Chi-Square test and Paired t-test were done to analyze the data. Results with $p < .001$ & $p < 0.05$ were considered to be statistically significant.

Results

Analysis shows the distribution of affected survivors in terms of demographic variables like age and gender. It was found that from the total sample of 133 affected survivors 21.8% (29) were male and 78.2% (104) were female who were assessed for the impact of disaster. The age distribution shows that 21.1% (28) of people belonged to the age group of 18-25 years, 25.6% (34) of people belonged to the age group of 26-35 years, 26.3% (35) of people belonged to the age group of 36-45 years, 24.1% (32) of people belonged to the age group of 46-60 years and 3.0% (4) of people belonged to the age group of 61 years and above.

Results reveal that from total sample of 133 affected people 9.8% (13) reported to have Loss of Property while 90.2% (120) have reported to have no loss of property. Similarly 54.9% (73) reported to have Loss of Livelihood in the family while 45.1% (60) reported to have no loss of livelihood and 78.2% (104) reported to have Loss of Life in the family while 21.8% (29) reported to have no loss of life in the family.

Chi-Square test was done to see whether there is any difference in Association between Gender and Loss and analysis shows that among women (104) 11.54% (12) reported to have 3 Items Loss (Property, Livelihood & Life) in their family, 32.69% (34) reported to have 2 Items Loss in their family, 44.23% (46) reported to have 1 Item Loss in their family and 11.54% (12) did not report to have any Loss in their family. While among men (29) 0.0% (0) reported to have 3 Items Loss in the family, 55.17% (16) reported to have 2 Items Loss in their family, 27.59% (8) reported to have 1 Item Loss in their family and 17.24% (5) did not report to have any Loss in their family. The difference in association between Gender and Loss was found to be statistically significant $\chi^2(3) = 8.5188$, $p < .005$.

Analysis reveals the Domains of Psychological Impact among the affected population which involves 3 main Domains (Intrusion, Hyper-arousal & Avoidance) and 6 sub-domains (Disturbed

sleep, Flashback, Intrusive experience – Intrusion; Physiological arousal, Irritability-anger – Hyper-arousal; Avoidance reaction – Avoidance). It was found in the result that 88.7% of the affected survivors reported to have disturbed sleep after the disaster while 11.3% did not report to have disturbed sleep, 91.7% reported to have Flashbacks while 8.3% reported to have no Flashbacks, 79.7% reported to have intrusive experiences while 20.3% did not report to have intrusive experiences. 37.6% of the affected survivors reported to have physiological arousal while 62.4% did not report to have physiological arousal, 27.1% reported to have irritability-anger while 72.9% reported to have no irritability-anger. 3.0% of the affected population reported to have avoidance reaction while 97.0% did not report to have any avoidance reaction.

Chi-Square test was done to see whether there is any difference in association between Gender and Impact. Analysis on Association between Gender and Intrusion shows that among women (104), 81.73 (85) reported to have 3 Reactions of Intrusion (Disturbed sleep, Flashbacks and Intrusive experiences), 12.5% (13) reported to have 2 Reactions of Intrusion, 5.77% (6) reported to have no Reaction of Intrusion while among men (29), 58.62% (17) reported to have 3 Reactions of Intrusion, 24.14% (7) reported to have 2 Reactions of Intrusion and 17.24% (5) reported to have no Reactions of Intrusion. The difference in association between Gender and Intrusion was found to be statistically significant χ^2 (2) = 7.23, p <.005. Analysis on Association between Gender and Hyper-arousal shows that among women (104), 21.15% (22) reported to have 2 Reactions of Hyper-arousal, 27.88% (29) reported to have 1 Reaction of Hyper-arousal and 50.96% (53) did not report to have any Reaction of Hyper-arousal while among men (29) 3.45% (1) reported to have 2 Reactions of Hyper-arousal, 37.93% (11) reported to have 1 Reaction of Hyper-arousal and 58.62% (17) did not report to have any Reaction of Hyper-arousal. The difference in association between Gender and Hyper-arousal was not found to be statistically significant χ^2 (2) = 5.12, p = 0.07. Chi-Square test could not be performed to see whether there is any difference in association between Gender and Avoidance because the number of people (both Male and Female) was less reporting to have Avoidance reaction. Among women (104) only 2.88% (3) reported to have Avoidance Reaction and 97.12% (101) did not report to have any Avoidance Reaction, while among men (29) 3.45% (1) reported to have Reaction of Avoidance and 96.55% (28) did not report to have Avoidance Reaction.

The number of Trainees/Female Health Volunteers for capacity building training program were 36 with an age range of 28-55 years. Result shows that 36.1% (13) were Auxiliary Nurse Wives, 11.1% (4) were Anganwadi workers and 52.8% (19) were ASHA workers.

To understand the level of knowledge among the participants (Female Health Volunteers) both pre and post training, Disaster Opinion Questionnaire was administered among the trainees. The compared result between the pre and post assessment are here as follows:

Figure 1

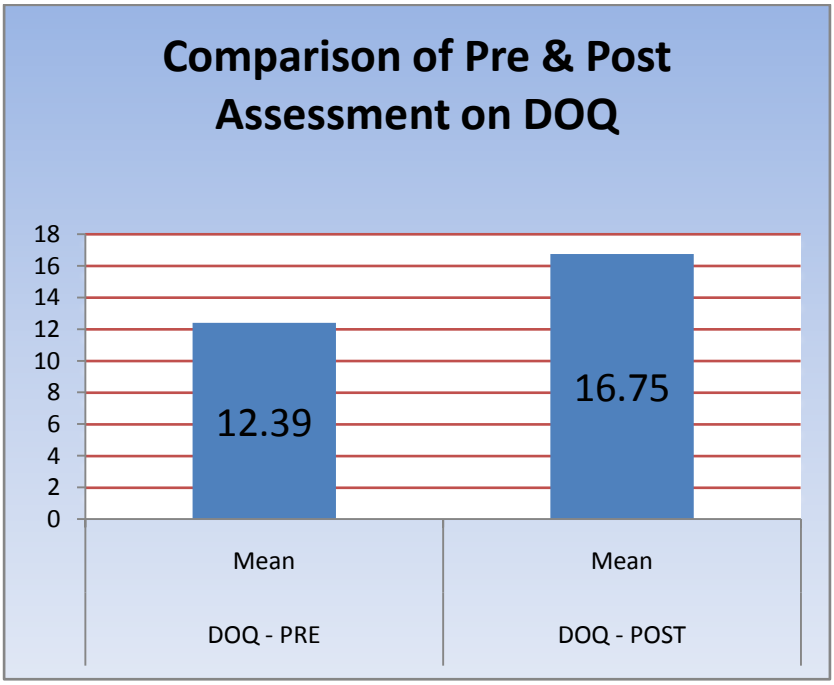

Figure 1 indicates the comparison of Mean Pre and Post Training assessment of the response of FHVs on DOQ. Paired t-test shows a significant difference ($t = 12.544$, $p<0.001$) between pre and post assessment scores of the trainees on DOQ. The mean post assessment is significantly higher than that of mean pre assessment (16.75 vs. 12.39) thus leading to a significant difference between the pre and post assessment scores, ($t=12.544$, $df =35$, $p<0.001$). This indicates higher knowledge level among the Trainees/FHV's post Training assessment on DOQ.

