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EDITORIAL

Indigenization of social work education in India

Social work education as a profession is often considered as an emerging profession. However it is more than 75 years old in India and has grown remarkably in past decades. In India training for the voluntary social workers started for the first time in the 1930's by the Social Service League (SSL) in Mumbai. Social work education exists with specific national education curriculum across the country however the content, the pedagogy, and the practice may differ from one state to another.

The social work professionals from the west and from the third world countries have attempted to develop theories, knowledge and models and have tested them in the third world countries. But the socio-cultural milieu and indigenous aspects of the third world countries often does not match those of the west. Western ideologies, technologies and institutions replicated in the developing countries often serve the interests of developed countries and subtly establish colonialism, as in the past.

As a nation, India is very diverse in cultural characteristics. It is pluralistic and democratic and democratic in nature with several political ideologies. There is interplay of socio, cultural, economic, political and even geographical factors which vary from one location to the other. People within India are different in ethnic, linguistic, cultural, regional, caste and religious lines. Indigenous knowledge is local knowledge-knowledge that is unique to a given culture or society. Social work professionals in other countries also face diversity in religion, traditional believes, culture and social developments.

The contemporary indigenization movement in social science is a post-colonial phenomenon and the notion of indigenization appeared in relation to social work for the first time in 1971. Indigenization includes awareness about the importance of indigenized culture in social work practice which comprises three different aspects: intervention, ideologies and cultural contexts. All these intermingle with clients and workers backgrounds and cultural exposure. In India, social work education systems can follow an 'indigenized model' considering the diversity of the country. This will enrich our students to understand the context and to practice effectively and to provide the best to their clients in all levels. In this context, the papers published in this journal, discuss the work conducted in India in varied settings from differing cultural contexts.

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Impact of Psychosocial Interventions on Psychosocial Needs of Persons with Glioblastoma- An Interventions Study

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Abstract

Background: Glioblastoma(GBM) is the most frequent tumour among all primary intracranial tumourswith a frequency about 15%-50%. In cases of a Glioblastoma, the patients move through the illness phases speedily from symptomatic phase to chronic phase and also cause severe disability. The psychosocial needs of persons withGlioblastoma are expected to be greater, because there is little time to adjust or adapt to the disease.

Methodology: The study aimed to assess impact of psychosocial interventions of persons with Glioblastoma.The present study carried out in NIMHANS from October 1st, 2012 to August 30th 2014.For the current study quasi-experimental research design was used. The in-depth interviews were conducted with 40 adult Glioblastoma survivors during crisis phase, acute phase and stable phase to elicit the phase specific psychosocial needs by using purposive sampling method.For each respondent 5-6 sessions of need based psychosocial interventions wereprovided.

Results: The socio-demographic details result showed that the participant's average age was found to be 49 years. The majority (70%) of participants were males' and 30% were females. The in-depth interviews were analysed with help of the thematic analysis by using R software.The psychosocial needs that emerged from the crisis, acute and stable phases and the results of psychosocial interventions, are reported in form of themes.

Conclusion: This was the first study in India which has been carried out to understand the psychosocial needs of persons with Glioblastoma.The psychosocial intervention was useful in meeting the psychosocial needs of the patients and it can be tested for its efficacy in a larger sample in future studies.

Key words: *Glioblastoma, psychosocial needs, Psychosocial Interventions.*

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Introduction:

Primary brain tumors are among the leading causes of cancer deaths. The global incidents of primary malignant brain tumors is approximately3.7 per 100,000 for men and 2.06 per 100,000 for women annually (1), (2).However, the epidemiology of malignant brain tumor in India is neglected so far, except in a few attempts restricted only to the gradation of tumor types. The incidence of primary brain tumor in India is 3.4 per 100,000 populations for males and 1.2 per 100,000 populations for females. It represents < 1% of new cancer cases detected every year in the country. There are various psychosocial needs identified in the literature i.e. physical needs, Informational needs, communicational needs, emotional needs, psychological needs, social needs, spiritual needs, and practical needs(3), (4).

The review of socio-demographic details report that the median age is 51 years for Glioblastoma respondents (Range: 21-72 years) for males and females. 49% of respondents were married, 18% were single and 2% were divorced. For a few respondents' marital status was not available (31%). Out of all the respondents, 58% reported history of substance use - either smoking or alcohol use (5), (6). Another study revealed 52% respondents were male and 31% respondents were female. The other socio-demographic details such as education, income, religion were uniquely reported elsewhere among glioblastoma patients.The review also reported that 75% of the glioblastoma patients were in stable phase and 8% had progressive disease phase(7), (8), (9). The respondents who followed Hindu religion were 3.4%, roman catholic 41.4%, Christian 6.9%, Muslim 3.4%, protestant 10.3%, non-religious but spiritual 3.4% and none of the respondent believed in god was 6.9% (10). The functional status 5.8 % was improved among glioblastoma patients after treatment, continued the same condition 4% and deteriorated 3.8% (11). From the review of literature it was clearly observed that socio-demographic details, illness characteristics were vary from person to person (12).The review also focused on unmet psychosocial needs during diagnosis phase, during treatment, unmet psychosocial needs- during treatment phase, advanced and palliative care phase, unmet needs and post treatment, follow-up and survivorship and phase unmet needs and miscellaneous time point (13), (14), (15), (16), (17).