Discussion

Disasters have been occurring globally over the ages causing insurmountable amount of death, destruction and disruption of entire systems that exist in physical and social environment. India with her unique climate and topography has often been described as a "theatre of disasters" (Parasuraman and Unnikrishnan, 2000). Epidemiological evidences have found that there are

certain populations who have been consistently vulnerable when disaster strikes. Gender (along with class, ethnicity and other social markers of identity, privilege, and marginality) intersects with each of these categories to reinforce people's susceptibilities to disaster. Household relations and dynamics also play a critical role in determining people's levels of risk and vulnerability because the domestic arena is where gender relations, roles and responsibilities, as well as the privileges and entitlements that arise from them, are enacted, (Bradshaw, 2004).

In the current study it is found that among 133 people who were assessed for impact of disaster 21.8% of them were male while 78.2% were female. This shows that more number of females got affected by the disaster than number of males in that particular area.

Analysis shows that affected population have undergone Loss of Property (9.8%), Loss of Livelihood (54.9%) and also Loss of Life (78.2%) in their family after the flash flood disaster.

Chi-Square test reveals that there is statistically significant difference between Gender and Loss where females significantly outnumbered males in reporting Loss (Property, Livelihood & Life), 92 females; 92.3% vs. 24 males; 82.75%, χ^2 (3) = 8.5188, p <.005.

That women are disproportionately affected by disasters is indisputable, (WHO, 2005). Women are especially likely to work in agricultural industry or the informal economy, both of which tend to be heavily impacted by natural disasters. Due to this fact and their lower educational and literacy levels, they are overrepresented among those who end up unemployed. While women are expected to continue performing traditional duties like childcare and nursing the wounded, those who have lost partners or parents must also take on the burden of providing financial support. Due to their caretaking responsibilities, they are not free to relocate in search of work, (Pan American Health Organization, 2001).

In the current study, the disaster affected population were assessed under 6 sub-domains of 'Reactions of Impact' (Disturbed sleep, Flashback, Intrusive experience – Intrusion; Physiological arousal, Irritability-anger – Hyper-arousal; Avoidance reaction – Avoidance) which falls within the 3 main Domains of 'Psychological Impact' (Intrusion, Hyper-arousal & Avoidance). Chi-Square test was done to see whether there is any difference in association between Gender and domains of Impact. Analysis shows that there is statistically significant association between Gender and 'Intrusion' where females exceeded number of males in reporting intrusive reaction, 98 females; 94.23% vs. 24 males; 82.75%, χ^2 (2) = 7.23, p<0.05. Chi-Square test was done and no association was found between Gender and 'Hyperarousal' (51 females; 49.03% vs. 12 males; 41.37%, χ^2 = 5.12, p-value = 0.07). Chi-Square test could not be performed between Gender and 'Avoidance' because only 3 females (2.88%) vs. 1 male (3.44%) out of 133 affected people reported to have

such reaction within 2 months of the disaster event. Thus it can be interpreted that only in terms of intrusive experience as an impact of event there is significant difference among male and female gender. However intrusion being present among significant number of people and hyperarousal among quite few (in both cases number of female was more) shows that affected people, specifically women, had significant psychological distress pertaining to Loss after disaster.

Thus while men are obviously affected (depending on context, often harder hit by disasters) the broad trend in South Asia and elsewhere is that women find it harder than men to withstand and respond to crisis situation (IFRC, 2006; Twigg 2004). While it has been suggested that 'women always tend to suffer most from the impact of disasters' (UN/ADPC 2010: 8), a recent empirical study highlights that it is where gender inequalities are high that women are more likely than men to be vulnerable to the negative effects of hazards (Neumayer and Plümper 2007).

Considering women's socio-economic and political position in the developing economy and their resultant vulnerability or susceptibility towards impact of disaster it is deemed necessary to involve women and girls and empower them in disaster response and risk reduction to address the gender inequality. The recent report from High Level Panel (HLP, 2013) has clear gender rhetoric with a goal to empower girls and women and achieve gender equality.

As discussed so far, current study has found that women are more affected by the disaster than men. To deal with such psychological impact among women a capacity building training program was done on the female health volunteers like ANMs, Anganwadi, and ASHA workers who are the main community level workers working directly with the affected community to empower them to provide psychosocial support/psychosocial first aid to the larger disaster affected community. To understand difference in the level of knowledge among the trainees (FHV/CLWs) both pre and post training, a paired t-test was done and analysis shows that mean post assessment is significantly higher than that of mean pre assessment (16.75 vs. 12.39) thus leading to a significant difference ($t=12.544$, $df=35$, $p<0.001$) in knowledge level of the Female Health Volunteers. Thus the result shows that there is significant gain in knowledge and information among the Female Health Volunteers and the capacity building program was able to empower them in active community participation of taking up significant role in provision of PSC/PSFA among the disaster affected community.

Considering empowerment in knowledge and skill of providing Psychosocial First Aid (PSFA) as the main focus of community capacity building program in the current study is supported by the IFRC as it suggests addressing psychosocial needs should be based on the principle that most acute stress problems during emergencies are best managed without medication, following the principles

of ‘psychological first aid’ (IFRC 2009). Encouraging women community participation as another factor for their empowerment as emphasized by this study is also supported by IFRC. A high degree of community participation is generally accepted as one way to encourage empowerment of the people (International Federation of Red Cross and Red Crescent Societies, 2003). In a study conducted by Susan M Becker, ‘Psychosocial care for Women Survivors of the Tsunami disaster in India’ it is shown that NIMHANS implemented the ‘train the trainer’ model of psychosocial care and psychosocial care was provided for 3 months to women survivors which significantly decreased the post-training-test score on IES (Impact of Event Scale), (Becker, 2009). This shows the reliability factor of the capacity building program done by NIMHANS which helps to enhance PSS (PSFA) in the community.

Conclusion

Disaster is a complex emergency leading to multiple impacts and mental health consequences of those impacts are most notably significant as cited by worldwide literature. Women as one of the most vulnerable groups affected by disaster owing to their socio-political situation in developing economy, it is imperative to understand the importance of their involvement in disaster response to address the existing gender inequality. This study focused on facilitating capacity of a group of women Health Volunteers to provide PSFA in the disaster affected community thus encouraging their community participation and empowerment to take on individual roles in disaster response and rehabilitation strategy. With the significant increase in knowledge post training, it can be thus concluded that Female Health Volunteers were ‘empowered’ to provide larger PSS in the disaster affected community in Guptakashi area of Rudraprayag dist. Uttarakhand.

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PSYCHO-SOCIAL ISSUES DURING THE MENSTRUAL PERIOD AMONG RURAL ADOLESCENT GIRLS

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ABSTRACT

INTRODUCTION:

The word adolescence comes from a Latin word 'adolescere', meaning to grow in maturity. In the life of every adolescent girl menarche is a significant event. The onset of the menstruation is a sign of reproductive maturity denoting the achievement of a major functional state.

In existing Indian cultural milieu, there are several traditions, myths, misconceptions, *mystery* and superstitions with regard to menstruation. Considering menstruation as unclean imposed many restrictions and isolation of women during the cycle creates negative attitude towards this phenomena in adolescent girls (Busari,. 2012) with this background the current study attempting the psycho-social issues of rural adolescent girls during the menstruation period.

METHOD:

Girls aged between 13-16 years studying at Government high school in Turuvekere Taluk of Tumkur district, Karnataka, constituted the study population. A total of 30 students from 8th, 9th and 10th standard were selected for the study using the simple random sampling method. A semi-structured questionnaire was used to collect information from the respondents.