Meeting patient's educational and information needs is important for coping and reducing uncertainty, decisions making and informed consent (18), future action and ensuring timely care is appropriate to meet individual's needs(19), (20). The interventions aimed to improve the accessibility of correct information, enhancing communication skills, and continuity of care. However, the efficacy of these strategies is largely confined to specific populations (21), (22), (23), (24).On the other side, pain is a common and often disabling problem in cancer patients. The studies reported that pain is experienced by 25% of newly diagnosed cancer patients and by 60% to 90% of patient with advanced cancer. These educational interventions on pain have showed more coping skills as a way of enhancing patients self-care efforts. The overall 50% of the studies testing pain, education plus brief cognitive therapy showed positive results (25), (26), (27), (28), (29).

In addition to that social support is associated with to cancer. The support that cancer patients receive from spouse, family members has helped in managing distress. The interpersonal skills are also important for these patients as they communicate their needs to their support network (30). The studies on brain tumour showed that patients had experienced stigma and discrimination during illness trajectory. Therefore, there is a need of social support to overcome the stigma and discrimination (31).In general, people believe that speaking about death and dying and their condition is likely to cause stress to patients and their families and this belief often leaves health care provider, relatives and friends of dying patients asking, what should I say?. In death related studies, the studies reported that being aware that death is coming and be able to prepare themselves within the likely time scale, be able to retain control over what happens, having dignity and privacy, have a choice and control over where death occurs, having access to information, access to any spiritual or emotional support, having to access hospice care in any location either hospital or at home, have control over who is present and who shares the end, be able to issue advance directives which ensure that wishes are respected, have time to say goodbye and be able to leave when it is time to go and not have life prolonged pointlessly(32).Hence, the review clearly states that brain tumour and efficacy of psychosocial intervention are to some extent successful. But grade specific psychosocial interventions are not given priority. Therefore, the study examines the following question like does Glioblastoma patient benefit from psychosocial interventions?

Methods and Materials:

Rational and Need for the Study:

The primary brain tumour Glioblastoma (grade IV), causes variety of psychosocial issues in the patient in different phases of illness. The effects of tumour existence, surgery, radiation, chemotherapy, and adjuvant medication combined creates Neuro-Cognitive complications for Glioblastoma patients.Brain tumoursalso affect day to day life activities severely and propagate a sense of fear about illness. This sense of fear I often coupled with inadequate knowledge.In cases of a Glioblastoma, the patients move through the illness phases very quickly- from symptomatic phase to chronic phase. The psychosocial needs of patients with Glioblastoma are likely to be greater, because there is little time to adjust or adapt to the disease. Therefore, providing psychosocial interventions are essential for persons with Glioblastoma (Grade IV).

Scope of the study:

The present study tries to understand the psychosocial needs in various phases such as crisis phase, acute phase and stable phase. It also includes the level of understanding ofdisease: i.e. knowledge related to illness (GBM) during hospitalization as well as during follow-up. This study would contribute to check the impact of psychosocial interventions on GBM respondents which in turn would provide a way to suggest clinical based psychosocial interventions for the population.

Aim:

- To study the impact of psychosocial interventions of persons with Glioblastoma Multiforme during hospitalization and follow-up.

Objectives:

1. To identify the psychosocial needs of persons with Glioblastoma Multiforme.
2. To prepare the psychosocial intervention package for the persons with Glioblastoma Multiforme.
3. To provide psychosocial interventions for persons with Glioblastoma Multiforme.
4. To study the psychosocial intervention impact on persons with GBM.

Hypothesis:

- Psychosocial interventions will enhance disease knowledge and be helpful in meeting psychosocial needs of persons with Glioblastoma Multiforme.

Operational Definitions: In the current study Glioblastoma Multiforme, psychosocial needs, illness knowledge, and psychosocial interventions were considered as operational definitions.

Research Design:

Quasi-experimental- Pre and post-test research design without control group was used in the current study. These designs allow the same group to be compared over time by considering the trend of the data before and after treatment. This research design was widely used by behavioural researchers(33).

Universe:

The present study was carried out in Nation Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore. All in-patients who are undergoing treatment of malignant brain tumour, particularly diagnosed and suffering with Glioblastoma Multiforme (GBM) in neurosurgery ward were considered as universe.

Sample:

The overall sampling for the study consisted of 40 brain tumour patients diagnosed and suffering with GBM, of which 28 were male and 12 were female subjects. The study subjects were selected by using cross sectional sampling survey method with the help of convenient and purposive sampling method from October 1st, 2012 to August 30th 2014. The forty respondents included in the main study for intervention. The sampling was decided based on the morbidity and mortality rate of the illness. The researcher provided psychosocial interventions for 40 respondents who met the inclusion criteria in the present study.

Inclusion and Exclusion criteria: Thepersons who are differentially diagnosed as Glioblastoma Multiforme (GBM),all adult subjects aged between > 18 Years and<60 years, those who newly diagnosed with suffering with GBM and undergone surgical interventions, patients having 1 month history of illness and who agreed to give consent for study were included. The persons with diagnosed suffering with low grad gliomas, recurrent GBM and other benign tumours cases were excluded in the study.

Tools and Data Collection:

A semi-structured interview schedule to collect the socio-demographic details and in-depth interviewwasconducted to elicit the psychosocial needs. The interviews were conducted at (pre-test) at the time of admission; post assessment was at the time of discharge (7-10 days) and after 6 months during follow-upcarried out for experimental group. Separate interview guidelines were used in each phase to elicit the psychosocial needs of persons with GBM. The interviews lasted on an average 30-40 minutes each point of time. All interviews were conducted by the trained psychiatric social worker -cum-researcher in day to day conversational style. The in-depth interviews were manually documented in the narrative form after each interview immediately.Further, it was felt that the sample size was adequate to reach a sufficient level of saturation, a term describing a point beyond which no new concepts will arise as result of further interviews (34). After identification of the psychosocial needs, the researcher provided psychosocial Interventions to fulfil the psychosocial needs. The interventions were lasted 4-5 sessions for a period 45-60 minutes.After psychosocial interventions feedback was collected from the participants. Subsequent to the participant recruitment, socio-demographic details and illness details were gathered from patient's hospital records.

Psychosocial Intervention Programme: The following psychosocial interventions were being provided; Patient education covered the causes of illness, nature of illness, prognosis of illness. Post-surgical counselling covered the education about pain, adjusting with body disfigurement, importance of retaining to treatment regimen, and associated side effects and importance of follow-up. Another intervention focused on enhancing social support and coping abilities covered the communicating personal needs, overcoming stigma and functional barriers, getting support from family, friends, significant others and coping with illness. Finally, the preparing the patients to face adverse conditions such as recurrence, identifying the recurrence, emergency management, identifying general causes for fear of death, eliciting personal views on death and preparing for the death.

Data Analysis: For qualitative data, the written narrative transcripts were entered into the computer software called R-QOL 3.0.2 version. The simple descriptive thematic analysis by Pope Ziebl and and Mays, the most common method of data analysis used in qualitative work was used in this study (35), (34). In the process, qualitative feedback transcripts were read a number of times to achieve understanding of the whole data. Then the hidden meaning was identified from words, phases, sentences and paragraphs and these were coded into different categories and clustered into emergent themes.Initially five transcripts were independently analyzed and coded by 3 trained Psychiatric Social Workers and discrepancies were resolved through discussion and thus the coding and categorizations were refined, following which analysis was completed for all the remaining transcripts by the researcher himself and his research team assisted in developing a final set of codes through consensus process which in turn helped to derive certain themes. The themes are presented in the result chapter. For quantitative data frequencies, mean and Standard Deviation.

Ethical Considerations: The ethical clearance was sought from the Institute Ethics Committee and written informed consent was taken and confidentiality was maintained.

Results:

Socio-Demographic Details:

The results showed that the respondents mean average age was49 years with the standard deviation of 8.21. The respondent's age was ranged from minimum 25 years to maximum 59 years.The respondents 70% were males and 30% females respectively. The table1 depicts socio-demographic details of the participants.

Table 1: Personal Details of respondents:

Variable		**N (%)**
Gender	Male	28 (70)
	Female	12 (30)
Education	Illiterate	16 (40)
	Primary Education	6 (15)
	Secondary Education	10 (25)
	Graduation	8 (20)
Marital Status	Married	37 (92.5)
	Single	3 (7.5)

Table 2: Knowledge Levels of Respondents:

Variable		**N(%)**
Not heard about tumour/cancer word even once	Yes	32(80)
	No	8(20)
Not aware of tumour or cancer	Yes	8(20)
	No	32(80)
Aware of brain tumours during psychosocial interventions	Yes	40(100)
	No	0(0)
Feeling fearful after hearing the word brain tumour or cancer during psychosocial interventions	Yes	4(10)
	No	36(90)

The above table 2 showed the result of disease knowledge levels of respondents. The respondents who were not heard about the tumour or cancer word even once 80%, not aware of brain tumour or cancer during illness course was 80%, aware of brain tumour or cancer during psychosocial interventions were 100% and reported not feeling fearful after hearing the word brain tumour or cancer during psychosocial interventions were 90%.

Qualitative Themes: The themes that emerged from qualitative data are continuity of care, accepting illness, adjusting with post illness conditions, overcoming stigma and increased social participation, and increased preparedness to face adverse conditions like recurrence and death these interventions were supported by verbatim reports of participants.

Continuity of care: The participants reported that *"The counselling sessions were helped me a lot. I understand my illness and I should undergomultiple treatments to get better from my illness. What should I do, I do not have other option, I must receive go my treatments such radio and chemotherapy. I did so, now I feel better" (P 2, P14, P 23, P 26).*

Accepting the illness: The participants reported that *"In the beginning, I hoped that it was blood clot in the brain. It was hard for me to believe that I am with Brain Tumour. After attending counselling session, I realised that I have to accept the reality and must learn to live with it (P 10, P 15, P 23).*

Adjusting with illness conditions better than earlier: The other participant reported that *"I am managing and adjusting with my condition well. The doctor(researcher) explained me how to adjust with my condition. Now, I am speaking with my friends and children and family members and prying the god to give strength whenever I feel sad" (P 10, P 35).*

Overcoming stigma and increased social participation: The participants reported that *"I am being supported well by my family members after talking to doctor (researcher). I am also not bothering if neighbours speak something wrong about me. They really do not know what I am undergoing" (P 23, P 25).*

Increased Preparedness to face recurrence and death: The participant reported that *"I feel myself that I researched my last days. Somehow every one dies soon or later I must die soon because of cancer (paused….) after some time I must die one day. I am prepared for that (cried……..P 22,)*

Another, participant reported that after undergoing psychosocial interventions he reported that *"my daughter's marriage was done. You (researcher) made me realized to finish my responsibilities as a father hastily. She got married last month, now I am happy. If I die soon no problem now [with sad mood …..P 5]*

Discussion: Theresearchers had given less attention on finding thepsychosocial issuesof GBM patients and addressing them by providing psychosocial interventions. There could variety of reasons for the same such as aggressiveness of tumor, dynamic nature of illness, and severe cognitive deficits associated with its treatment. This current study made an attempt to fulfil this gap.In order to this, we believe that this is one of the first study which carried out to understand

the psychosocial needs and to test the impact of pscyhosocial interventions on this population. This study highlighted that the psychosocial needs of Glioblastoma patients which were at the forefront are lack of awareness on brain tumors, not retaining to continuity of care, denial of the illness, post-surgical adjust mental issues, community stigma, less social participation, fear of death reported in our previous study. The socio-demographic details of participants were similar to other traditional setting in India reported elsewhere(31).