RESULT

Most of the adolescents were in 15 year age group (40%) and were hailing from below poverty line families. Many of the girls lacked knowledge about menstruation and often they believed that women are vulnerable to be possessed by devils and spirits during menstruation. Interestingly respondents reported that the visiting of holy places during menstruation was strictly restricted (95%) and visiting relatives, friends, and neighbours' house was also restricted (86.7%). Many of the girls (86.7%) didn't attend ceremonies like marriage, naming ceremony during a cycle. 86.7% reported not working outdoors during menstruation.

Key Words: Rural, Menstruation, Adolescent
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PSYCHO-SOCIAL ISSUES DURING THE MENSTRUAL PERIOD AMONG RURAL ADOLESCENT GIRLS

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INTRODUCTION

In the life of every adolescent girl menarche is a significant event. The onset of menstrual periods in a girl is a sign of reproductive maturity, denoting the achievement of a major functional state.

It marks the transition of a girl to a woman. The menstrual period is a biological phenomenon that occurs throughout the reproductive life of every female. Despite the fact that menstruation is a normal physiological process it is often not discussed openly especially in the rural areas due to some cultural restrictions. These impede the flow of information across generations. (Busari, 2012).

In existing Indian cultural milieu, there are several traditions, myths, misconceptions, mystery and superstitions with regard to menstruation. Considering menstruation as unclean imposed many restrictions and isolation of women during the cycle have created negative attitude towards this phenomenon in adolescent girls (Khanna et al,.2005).

Singh et al 2006 have reported of a number of taboos and social / cultural restrictions like not being allowed to take bath, cook, change clothes, comb hair and enter holy places and not visit neighbours' houses. Women are regarded to be dirty or impure during a cycle. Food restrictions on rice, curd, milk, radish, potato, sugarcane and onion are also practised.

The experience of menarche can often be negative and traumatic to an adolescent girl having many psycho-social difficulties during the menstrual period with various misconceptions and restrictions practised during menstruation. They may develop a negative attitude towards this physiological phenomenon. Majority of the girls are hesitant to discuss this topic with their parents and and lack

knowledge about menstruation and puberty. They often are unaware about the physiological changes in the body of an adolescent girl.

This study attempted to understand the psycho-social difficulties of menarche and menstruation among adolescent girls with respect to their life situation and scope of promoting quality of life by appropriate intervention programmes for these girls.

MATERIALS AND METHODS:

Adolescent girls (age range 13-16 years) studying at government high school of Turuvekere taluk in Tumkur district of Karnataka were the study population. A total of 30 students from 8th, 9th and 10th standard were selected using the simple random sampling method. After obtaining written informed consent from participants further history was obtained. Adolescent girls who had not attained menarche, who were unwilling to participate and girls with mental retardation were excluded from the study. On any day the first two adolescent girls meeting the inclusion criteria were recruited; after completing their interviews, which took about 60-90 minutes, the next participant meeting the criteria were recruited. In this way, about 2-4 girls were recruited on each day.

Tools: A semi-structured questionnaire, validated by field experts, was used to collect information from respondents.

Results:

There were 30 participants with a mean age of 14 years, 60% of students were from the 10th standard belonging to below poverty line of Hindu religion hailing from a rural background..The parents were working at household or as coolies in the agricultural lands. Mothers of most girls were illiterate and some had primary school education.

Results showed that adolescent girls were restricted from visiting holy places (89%) and also visits to relatives, friends and neighbours' house were restricted (80.4%) during menstruation. Over three fourth (76.6%) did not attend ceremonies like marriage, naming ceremony during the cycle. Over two thirds (68.6%) didn't work outdoors during cycle. A minority were not allowed to attend school during these days.

Over half reported (63%) living in a separate room during menstrual days. A third did not sleep on their bed and over half (55%) were not allowed to do household activities. The food restrictions were practised by over half (56.7%) during menstrual days. They involved foods like butter milk/ curd, egg, milk, jaggery and sweet.

Discussion:

This study highlights the important psycho-social issues of adolescent girls faced during menarche and menstrual periods. 60% of the girls expressed feeling stressed, lonely and sad. They also expressed concern that they are not allowed to sleep on their routine bed and need for staying in a separate room. They are also not allowed to attend any ceremonies and visit holy places. These influenced the need to study their knowledge level and the practices they follow during menstruation.

43% of the adolecent girls reported of facing gynaecological problems due to unhygienic practices during menstruation. This is consequent to their strong bondage with the traditional beliefs and misconceptions during menstruation. Ghattargi et al,.2005 Study showed that repeated use of unclean cloth and improper drying of clothes would spread vaginal infections.

This study highlights the need for professional social workers to provide appropriate intervention programmes for adolescent girls as well the parents and other family members. This may assure a better quality of life for the adolescent girls from rural background. The intervention should provide scientific knowledge and resolve misconceptions about the menstrual periods and with a better understanding of facts. This may be further facilitated by incorporating the topics in the school curriculum and in form of workshops, conferences, training modules etc.

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Acknowledgment: This work is supported by Mr.Nagaraj,Vice principal of Govt pre-university of Turuvekere.

DISTRESS AMONG CAREGIVERS OF MALIGNANT BRAIN TUMOR PATIENTS

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ABSTRACT

Background: In the recent years an increase in the occurrence of brain tumor cases has been seen. Studies depict that the patients and their next of kin are preoccupied with existential thoughts and death anxiety, depression, fatigue, and health issues. Caregiving can be seen as one of the biggest challenge undertaken by an individual. The present study was carried out in NIMHANS, Bangalore. The aim of the present research was to study the level of distress in terms of depression, anxiety and stress among caregivers of malignant brain tumor patients.

Materials and Methods: The sample consisted of 57 caregivers of malignant brain tumor patients, selected with the help of Cross sectional survey method. The researcher used structured interview schedule to collect the data, Depression Anxiety and Stress Scale (DASS-21)(Lovibond & Lovibond, 1995) was used to assess the distress.

Results: In the present study it was seen that male and female caregivers do not significantly differ on depression and anxiety, however significant difference was found for stress. Male caregivers experience more stress (M=27.0612, ±5.08) than the female caregivers (M=23.25, ±4.26). Depression, anxiety and stress among caregivers do not significantly differ based on their marital status, age, religion, educational qualifications, Income, Caregiver relationship.

Conclusion: It is suggested that psychosocial interventions need to be adopted by the treating team for reducing the distress experienced by the family members and adopting positive coping strategies.

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DISTRESS AMONG CAREGIVERS OF MALIGNANT BRAIN TUMOR PATIENTS

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Introduction

Growth of a tumor in the brain can have a devastating effect on an individual. The patients of brain tumors may present with varying severity of clinical symptoms. Some of the patients may present with headaches, weakness in limbs, hemiparesis, change in behavior and some other may present with altered sensorium. Those familiar with brain tumors and their effects attest that brain tumors are unique among medical conditions (Lipsman, Skanda, Kimmelman & Bernstein, 2007). Brain tumors, whether malignant (cancerous) or benign (noncancerous), cause structural damage to the brain, the impact is evident on physical, psychological and social dimension of one's life. Physical changes may include sensory loss, balance problems, loss of control on hands and legs, chronic seizures etc. Psychological impact of tumors could be personality changes, behavior problems, anxiety, and depression (Andrewes et al., 2003). In addition, many people with brain tumors experience cognitive changes. Cognitive deficits that arise include slowed thinking, memory loss, and difficulty multitasking. Studies have documented cognitive impairment in as many as sixty to ninety percent of patients with different types of brain tumors (Meyers & Brown, 2006 and Tucha et al., 2000).