The study results had found that GBM patients having about 80% participants had no awareness or had less knowledge on brain tumors. After undergoing psychosocial interventions it was observed that 100% participants aware their illness its causes, name of disease, prognosis and social consequences. On the other side, the psychosocial interventions helped to retain to continuity of treatment regimen such as radiation, chemotherapy, and physiotherapy in case of upper and lower limb weakness. The interventions also helped in accepting their own illness, adjusting with post-surgical conditions such as pain, body disfigurement, adhering to drug compliance, increased interaction with family was found. This finding was supported by other studies that prove education for cancer patients will improve accessibility of information, continuity of care, and enhance communication. However, the efficacy rates of psychosocial interventions varied with specific populations(21), (22), (23), (24). The study results also revealed that the social stigma, decimation, and reduced social participation was rampant among this cohort. This finding was similar to another finding that the increased knowledge through psychosocial interventions builds upconfidence levels among persons with Glioblastoma to solve their own problems like dealing with stigma, and initiated to participate in social occasions such as marriage was reported. The support that cancer patients receive, often coming from spouse or family members, is most helpful to patients in managing distress and increasing healthy interpersonal skills(31), (30).

Another significant theme of the study was fear of death among all participants. Death is a serious event, initially silence was an answer. But in subsequent sessions, they expressed their views in order to death. They considered death as an inevitable event, but also accepted that there is no chance to escape death and few talked about death as a nightmare. Over a period of time they accepted death was part of life by generalizing and said one day “Everyone will die some or the other day”. For majority psychosocial interventions were helped and prepared them to finish the unfinished jobs at home like children marriages, property distribution, and repaying debts. Many people believe that speaking with patients about death and dying and their terminal condition is likely to cause stress to both patients and their families and this belief often leaves health care provider, relatives and friends of dying patients asking, what should I say?. Being aware of death is nearby, ensuring place for dignity and privacy, providing emotional and spiritual support, and fulfilling last wishes of dying person and preparing them to say goodbye and be able to leave this current living world essential (32).

Our findings of the study should be interpreted in light of the following limitations; the study sample was small, participants were from various cultural backgrounds which limits the generalizability of the findings.

Conclusion: Thus, we conclude that psychosocial interventions such aspatient education, post-operative counselling, enhancing social support and coping abilities, preparing for death were useful for persons with GBM, its efficacy can be established on larger sample further.Therefore,the Social Workers who work in the medical field, Neuro-Oncology and End of life care should give priority to identify the psychosocial needs of persons with GBM and take speedy measures to address them at the earliest.

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Understanding Adolescent Adjustment and Life Skills- An Implication for Social Work Interventions

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Abstract

Background of the study: The dynamism in the phase of adolescence is very well established. For a holistic well being of the adolescents, adjustment to various domains and life skills should be ensured. To meet this, the socio-demographic/ cultural background and gender has a role to play. Thus understanding of gender based adolescent adjustment and life skills is imperative which would enable preparing for the problem and developing gender specific interventions. This gives an insight into the life skills, present- strengths- in the adolescent girls of Mangalore and the need for the programme. Also, while developing domain specific programmes, the life skill that needs to be focussed will be known

Materials and Methods: A sample of 90 adolescent girls (class 8th to 10th) were selected through simple random sampling from two schools of Mangalore city selected through convenient sampling. Data was collected using the Pre Adolescent Adjustment Scale (PAAS) by Parik and Rao developed in 1967 (1) and Assessment of Life Skills Scale by Vranda (2) and was analysed using SPSS 17.

Results and Conclusion: The adolescent girls from mid phase (14.40 years) belonging to middle socio-economic status had healthy adjustment in all except general areas. The level of adjustment, however, was at the moderate level. They had low decision making and problem solving skills. Significant positive correlations were found between level of adjustment and life skills. The implications are discussed.

Key Words: Adjustment, Adolescent, Life Skills

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Introduction:

A very well known statement with reference to adolescence is "A phase of stress and storm". As established by literature adolescence is a stage from age of 10 to 19 years and the 'stress and storm' is usually during the early adolescence phase. This is because of the tremendous changes associated with the phase. Adding up to the changes that one struggles to muddle through, there would be other external challenges as well, all of which will make it tough for the adolescent to strive through. The same is elucidated below.

Family: The adolescents view themselves as adults and would want to be treated like one. In addition, autonomy is developed due to which one would want to take their own decisions. However both of these are hindered by the family who continue to treat the adolescents like children in most cases. Some of the common issues faced by adolescents in families as highlighted by Morgan and King (3) are

1. Teenagers demand to be treated like an adult which often is not accepted by the family
2. Due to the development of moral reasoning the adolescents can think of reasonable alternatives to the parental rules. Thus when parents frame rules there is absence of automatic obedience and more of resistance.
3. While the common problems faced by girls centre around the stringent rules imposed on them; conflicts that boys develop are most often to do with need for authority and privileges
4. Due to the above changes the parent child relationship changes

These changes demand a need for adjustment among the adolescents. In addition to this family environment has a key role to play in one's development. Problems in family, like conflicts, can result in child maladjustment (4) naturally affecting further years of life including adolescence.

School: The issues experienced at school that demands adjustment are similar to that of family. Even at school confining diligently to rules is difficult unlike a child. The rules framed are disliked by the adolescents and the absence of anyone who could understand them makes coping difficult. In addition, the focus shifts from academics to peer group and associated activities. The efforts by the teachers to deal with it are often resisted. Adjustment that one has to make in school is related to these issues.