The repercussions of a brain tumor significantly impact quality of life for both patients and loved ones. In recent years, a quality of life model for understanding survivorship has emerged in the cancer/disease community; it encompasses not only physical well-being, but also psychological, social, and spiritual well-being (Ferrell & Hassey, 1997). People in the broader cancer community have accepted that a person is a survivor from the time of diagnosis through the balance of life (Rowland, Hewitt and Ganz, 2006). However, patients facing a brain tumor diagnosis (whether malignant or benign), as well as their health care team, may not identify with this definition of survivorship. There has been a tendency for the focus on the acute control of the tumor to overshadow addressing the many long-term and sub-acute quality of life issues that affect brain tumor survivors.

Distress

Distress can be operationally defined as an experience of fear (anxiety), sadness (depression) and stress as a normal reaction towards an abnormal situation. The abnormal situation here is being in

the hospital and looking after their young one. Family members of patients with cancer experience distress due to caregiving roles, and this distress has been shown to continue over time and may be exacerbated by changes in the patient's condition (Given and Given, 1998).

The emotional impact of providing care is linked to caregiver negotiations of the caregiving role, as caregivers may be unfamiliar with the care they must provide and may not be aware of or able to utilize available resources (Harris et al., 2009). Demitrepe-Saygili and Bozo (2011) studied the predictors of depressive symptoms of mothers of children with leukaemia. Gaugler et al., (2009) with their study tested the hypothesis that various components of the stress process model were related to negative outcomes (depression, guilt, negative health) in cancer caregivers.

When a person is diagnosed with a severe disease like Brain tumors, existential questions and death anxiety are intensified. Adelbratt and Strang (2000) have documented that both, the patients and their next of kin, are preoccupied with existential thoughts and death anxiety (Adelbratt & Strang, 2000). Sherwood and associates (2006) demonstrated that caregivers of persons with primary malignant brain tumors experience depression, fatigue, and health issues (Sherwood, Given & Given, 2006). The impact of this particular illness on family can be summarized in three themes (a) the diagnosis of a brain tumor is a shock; (b) immediate family role changes occur; and (c) there are psychosocial effects for the caregiver, his or her family, and the person with the brain tumor (Houldin & Lewis, 2006).

One of the important aspects of providing better care for patients with terminal illness and their caregivers is to understand their experiences, symptoms, and concerns about life. It requires research into what patients and their caregivers perceive to be the greatest problems with the dying process, the care they receive from the health system, and other issues. The purpose of this study is to understand the complexity of psychosocial problems faced by the caregivers, and address this issue with the help of suitable psychosocial intervention programme. The aim of the intervention is to provide psychosocial support to the caregiver's and the family of the patient with malignant brain tumor.

Aim & Objectives: The aim of this study was to measure distress experienced by caregivers of malignant brain tumor patients. The objectives of the study were to (1) measure the level of depression experienced by the caregivers, (2) To study the level of anxiety experienced by the caregivers and (3) To measure the level of stress experienced by the caregivers.

Materials and Methods

The present study was carried out in NIMHANS, Bangalore. Family caregivers of patients undergoing treatment of malignant brain tumors in neurosurgery units were considered as universe. Caregivers who are above the age of 18 years and actively engaged in taking care of the adult patients with malignant brain tumor, undergoing treatment in neurosurgery unit of NIMHANS were included in the study. Those caregivers who have been earlier diagnosed to have psychiatric illness, or had undergone treatment for any psychiatric illness and Caregivers who are not willing to participate in the study were excluded from the study. During the period of study a total of 117 caregivers of patients admitted in neurocentre, with a diagnosis of malignant brain tumor were screened. Thus, during the period of study, a total of 57 caregivers were selected with the help of Cross sectional survey method (Somekh & Lewin, 2005).

The caregivers were personally interviewed by the researcher with the help of structured interview schedule, it consisted of a standardized tool - Depression Anxiety and Stress Scale (DASS-21) (Lovibond & Lovibond, 1995). The DASS is suitable for screening "normal" adolescents and adults. It is a set of three scales, viz., depression, anxiety and stress. Each of the three DASS-21 scales contains 7 items. It follows Likert Type Scaling. The scales had excellent internal consistence: 0.96, 0.89, and 0.93 for depression, anxiety, and stress respectively.

Gender wise distribution of the caregivers showed that nearly 86% were male and 14% were female caregivers. Only 8.77 % were illiterate, 66.6% were educated upto high school, only 24.6% were educated PUC and above. Nearly 60% were from rural background, nearly 23% were from semi urband and nearly 18% were hailing from urban background. A vast majority of caregivers, around 90% were married and remaining 10% were single.

Results & Discussion

The results computed from the DASS-21 revealed that a little more than half (54%) of caregivers undergo extremely severe depression and nearly a quarter (24.5%) undergo severe depression, moderate level of depression is seen among 14% of caregivers. Anxiety level among caregivers indicated that more than half (56%) of them experience extremely severe anxiety and 36.8% moderate level of anxiety. Extremely severe level of stress is experienced by 19% of caregivers and severe level of stress is experienced by more than half (52%) caregivers.

Table-1: Level of distress (Depression, Anxiety and Stress) experienced by caregivers:

Distress	Level	F	%
Depression	Mild	4	7
	Moderate	8	14
	Severe	14	24.5
	Extremely severe	31	54
Anxiety	Moderate	21	36.8
	Severe	4	7
	Extremely severe	32	56
Stress	Mild	5	9
	Moderate	11	19
	Severe	30	52
	Extremely severe	11	19

***Table*-2: Differences on Distress among Male and Female caregivers**

Distress	Gender of Caregiver	N	Mean	Std. Deviation	Mann-Whitney *U*	*p* Value
Depression	Male	49	26.449	6.64913	133.0	0.144 NS
	Female	8	23.75	5.59974		
Anxiety	Male	49	19.2653	5.48777	145.00	0.233 NS
	Female	8	16.75	5.54849		
Stress	Male	49	27.0612	5.08432	94.54	0.018**
	Female	8	23.25	4.26782		

Level of Significance: * = 0.05, **=0.01, ***=0.001 and NS= Not Significant

The mean differences on depression, anxiety and stress were studied among male and female caregivers. The means of each dimension were computed for males and females separately, further Mann- Whitney *U* was used to find significant differences among male and female caregivers. It was seen that male and female caregivers do not significantly differ on depression and anxiety,

however significant difference was found for stress (*U*=94.54, p=0.01). Male caregivers experience more stress (M=27.0612, ±5.08) than the female caregivers (M=23.25, ±4.26).

***Table-3:*Differences among caregivers on Distress with respect to their Marital Status**

Distress	Marital Status	N	Mean	SD	Mann-Whitney *U*	*p* Value
Depression	Single	6	24.666	4.13118	111.5	0.276 NS
	Married	51	26.235	6.77226		
Anxiety	Single	6	16.333	6.121	110.50	0.261 NS
	Married	51	19.215	5.42702		
Stress	Single	6	23.333	5.88784	105.00	0.205 NS
	Married	51	26.902	4.9528		

Level of Significance: * = 0.05, **=0.01, ***=0.001 and NS= Not Significant

The mean differences on depression, anxiety and stress were studied among caregivers based on their marital status. The results of Mann-Whitney *U* test showed that there was no significant difference among single and married caregivers on their experience of depression, anxiety and stress.

***Table-4:* Mean Differences among caregivers on Distress with respect to their Educational Qualification**

Distress	Caregiver Education	N	Mean	Std. Deviation	F Value	p Value
Depression	Upto Primary School	8	29.00	7.010	2.335	0.084
	Upto High School	20	28.00	3.727		

	Upto Secondary School	15	23.60	7.528		
	PUC & Above	14	24.28	7.394		
Anxiety	Upto Primary School	8	21.00	8.280	1.694	0.179
	Upto High School	20	19.90	4.833		
	Upto Secondary School	15	16.40	5.082		
	PUC & Above	14	19.00	4.557		
Stress	Upto Primary School	8	27.25	6.041	1.221	0.311
	Upto High School	20	28.00	5.311		
	Upto Secondary School	15	24.93	4.399		
	PUC & Above	14	25.71	4.890		

One way analysis of variance was computed to assess the differences on Depression, Anxiety and Stress. It was seen that depression, anxiety and stress among caregivers do not significantly differ based on their educational qualifications.

Table-5: **Mean Differences among caregivers on Distress with respect to their Relationship with Patient**

Distress	**Caregiver Relationship**	**N**	**Mean**	**SD**	**F Value**	**p Value**
Depression	Spouse	10	26.40	6.44981	0.077	0.926
	Son/Daughter	24	25.66	6.42459		
	Brother/Sister	23	26.34	6.9453		
Anxiety	Spouse	10	20.20	7.80028	0.546	0.582
	Son/Daughter	24	19.16	5.17239		
	Brother/Sister	23	18.08	4.80448		

Stress	Spouse	10	27.40	6.93141	0.278	0.759
	Son/Daughter	24	26.00	4.64384		
	Brother/Sister	23	26.69	4.88444		

The table shows the mean values of Depression, Anxiety and Stress for caregivers based on their income. One way analysis of variance was computed to assess the differences. It was seen that Depression, Anxiety and Stress do not significantly differ based on their relationship.

Discussion

In the present study it was seen that male and female caregivers do not significantly differ on depression and anxiety, however significant difference was found for stress. Male caregivers experience more stress (M=27.0612, ±5.08) than the female caregivers (M=23.25, ±4.26). Depression, anxiety and stress among caregivers do not significantly differ based on their marital status, age, religion, educational qualifications, Income, Caregiver relationship. Researchers (Langer, 2003) in a study highlighted findings from the cancer-specific. Female caregivers reported greater depression and anxiety than male caregivers. Except for gender, socio-demographic characteristics have been less likely to be associated with emotional distress; although Cameron et al.(2002) found that those caregivers with less than a high school education were more distressed than those with higher levels of education (Cameron et al., 2002).

The caregivers experience varying emotional reactions to physical condition and patient symptoms. This can cause distress in caregivers as the patient's health declines (Carey et al., 2006). For the patient with advanced disease, family assistance with symptoms may increase as the patient's disease progresses and the patient's health declines. Persons caring for a loved one with cancer have been shown to be at risk for negative emotional responses such as depressive symptoms, anxiety, and burden (Given et al., 2004; Kozachik et al., 2001; Given et al., 2008). It is not known if worries about money, which may be exacerbated by disease-related costs, influence the emotional health of caregivers. One of the consistently reported predictors for caregiver distress includes caregiver gender (Northouse, 2005). A Sweden based study (Adelbratt & Strang, 2000) explored to what extent patients and their next of kin experience death anxiety, both the patients and their next of kin are preoccupied with existential thoughts and death anxiety. The problems are easily overlooked as the death anxiety is not always expressed directly.

Conclusion

The present study was an attempt to assess the distress of the caregivers of the malignant brain tumor patients. The findings from this study reflect opportunities for continued progress in services for the brain tumor patients and families. Both challenges and opportunities exist for improving programs for patients and families, and for expanding the standard of care to include a broader range of services that address the range of quality of life needs. The findings of the study have several implications for Psychiatric Social Work Practice. Future research should incorporate follow – up interviews with the families who failed to complete the study. Adopting a psychosocial intervention is strongly suggested to help the patients and the families to overcome distress. The psychosocial intervention has been found to be effective in reducing the burden, increasing the knowledge, reducing the distress experienced by the family members and adopting positive coping strategies.

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PROFESSIONAL SOCIAL WORK – INDIGENOUS BASE AND EMERGING TRENDS IN INDIA

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PROFESSIONAL SOCIAL WORK – INDIGENOUS BASE AND EMERGING TRENDS IN INDIA

There has been a long and ancient tradition of social work practice. The inspiration for it may have been varied: religious, humanitarian and secular. There were several phases of humanitarian work, relief, social reform and institutionalized welfare services. Most of it was voluntary effort; some of it had state support. The emergence of social work as a profession was not occurring in "a vacuum" . There was an indigenous base already in existence. The idea of introducing formal training of social workers through a permanent institution i.e. Sir Dorabji Tata graduate school of social work was an attempt to try out the adaptation of professional methods of social work to the local situation. The Indian forerunners like Gopal Krishna Gokule established an agency of the servants of India society to offer series of lectures on social problems to social work practitioners working in several welfare agencies. The principle that knowledge of facts and concepts (data and theory) was an essential characteristic of professionalism and scientific approach was already recognized.

There is criticism about the inclusion of case work, group work and community organization, as an example of blind copy of the American social work syllabi, the curriculum development centre in social work education in its report (1990) observed that the major tasks would be to promote social change and development while recognizing that groups or individuals already affected by the problems emanating from the structural factors in society will need help in meeting their immediate problems and needs. Thus, while the overall thrust of the task of social work should be

developmental and promotive, tasks which are remedial and rehabilitative cannot be over looked" (Government of India, 1990).

Being an ancient civilization, India's history and philosophy is rich and varied. It in fact constitutes the broad base of the pyramid of social work practice in India (swami Ranganathananda, 1968). Every school of social work has such a course in its syllabus. In the course, 'man in society', there is the content of cultural anthropology which provides the profiles of Indian communities. The course on Indian social problems is more indigenous than any other course; even in the "Dynamics of human Behavior" indigenous cultural milieu is woven into the common human features.

Field Orientation : The Tata Institute of social work, when it was established in 1936, introduced Diploma in social service Administration, and not in case work, group work or community organization. That indicates an altogether original thrust and purpose and not an imitation. Labour welfare and personnel management, which was redesignated as personnel management and Industrial relations, was a course unique to Indian social work schools. This course content was no copy of American/western social work education or practice.

Christian missions and other humanitarian welfare agencies of India started institutions for the orphans, the physically and mentally handicapped, long before the professional social work was started in India. Hence course such as family and child welfare, institutional management, social welfare Administration were useful and relevant in this context similarly there were some institution already functioning in India under correctional administration. Hence there was nothing non-indigenous to start the course of criminology and correctional administration. There was also legislation enacted in our country for the management of these institutions. As for the courses on social pathology, social problems such as poverty, broken homes, drug addiction or alcoholism, industrialization, urbanization, do not become western or American simply because , they were first articulated there. Since, they were of universal validity; they should be shared by us and the knowledge to be suitably adapted to Indian conditions.

Over the years, the Indian experience developed hundred per cent data base and policy perspectives on its own. The Indian schools of social work developed their own syllabi field-wise and oriented to target groups, based on social problems and welfare services of India. There was rich harvest of Indian literature on Indian social problems and welfare services made readily available to the Indian social work educators and practitioners with the advent of Indian conference of social work (renamed as the Indian council of social welfare, ICSW) during 1947. The professional social

workers had taken initiative of presenting series of papers on pressing Indian problems of the day. The contribution of social work educators and practitioners based on their knowledge and experience of the Indian social work scene was cent percent indigenous. The ICSW brought out series of the issues of social work Forum which added up to a rich source of indigenous literature. Since 1950, the social work forum published its papers on the topics: relief and rehabilitation of displaced persons, problems of beggary, delinquency or crime, the issues on population growth, family planning, rural community development, working and living conditions of Indian labour, slums in the Indian cities, tribal communities, national social policy, policies on children, youth, women etc.