Peer group: During adolescence a lot of significance is attached to peers. This goes in line with efforts to enhance one's social horizon. Developing heterosexual relationship becomes the focus. For an adolescent with family disturbances the peer group provides refuge. There would be different groups developed- unisex cliques and mixed sex cliques. As the identity establishment is most often based on the peer relationship, getting into any of the cliques is quite common. In the process, an adolescent would involve in activities even if it is disinteresting. This is also associated with the risk taking behaviour and the adolescent's succumbing to peer pressure. Denial of some of the peer pressures would result in conflicts and the need to resolve them. All of these demand for a need to adjust, the absence of which would make them vulnerable to mental health issues.

With regard to above areas, the adjustment issue is universal for all adolescents. However the magnitude of adjustment problem experienced varies based on gender and other factors.

General adjustments: A voluminous modification around the sphere due to modernization has fetched in number of complications for the adolescents of new generation (5) demanding one to adjust to the same. General adjustment involves the adjustment one is required to make in various other areas.

Adjustment refers to the extent to which one is able to cope with various challenges faced. It involves being flexible in order to live harmoniously with the surrounding changes. The adjustment problems during adolescence are not uncommon and are very well established by literature. A study conducted by Lois and Emerson (6) showed adolescents had unsatisfactory adjustment in the emotional domain, unsatisfactory adjustment in the social domain and very unsatisfactory adjustment in the educational domain. A positive correlation between all the three domains has been found. Likewise an Indian study on level of emotional adjustment among adolescents showed low level of emotional adjustment (7). The adjustment is determined by various factors like number of family members, age, family income, religion and community (5)

Adolescent mental health begins with the extent to which one is able to adjust to the phase and other aspects of life. The adjustment level is determined by a number of factors. These factors are commonly referred to as protective factors. Positive correlation between protective factors and adjustment has been shown through numerous studies. To substantiate, the family environmental factors like cohesion, expressiveness conflict, acceptance and caring, independence, active-recreational orientation, organization and control showed significant role in socio-emotional and educational adjustment of adolescent girls (8). The extent of life skills present in one, a protective factor, is no exception to this.

Life skills are defined as abilities for adaptive and positive behaviour that enables individuals to deal effectively with the demands and challenges of everyday life (9). There are ten life skills identified by the WHO. Good life skills ensure better adolescent adjustment which further ensures their well being. An overview of the literature below substantiates these points.

Materials and Methods

The aim of the study was to understand the adjustment of adolescent girls and presence of life skills. Objectives were

1. To examine the areas of adjustment difficulties for adolescent girls
2. To assess the level of overall adjustment among adolescent girls
3. To assess the life skills among the adolescent girls
4. To measure the relationship between adolescent adjustment and life skills

Cross sectional descriptive research design was used. The universe of the study was adolescent girls of Mangalore city. The adolescent girls of class 8th – 10th (13- 15 years) of two schools formed the population of the study from which sample was drawn.

Process of Sampling: The sample was selected from two urban schools. To control for various education related confounding factors, the inclusion criteria for the selection of schools were as follows: comprise of only female students, are private institutions, follow state syllabus and are located in the Mangalore City. Out of the 4 schools meeting the criteria, two schools gave their consent to conduct the study. Both these schools had both English and Kannada medium of instruction respectively. The English Medium section majorly encompassed students from different strata of middle income families and a few from lower socio- economic status. From these schools, the students who were fluent in English and were interested in participating in the study were included in the sample frame. The sample was selected through simple random sampling (lottery method). The data of a few students, who were reported to be possibly having behavioural/mental health issues as per the teacher's account, were excluded. These were included during data collection as they were interested.
The study period was June to December 2014.

Data Collection: Data was collected using two scales (details mentioned below). Students were given detailed explanation on the process of responding to the items of the scale. The availability of the researcher enabled clarification of doubts pertaining to items. An attempt was made to avoid social desirability by ensuring confidentiality and re-explaining the purpose of the study.
The following scales were used to collect the data.

a. Pre Adolescent Adjustment Scale (PAAS): A 40 item scale measures adjustment towards home, school, teachers, peers and general issues developed byRao and Parik in 1967 (1). The adolescent had to answer with either a "yes" or a "no". High positive scores indicate good adjustment (midpoint being 17) while high negative scores indicate poor adjustment. Through the teachers' rating from 4 schools, PAAS has been validated. For all areas, the calculated Mann-Whiteny U values were significant. Test-retest reliability values for different areas range from 0.28 to 0.54. (Malhi, Kumar, Singh; 2001).

b. Assessment of Life Skills Scale: This is a 115 item scale that measures the life skills in adolescents developed by Vranda (2). It is a 5 point rating scale- each statement followed by 5 responses of Never, Rarely, Sometimes, Usually and Always. Higher scores reflected higher life skills. Validity was established. Internal consistency (co efficient alpha- 0.94) and test retest reliability were also established.

Ethical Considerations: Informed consent from the principal and informed assent from students was taken. Those students with problems in adjustment and low life skills were brought to the notice of the school counsellor so that the issues could be addressed. Modules, prepared by the researcher, for life skills training programme were provided to the school counsellors so that the same could be delivered to the students in small groups based on their availability. This was already initiated and a first few sessions were conducted jointly by the counsellor and researcher.

Data analysis:SPSS 17th version has been used for analysing the data. Descriptive statistics and correlations have been used for the data analysis.