After ICSW, other NGOs such as the Indian council of child welfare, All India conference of women, started producing indigenous literature. Though this literature has no level of academic rigour, but it provided a gold mine of source material to the social work educator. The Indian journal of social work, published, scholarly and well- researched papers and generated massive volumes of literature on Indian social work.

The social welfare and backward classes division, of the National planning commission, the program evaluation organization, the central social welfare board, the ministry of social welfare, the Indian council of social science research, the census of India, the ministries of education, health, labour, community development, rural development, have all been producing voluminous literature which serves as immense reservoir of reference material of Indian society relevant to the various courses taught in the schools of social work in India. Courses such as social policy, social planning, social administration, social action, social research, social legislation etc. were expanded and introduced from the rich and varied material mentioned above.

Quite a few western social work educators got acquainted with mass problems in countries like India and started saying that social work in developing countries should be indigenized. Developing countries may be lagging behind in development, but they were pioneers in imparting developmental orientation to social welfare. Indian social work did not need any imported wisdom about indigenization action because it has itself given a major developmental thrust to social welfare India has compiled, published and revised two editions of an encyclopedia of social work; it is more than enough source material to social work teachers. Probably, the criticism seems to have been based on existence of text books on methods of social work. But in recent years, there have been publications of text books on methods of social work based exclusively on Indian case material. Many leading teachers in schools of social work have been working with service centers

and welfare institutions and gathered rich case material. They do form part of their classroom teaching as well as in the conferences on field work placement and supervision.

Integrated Methods:

In most schools, the method courses have been integrated into one course. The teacher would illustrate and demonstrate how a combination of two or more methods would be appropriate and effective in different settings in that particular field. While teaching methods course (s), the teacher would mention the different field situations in which the methods or a combination of the methods would prove efficacious. Since the field practice is wholly Indian, the application and adaptation of methods is the most direct process of indigenization.

Interface with NGOs:

NGOs have a long and strong tradition of service and experience (Chodary, 1991). Many of them are the leading employers of professional social workers. Their roots are very much in the Indian soil. They naturally influence, even direct the approach of the professional social workers employed by them. There are instances of more active interaction and collaboration between the professional and voluntary social workers.

There is better understanding of respective roles between professional social workers and those who are known as constructive workers or followers of Gandhian philosophy (DasGupta,1967). The Gandhian Workers thought it worthwhile to enter into sustained dialogue with some of the leading professional social workers. Mere service, they realized was only an eye wash approach. On the other hand, the professionals saw considerable force in dedication and commitment to the cause of the disadvantaged as an effective reinforcement of competent professionalism. The constructive workers are known to be "true to the soil" group of inspired workers. They found the trained social workers worthy of appreciation and some degree of emulation. That was one of the surest tests of the trained social workers rooted in the Indian ethos.

Social Policy adapted to Indian conditions:

In 1950, India adopted a democratic, republican constitution, which incorporated fundamental rights and Directive principles of state policy, embodying justice, political, economic and social. The government of India formulated national policies on population, family planning, education (1968 and 1986), health (1983), housing development, welfare of the weaker sections of the population (Article 44 and 46), child welfare (1974), women's development and youth development

(1988) etc, (Kulkarni,1982). All these set out not only the objectives of development in the respective areas but also the plans and programmes to be formulated and implemented within a time frame. The professional social workers were involved in the formulation of National policies and plans and large number of them worked in the ministries and the departments of social services at the central and state levels, at the administrative and supervisory positions in the state, districts and blocks in the rural areas. The schools of social work and senior social work educators were invited to plan the training and orientation programmes. They trained supervisory and field personnel, para professionals and auxiliary personnel. They have also served as researchers, evaluators, consultants and specialists in the country wide programmes. Some of them have also become social activists working for society. Even those who acquired their training in the American schools of social work have given indigenous performance useful in the Indian conditions by understanding Indian social reality (P.D.Kulkarni,1993).

Hammand (1988) quotes to say that "the profession's value orientations of self-reliance, self-determination have been considerably fostered and influenced by the liberal values and beliefs of the American society and may not be acceptable in other countries". Professional social work in India shares the same values with commitment. But it derives its strength as much from its long and rich civilizational heritage as from the global forces of modernization.

The United Nations carried out five surveys which indentified significant developments and trends in the training programmes in social work in different countries. The surveys, specifically the third and fourth highlighted the limited applicability of the U.S. model of social work education and suggested the need to promote indigenous methods, curricula and study material (United Nations). In view of the fact that Indian social work educational institutions have been accepting the basic framework of U.S. social work for over fifty years, they seem to have been trapped into maintaining the status quo. The absence of research to develop indigenous approaches and study material is yet another factor in this context. Finally, it should be pointed out that many international Non-governmental and voluntary social welfare agencies which are mainly financed and controlled by U.S. Social work interests have also been responsible for promoting the influence of U.S. Social work directly or indirectly throughout the world.

If social work has to move toward professionalism in any society and has to become effective, it must have indigenous foundations incorporating dominant cultural philosophies on the one hand, and projected goals which are being promoted on the other (Nagpaul, 1988b).

Social work education in India has become irrelevant to the needs of Indian society, because, what is needed in Indian society is a primarily preventive and macro based social work' (Mandal, 1989). Indian social work educators must accept this challenge and evolve a new strategy to transform the existing social work education to develop and use indigenous study material unless it is done, social work as a profession is not likely to establish its roots in that society.

Macro- Based social work:

The purpose or content of social work education is crucial. It reflects the philosophy of development and direction of change. It is constrained by the vision and mission of the profession and the theoretical knowledge and skills of practice, available at a given time.

Social work profession is the product of industrial civilization. It emerged in the first half of the 20th century in Europe and U.S.A which have more than a hundred years of literacy, industrial development, near universal employment and social security. Its focus was on the micro level malfunctioning of individuals, families and local communities. Correspondingly the techniques of social case work, social group work and community organization were applied to the above problems. The macro-level malfunctioning of socio-economic and political system was not taken into consideration. In fact, the professionals were expected to remain 'neutral' to the prevailing economic and political system. Some of the field –based researchers drew attention to the macro-level malfunctioning of the prevailing social system. They emphasized the need for an integrated view of micro-macro requirements of development.

The APASWE/ peking university seminar held in Beijing, china (1988) lamented that the widespread introduction of American and European models as representing cultural imperialism – an effort to impose the culture of a more powerful society on a less powerful one. The seminar suggested that each country should work out its own model of social work education to suit its requirements.

A purview of the changing patterns of social work education in developing countries gives the following clear indications:

1).The model of social work education of the developed countries no longer suits the requirements of the developing countries.

2). The model must suit the historical and cultural roots of each country.

3). It should meet the socio- economic requirements of the majority population of the country, especially the challenge of poverty.

4).The purpose of development should be clearly defined, keeping in view the existing realties and the future of line of change.

In the Indian context, it is suggested that there is the need for three alternative models of social work education. In 1984, Armaity S.Desai expressed the need to seek relevant education in the following terms, " we need to move away from too much dependence on provision of services to organizing people to promote change; from institutional to non-institutional programmes; from remedial to factors which seek to affect the very causes which create poverty; from private concerns to public issues; from research with a problem focus to one of action oriented studies – testing ways and means to solve our multiple problems, building models and testing processes and approaches (Desai, A.S.1984).

Mcher C.Nanavaty, expressed a similar opinion stating "… Social work has to relate to social change for removal of poverty rather than promote adjustment to the existing societal process" (Nanavathy, 1985).

Prof.P.D.kulkarni lamented, since there is erosion of idealism, social work in the interest of social justice, should now the oriented to securing human rights for the deprived of the world (Kulkarni, 1986).

Prof.P.Rama Chandran observed that the focus of social work in the coming years will be on the liberation of the marginalized poor in tribal and rural areas and urban pockets of India. The methodology of social work will be a "people centered" approach involving their conscientisation and thereby ensuring their participation in the process of liberation (Ramachandran,1986).

Professional social work –Emerging Trends:

Social work education and practice by its very nature is kaleidoscopic. A nearly centaury old profession has been changing its form and pattern from case work or medical social work, to group work, community organization, welfare administration, integrated / generalist social work, social development, environmental protection, sustainable development, human rights, systematic change and to radical social work intervention, to meet the needs of people and to address changing realities of societies in different parts of the region. Although the roots of problem oriented and remedial social work are very thick and deep, some far-sighted social work educators and

practitioners have sought in a timely way to influence the direction and future of profession towards social development, sustainable development, human rights perspective and of late, corporate social responsibility interventions, without understanding the relevance and significance of remedial social work. Social work education argue that social work profession needs to have a broader developmental perspective to address major issues confronting the world today and also the issues that are likely to come up in the future also.

Social work need to be society- centric not problem oriented. Its emphasis would be on re-building societies, 'not on solution of problems only after they arise. The technology and methods that it uses in the new context will thus have to be substantially different than what it does today. Here the need is to work with the society, not with individuals. It is said that there are not delinquent children but only delinquent parents who need to be educated and reformed. What we have at hand today is only a chronically disorganized and delinquent social milieu, an unjust and exploitative society which uses the resources of weaker sections for exploitation. Social workers are working within given social structures and existing set of values. They are accepting the social system as it is and the prevailing values, and not trying to change, modify and replace them. They must work for changes in the social structures and policies. There was no talk of bringing in any radical change in the society so that poverty no longer dominate the scene. Social work was not committed to "society centrism", its functions were to help the deviants and the victims of the unjust social order to adjust to the process of exploitation or to use a more tragic term to "defend" the society from its offenders.

Social work in India could not remain neutral to the problem of poverty especially from the time when removal of poverty (Garibi Hatao) became the central theme of our national policy. Social workers should analyze the causes of poverty with the help of its own concepts and tools and move towards a new society where poverty and deprivation, the two chief catalysts of disorganization, would have disappeared.

Social worker's role:

The study of social relatives makes it evident that the entire model that leads to violence and exploitation will have to be changed so that the oppressed and the afflicted are to be helped. The emphasis will therefore have to shift from helping the individual to building of a perspective plan for societal growth. The emphasis similarly be, as part of this plan, on the removal of affluence leading to disparities and exploitation, and not on insisting that the weaker sections adjust to the

exploitative order. Social work should thus lead to society centrism and not to programme orientations. Its role should not be to establish control over the weaker sections but to create a decontrolled, liberated society whose aim shall not be to perpetrate but to end all social work (Dasgupta, 1984). It is necessary to root out the process that creates social injustice rather than maintain the system that creates deprivation and then expects social workers to attend to the victims of the process thereafter.

Strategies of working with people:

The use of community based work, and social action method can be adopted as strategies of work based on the experiences of social movements. Community power and involvement will go a long way to set up new programmes by the community for its own welfare and development.

The strategies of work with people include: 1).Institutions to be re-developed in the micro-society; 2)transfer of social work obligations to the client –community itself; 3) Resource building at the village level; 4) study and investigation to find the resources for social development; 5) to act as agent of under-dog and shift to non- institutional communication 'family' oriented service. The priority of social work should be the poor – Antyodaya, unto the least.

Synergy and Networking :

The social worker is often identified by other professions as being competent to deal with the social problems of individuals and families. It is sometimes felt also that he is more competent to deal with the pathological problems of the disadvantaged portion of the population, for developing effective medico- social treatment and psycho-social treatment to the patients, for improving the strategies of working with school system, for collaborating with NGOs, voluntary organizations, government departments and agencies, courts, police, industries, civil society and people's organizations. If the worker is to play vital role in social planning, social legislation, and public administration, he must be better trained in indirect methods of intervention (Kulakarni, P.D., 1967).

There is more than ever the need for the development of interdisciplinary teams in the rebuilding of the institutional organizations, teams in which the social worker is an equal partner. The social worker in the team must serve as the spokesman and advocate of the future population in the area; he must verbalize the needs and aspirations of the people to be served. The practitioner of social or social welfare, must penetrate and participate in the power structure where social policy decisions

are made. This penetration will not occur, unless we are prepared to demand it. (Kulakarni,P.D,1967).

Interface with NGOs:

The schools of social work will identify certain areas to collaborate with NGOs by sharing ideas, experiences, expertise and other resources. These areas include child labour, income generation, public health, street children, child trafficking, child rights, human rights, gender issues etc., The cooperation has taken the form of field work training , placement of students, project work, lectures on developmental issues (i.e HIV/AIDS; environmental protection, child abuse, gender and gerontology), involving both faculty and students in research projects undertaken by NGOs. The schools of social work can render consultancy services to the NGOs by extending academic inputs, preparation of project proposals. Drafting the constitution for the NGOs and guiding them in effective delivery of services, using professional skills and methods of social work.

Cooperation between schools of social work and NGOs enables to:

- Enlarge the organization's area of operations, creating synergies and networking .
- Achieve economics of scale, reducing expenses on both sides, and improving efficiency by avoiding overlapping and duplication of services
- Enrich and increase general welfare

NGOs and voluntary organizations look to professional social workers for their expert guidance, scientific knowledge, skills and professional training. The professionally trained social workers will cooperate and collaborate with NGOs, using methods of social work. The voluntary organizations dealing with children, women, mentally retarded, physically handicapped will use social case workers to deal with individual problems. The professionally trained group worker will work with groups formed by voluntary organizations for promoting the groups of youth. Women, children, self -help groups, DWACRA groups. Many NGOs are now working with rural, urban and tribal communities by engaging trained social workers, using community organization method. With the help of trained social workers, the voluntary organizations are undertaking research on various problems like HIV/AIDS , human trafficking, child labour and other related issues. The social workers in the role of social actionists create awareness about the problems in the community. The NGOs are using the method of social action with the help of professional social workers for bringing about change

in the institutions, for launching social movements, and bringing about legislation and its amendments through lobbying.

Synergy between social work and Industry :

In recent years, social workers are being increasingly employed in industries to implement development programmes under corporate social responsibility (CSR). Corporate social responsibility (CSR) can be described as the continuous commitment by corporations towards the economic and social development of communities in which they operate. Industrial groups undertake large scale corporate welfare programmes to demonstrate that private wealth play an important role in poverty alleviation and the socio-economic development of the nation.