Results

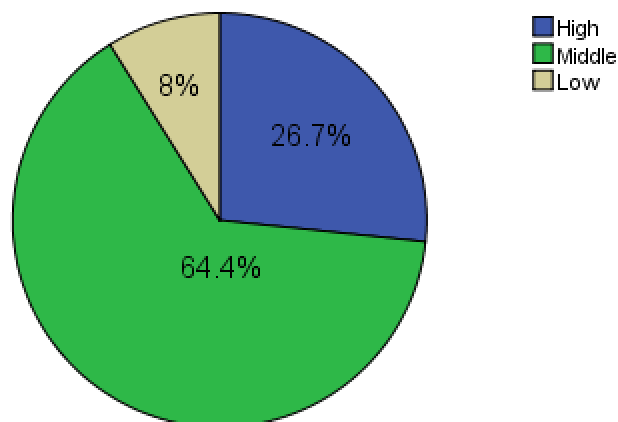
The data has brought out interesting results which is discussed below.

Table 1: Mean Age of the Respondents

Mean Age	14.40 Yrs
SD	.92

As represented by the table, the mean age of the participants is 14.40 (SD.92) indicating that the sample is representative of the girls belonging to mid adolescent phase. In addition to the age, other determinant of the level of adjustment is the socio-economic status that one belongs to.

Diagram 1: Socio Economic Status



With regard to the present study, majority (64.4%) of the students, were from the middle socio-economic families as indicated by the diagram above. More than one-third of the participants belong to higher (26.7%) and very few (8%) belong to lower middle socio- economic group. Thus, the sample represents the female adolescent group from middle socio- economic status whose requirements are generally fulfilled.

In order to understand the level of adjustment of these mid- adolescent girls belonging to middle socio- economic status, the domain scores on PAAS was analysed the results of which are described below.

Table 2: Level of Adjustment in Various Areas

Variable	Mean	SD
Adjustment at House	4.85	4.31
Adjustment at School	2.55	2.52
Adjustment with Peers	4.28	2.35
Adjustment with Teacher	2.25	4.20
Adjustment to other general issues	-0.38	2.92
Overall Adjustment	13.20	9.36

The table is representative of the results of 89 participants as one of the respondents did not respond to some of the items of the scale. The results provide an insight into the level of adjustment the girls have at home, school with peers, teachers, in general and overall adjustment. Each of these areas will be discussed individually for a better understanding.

In this study, adjustment at home was measured through the adolescents' perception of parents, siblings and neighbourhood. This includes their perception of the extent to which the parents are permissive, involved and supportive and the girls' relation with siblings/ neighbours. The respondents of this study have moderate adjustment at home, indicated by the mean score of 4.85 (Scores above 5-high adjustment).

Likewise at school, though the girls have no maladjustment, the level of adjustment is moderate indicated by the mean score of 2.55 (lower than the midpoint score of 3). It can be interpreted that, the students do not consider the school to be a burden. Even if they do so, it may be to a minimal level as there is no maladjustment. Therefore, the adolescent girls appear to be accepting the school rules and perceive to have liberty at school. Importantly, they may not be experiencing any negativity with peers and teachers, making them healthily adjust to the school. Adjustment with the teachers is a prime requirement considering the time spent in school.

The level of adjustment to the teachers is moderate as represented by the mean score of 2.25 (which is lower than the midpoint score of 3). This explains the adolescent girls' perception of the teachers to be encouraging, authoritative, understanding and supportive.

As far as adjustment with peers is concerned, the adolescent girls are very well adjusted represented by the mean score of 4.28 which is higher than the midpoint sub scale score of 3. This indicates that the girls are satisfied with their peers, are happy to be with their peers and trust them.

While the adolescent girls have no mal- adjustment in the domains of home, school and with teachers and peers, there is maladjustment to various day to day stress indicated by the mean score of -0.38 in the domain of general adjustment of PAAS. As per the scale general adjustment

includes one's level of self esteem, the extent to which one enjoys leisure, ability to manage ones emotions and express oneself properly. These reflect on the intrinsic factors of adjustment. The maladjustment under this domain could be because of the poor self awareness and acceptance.

Overall the adolescent girls are adjusted to various domains except to the general area. However the level of adjustment needs to be enhanced further from moderate to high for better well being indicated by the mean score of 13.20 (midpoint score of 17 and the maximum score being 34). When some of the protective factors- like life skills- are enhanced the same may be possible. Hence the life skills was assessed, the results of which are described below.

Table 3:Mean Scores of the Overall Life skill and of Some Domains

	Overall Life Skills	Decision Making	Problem Solving	Communication	Coping with Emotions
Mean	404.04	33.04	46.08	35.71	31.97

To deal with the adolescent issues of experiencing ambivalence, involvement in risky behaviours and experiencing 'Stress' and 'Turmoil' there is a need for one to be good at taking decisions, to solve the ambivalence/ problems, be well versed in expressing one's feelings and be able to manage the consequent stress and turmoil. These vary based on gender. Among the 10 life skills, decision making, problem solving, communication skills and the ability to cope with one's emotions are the core life skills that help address the aforementioned issues. Moreover, the components considered under the general domain (measured though PAAS), to which the adolescents are maladjusted, are similar to these four life skills. For these purposes, the results of only these domains were analysed.

The mean score of 404.04 reflects on the moderate life skills in the adolescent girls. As far as specific life skill is concerned, the girls have low decision making and problem solving skill as indicated by their mean scores of 33.04 and 46.03 respectively on the life skill assessment scale. Though they are deficient, of these important skills, the communication skill and their ability to cope with emotions are moderate as reflected by the mean scores of 35.71 and 31.97 respectively. The results throw light on the girls lacking the 2 important life skills which could impact one's adjustment level considering the relation between the two variables highlighted by the results below.