The new economic reforms in the country marked the beginning of the economic liberalization and the free market economy in India. The major impact of these economic reforms has been the transformation of Indian industries and businesses into large global enterprises. The conceptualization of corporate social responsibility up till the 1990's was purely in terms of philanthropy or charity. The post-liberalization phase has seen a fundamental shift from this philanthropy-based model of corporate social responsibility to a stakeholder –participation based model. The industrial groups like the Tatas stated, "over the years the nature of company's involvement with the community has undergone a change. It has moved away from charity and dependence to empowerment and partnership". In the stake holders model , the community in which the corporation is present is seen as a stakeholder in the company and therefore, the company has certain obligation and duties towards it like it has towards its other stakeholders (customers, employees, shareholders).

Corporate social responsibility one way benefits the industry as 'reputation capital' for capturing markets. It is a new business strategy to maximize profits. It serves the purpose of showing accountability, transparency on the part of the industry or business. It promotes sales, customer loyalty, reputation, cooperation with local communities, tax benefits and rewards. corporations are innovating to increase efficiency, effectiveness and accountability. The focus has been participation at all levels. A host of innovative programmes and schemes in several areas like education, health care, rural development, environment protection and disaster management in which professionally trained social workers are involved at various levels right from planning, stage down to the grass root level implementation of the above programmes. Lupin India Ltd, has started a project for providing sustainable development in 154 villages

across Rajasthan. Cipla, another India pharma offered to sell anti-HIV drugs at lower prices worldwide, increasing the accessibility of these drugs.

Ranbaxy operates seven mobile health care vans in various parts of northern and central India. Tata consultancy services has set up fully equipped computer training laboratory for the welfare of the physically handicapped.

The Indian public sector has had a long tradition of corporate social responsibility and the initiatives of corporations like the Oil and Natural Gas Commission (ONGC), Steel authority of India Ltd. (GAIL) have critical in the development of several backward regions of the country. Indian Airlines and Bharat Heavy electronics have been widely acclaimed for their disaster Management efforts.

The schools of social work, the professional social work experts and the professionally trained social workers collaborate with the industries in respect of planning and implementation of the CSR programmes, using their expertise, professional training, methods of social work and intervention strategies of working with people, at individual, group, community and societal level. The avenues of employment have increased for the professionally trained social workers consequent on the introduction of CSR programmes in the Indian industry and business corporations.

Interdisciplinary Collaboration :

The social worker is indentified by other professions as being competent to deal with the social problems of individuals, families, groups, communities and the larger society. It is sometimes felt also that he is more competent to deal with the pathological problems of the disadvantaged portion of the population. There is the more than ever the need for the development of interdisciplinary teams, for developing effective medico-social treatment and psycho-social treatment to the patients, for working with school system, for collaborating with NGOs, voluntary organizations, government departments and agencies, courts, police, industries, civil society and peoples organizations. The social worker in the team must serve as the spokesman and advocate of the clients that approach him or the agency; he must verbalize the needs and aspirations of the people to be served. The successful practitioner of social work must enable his client to help himself, whether his client is an individual or a collectivity. This he may do himself or in association with other organizations or professions like law ,medicine, school system, medical setting, psychiatric setting, the community, the police, correctional institutions.

Distance education: Web-Based Learning:

Web-based social work education in the era of informational technology has become a reality throughout the educational instructions including social work due to the use of television and computer networks (Regan and youn, 2008). Distance education in social work is not only a medium for the teaching of social work; it could also be a significant force in fulfilling social work's commitment to equality and social justice.

Political Participation of social work:

The challenge is to convince social work educators have integral they are to fostering student's interest in politics and inspiring them about the need to create social change through the legislative or political process (Ritter, 2008). The social workers play the role of lobbyist for bringing about legislation, or amendments to legislation, canvassing support for the bill, by convincing the members of the parliament or legislature. Several social legislations on environment, social problems, women and child trafficking, child labour, and other social issues, have been brought out with the intervention and lobbying of professional social workers, social activists and social scientists.

Globalization of social work education and practice:

It is emerging force that shapes the 21st century requiring social work education to address economic, social, political, health and environment issues impacting on people beyond national boundaries. The global context of social work practice requires programs to integrate social and economic justice content on interconnectedness of oppression, human rights, complex nature of culture and personal identity, as well as global interdependence in collaborative effort in resolving global issues (Link and Healy, 2005).

Social Advocacy:

In all profession, advocacy has acquired a cardinal attribute for action, more so in the profession of social work. It depends on the commitment the social worker holds for the cause. Social workers promote advocacy for a social cause, be it in the field of community organization, locality development, social planning and social action. Social advocacy is a means to raise the

consciousness of the poor as well as people at large, and also to make the delivery system more responsive. The agenda of the national centre for advocacy studies on the rights of constructions workers and drafting a bill, child labour, protection of forest lands, deep sea fishing, women's political participation and rehabilitation fall in this category. They are exploring alternatives to the present, "jobless, rootless, ruthless and futureless growth; some of them are exploring possibilities on Gandhian lines; they are stressing the importance of civil society, spirituality, and the development of the inner self, and are working towards a sustainable society.

Lobbyist And Activist:

The social workers play the role of lobbyist for bringing about legislation or amendments to legislation. In order to alter the law or policy, the social worker turns a spokesperson of the community. If it is difficult to change the status quo, he plays the lobbyist role. A lobbyist seeks to redress mostly within the established system. An activist challenges the system as a whole and demands a radical replacement of it. There are difficulties in the activist's role in rooting out the existing system.

Environment Protection :

Social workers should mobilize the public against polices harmful to environment, social workers should utilize citizen groups and voluntary organizations for campaign and lobby for action and legislation. The role of professional social worker is to educate the masses. Our basic task is to educate ourselves in order to be able to educate others. We have to take the lead in involving ourselves in issues that concern people and be catalysts of movement to protest against the forces of destruction of nature.

Human Rights Perspective:

Since social work profession has commitment to social justice, its role in promotion of human rights is implicit. Social workers may view social justice in terms of redistribution of goods and services to the poor and the disadvantaged. They should work for the protection of human rights. Human rights are universal. The social workers may face difficulties to implement universal human rights in their indigenous practice. The role of social work may be limited according to the political reality. The government may restrict human rights. The social workers have to play educative role in implementing universal human rights and try to overcome the above limitations and difficulties. The strategy of social workers could be to accept the 'core'

rights, such as freedom from torture, dignity of treatment and equal consideration under the law and work for safeguarding the autonomy of the individual.

Scope of social work practice – All pervasive:

The professionally trained social workers are working in the field of medical and psychiatric social work, correctional social work, school social work, community development and NGO sectors. Some of them are even running their NGOs, other categories of social workers like the untrained workers and volunteers also work side by side with them as a team. This practice has positive implications. It is good because, social workers should not work in isolation. Trained social workers should work with other professionals like doctors, psychiatrists, psychologists, physio-therapists, para professionals and NGOs to make social work intervention more effective by adopting interdisciplinary team approach. They work as a team with others. Others should also join in the team to present their specific discipline and expertise to improve the quality of services. The resent day trend is towards convergence, synergy and networking of the institutions and professions. Ultimately all professions deal with human welfare and betterment of human conditions. The content and syllabi of social work education at the time of its inception, was not the same as it is now adopted in the schools of social work. We have incorporated a wide range of topics and fields of social work in the syllabi of social work education, covering the areas such as human rights, environment, gender issues, child rights, displaced persons, social justice and empowerment, correctional social work, globalization, in addition to the traditional issues of poverty, deprivation, physical and social disabilities, weaker sections etc., The scope of social work education has become comprehensive and all pervasive, dealing with every aspect of human life and betterment of human conditions.

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