Table 4: Correlation Between Life Skills and Level of Adjustment

		Adjustment	Life skills
Adjustment	Pearson Correlation	1	.460**
	Sig. (2-tailed)		.000
	N	89	89
Life skills	Pearson Correlation	.460**	1
	Sig. (2-tailed)	.000	
	N	89	90

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

The table above indicates that there is significant correlation between life skills and level of adjustment among adolescent girls. Higher the life skills, better is the level of adjustment. In this study the adjustment at home, school, with peers, teachers and general adjustment is looked into. Thus, high adjustment in all of these areas is determined by the extent of life skills present in the girls as life skill becomes one of the protective factors.

Discussion

Adolescence is a period when the issues in various spheres would be building up in response to the phase related characteristics. Meeting these normative developmental tasks can be challenging and can impact one's level of adjustment in various domains of life. Various factors determine the level of adjustment among adolescents. The common determinants being gender, age and socio-economic status (10).

The sample of this study was representative of the girls belonging to mid-adolescence phase from middle socio- economic status of Mangalore City. Though the studies on role of gender on adjustment is inconsistent, there are studies that show girls being more stressful and thus having difficulties in adjustment than boys. In addition to this, the adolescents who belong to the mid-adolescent phase are found to be having more problems than those from other phase of adolescence (10). Likewise socio- economic status has a role to play in determining the level of adjustment among the adolescent. To substantiate, higher socio-economic status means better scope for grabbing various opportunities, meeting one's tangible requirements with ease as there is absence of financial stress and thus better adjustment. Similar discussions were made by Kiang et al's (11) study which established correlation between academic adjustment and socio-economic

status. Another study established adolescence from middle socio- economic status to be more anxious than others (12). Thus, the findings of the current study becomes important.

The findings point out that adolescent girls of mid phase belonging to middle socio- economic status have no mal-adjustment to the family, school, teachers and peers. Family environment determines the level of adjustment at home. A cohesive, organized, achievement oriented family that emphasises on moral and religious issue, independence and minimal conflict contributes to better level of (13). As far as school is concerned, dissatisfaction at not having adequate extracurricular activities, lack of pleasant experiences, being pressurized by teachers to strive beyond their potentials, monotonous methodologies and evaluation systems that made it more difficult to enjoy the experience of education can contribute to adjustment issues in school (6). The healthy adjustment of the girls in family explains the healthy family environment. Likewise, the adjustment to school, peers and teachers specifies the conducive environment in the school and the absence of aforementioned negative characteristics in the schools. The measures taken by schools today for the well being of the students like presence of a counsellor, friendly relations between teachers and students and numerous other ways to reduce burden on students could be the reason for healthy adjustment. The high adjustment to peers reflect on good relationship shared which enables them in expanding their social horizon consequent upon which is the identity development and self esteem. These, have facilitated healthy overall adjustment. These findings are in line with earlier study by Yellaiah (14). However, the adjustment in each of the sub domains and overall adjustment is just at a moderate level as highlighted by the scores which implies the need for a professional intervention to enhance it further. In addition to this, the maladjustment to the intrinsic aspects draws special attention. A study that explored the emotional adjustment of the adolescent girls also showed similar results (6).

Life skills could enhance one's adjustment level in the general domain or any other. Adolescents generally tend to have problems with decision making (15) which could naturally impact the problem solving skill. The current study also reflects the same. Likewise, just moderate level of skills for coping with emotions and communication could be a reason for maladjustment in the general area measured through PASS. The low scores on decision making and problem solving implies the need for regular programmes aiming at enhancing life skills enhancement and thus ensuring better adjustment to various domains as the two variables are significantly correlated. This is corroborated by various studies. A study conducted by Yadav and Iqbal (16), showed that the adolescents who received life skills training improved on emotional adjustment, educational adjustment and total adjustment except social adjustment in addition to other aspects such as self esteem.

Therefore it is necessary to develop this protective factor among the girls. With Group Work being one of the methods of Social Work and with the use of various theoretical perspectives, programs to enhance life skill can be developed.

Some of the limitations of the study were: the convenient method of school selection, small sample size and the inability to generalize the study to adolescent girls of other phase and socio-economic status.

Implications of the study

1. For Social Work Profession**:** Considering the relation between adjustment level of the adolescent girls and the life skills one of the major implications of the study is to develop standardized programmes using Social Work principles, methods and theoretical perspectives. Gender based perspective shouldn't be ignored. The study also reflects on the need to conduct programmes with teachers and parents to facilitate better adjustments at home, schools and with teachers. In addition to this, the study implies the need to conduct frequent sessions of life skills promotional programs. The need for School Social Workers is also evident. To meet the manpower limitation, the Social Work students can be trained in development of programmes and implementation of the same. This also enables to develop number of standardized programs and cover larger adolescent population.
2. Policies**:** One of the challenges that the School Counsellors/ Social Workers experience is the inability to conduct regular mental health programmes for the students due to the curriculum of the students. Researchers interested in studying the school children/ adolescents have even greater challenges. Policies that will ease this process is required. The study reflects the need for the same.
3. Research**:** The adjustment domains taken up for this study are only a few. There are multiple domains to be considered while exploring this topic. Adjustment to these varied domains needs to be studied. Research on the efficacy of Social Work Interventions on the level of adjustment to these numerous domains, of an adolescent's, life is required so that empirical evidence is established.

Conclusions:

The study attempted to understand the adjustment and life skills among adolescent girls. It gives an insight into the subject, specifically related to adolescent girls of mid phase belonging to middle socio- economic status of Mangalore city. It is definitely pleasant to note the healthy adjustment and moderate level of life skills among the girls. Yet, the problem areas and scope for further improvement cannot be ignored. Formulation of the programs and appropriate interventions is the only step towards ensuring better well being of the adolescent girls. This is applicable to the entire adolescent population.

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Conflict of Interest

None

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Impact of Psychosocial Care Training among Volunteers Working with Children in Difficult Circumstances

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Abstract

Background of the study: Issues of children invite wider attention and their care and protection is part of International agenda. India is a nation with large child population. Culturally, children here enjoy the care and protection from the parents. However, the percentage of children falling into the category of difficult circumstances is increasing alarmingly. According to the Department of Social Justice, Government of Kerala, the major issues reported among children above the age of 6 years include school drop outs, child abuse, adolescent issues, HIV infection, child labour, illegal trafficking, street children, children with disabilities and others. Volunteers and other stakeholders deputed for the care and protection of such children needs to be sensitive to the mental health needs and issues.

Materials and Methods: With the aim of enhancing the knowledge and skills of the 31 volunteers engaged in working with children in difficult circumstances, the Department of Psychiatric Social Work, IMHANS had organised a 2 two day psychosocial care training workshop for them. Participatory methodology with role plays, group discussions, activities, mediums and energizers were used in the programme. A workbook including assessment tools was specially prepared for the programme with inputs from the module[1] used at NIMHANS Bangalore.

Result: Assessment done before and after the training programme indicated a significant ($p<0.05$) improvement in the level of knowledge of the participants.

Conclusion: Periodical psychosocial care trainings for volunteers result in enhancement of their knowledge and skills which ultimately can benefit the children in difficult circumstances.

Key Words: children, difficult circumstances, psychosocial care, volunteers, training

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Introduction

Blessed are those children who grow up in a family environment under the care and protection of their parents and grandparents, privileged to have the company and support of the relatives and friends. A childin a congenial family environment with proper attention and guidance allows moulding into a healthy personality.India has 40% child and adolescent population[2]below the age of 18 years and not all children growing in our country are privileged. A large chunk of the children fall into the category of "children living in exceptionally difficult circumstances". This vulnerable group is prone to domestic violence, abuse – physical and sexual, malnutrition, HIV infection, child labour, substance abuseand so on that cripple their life due to the fragile state of their development. It alsoleavesbehind deep wounds in their psyche. Their right tohavecare and protection is often violated.

United Nations Child Rights Convention[3]calls for the active participation and cooperation of the international community in the care and protection of such children in exceptionally difficult conditions, specifically in the developing countries like India. The convention asserts that the child has the right to survival, good health, quality education, freedom of expression, freedom to be heard and enjoy their own language that can ensurea normal physical, psychological and social development. The concept of "care and protection" thus encompass mental health aspects as well and not merely the physical care and protection. Members of voluntary agencies, policy makers and other stakeholders should be sensitised to this aspect and opportunity should be created to train and equip them with the basic knowledge and skills in providing psychosocial care to children.

In India, in the National Policy for Children[4] commitment of the state to promote and safeguard the right of all the children, especially to those marginalised and disadvantaged is highlighted. The guiding principles of the same document emphasises that the mental, emotional, cognitive, social and cultural development of the children should be addressed. In these days, physical aspects of care and protection to children are being addressed to a greater extent by governmental and voluntary agencies. The mental health part receives lesser attention due to lack of awareness and partially also due to non-availability of adequate trained mental health professionals.

To address this scenario, capacity building workshops on psychosocial care are conducted for volunteers by various agencies to equip them with the basic mental health knowledge, skills and attitude to facilitate psychosocial care services to children in difficult circumstances. To name few such organizations active in organising such programmes in India are NIMHANS, Every Child, Butterflies,UNCEF, etc. According to WHO[5], psychosocial care programmes assist in enhancing the psychological and social development of children in difficult conditions and strengthen the protective factors that can minimize the negative impacts.

"Training handbook on psychosocial counselling in especially difficult circumstances – a trainer's guide" by UNICEF[6]expects the participants to gain knowledge about children in especially difficult circumstances, basic counselling skills, principles and process and its implementation. The model of psychosocial care programme for children in difficult circumstances developed at NIMHANS[1] has curative, preventive and promotive interventions for children. The capacity

building training programmes conducted by NIMHANS for community level workers were found to be effective with a significant enhancement in the level their knowledge during the pre-post analysis[7].

Methodology

Institute of mental health and Neurosciences (IMHANS), Kozhikode had always been in the forefront of delivering child mental health services in Kerala. Its activities are spread over the entire Malabar region comprising the districts of Malappuram, Kozhikode, Wayanad, Kannur and KasargodDistricts.Child Development Services (CDS) of IMHANS is the only such centre in the North Kerala in the Government sector which provides free treatment to children with mental health disorders and developmental disabilities. Community Developmental Disability Program (CDDP) is another unique outreach program for children and adolescents with developmental disabilities and psychological disorders implemented with the support of NRHM. Under this programme, a multi disciplinary developmental disability team visit selected PHCs/CHCs or other outreach centres on pre fixed days and provide early identification, remedial therapy, counselling and other psychosocial interventions. Institute amply enjoys the support and cooperation from the health and social justice departments of State Government, local self governments and voluntary groups and agencies.

Volunteers of ‘Our responsibility to Child’ (ORC) and the caretakers of the Children’s Home (Boys) under the Department of Social Justice requested for a psychosocial care training for working with children in difficult circumstances. The Department of Psychiatric Social Work, IMHANS, Kozhikodeconducted the programme on 27th and 28th September, 2014.The broader aim was to train the participants the basic concepts of psychosocial care, equip them with the knowledge, skills and techniques in imparting the same and assess the impact of the said training. A total of 31 persons participated in the workshop and all were included in the assessment process. Training was based on a participatory methodology using a workbook prepared in Malayalam language with inputs from the validated module used at NIMHANS Bangalore[1]. Translation and back translation of the module and the tools was done with the help of experts and approvalfor the study was obtained from the research committee at IMHANS, Kozhikode.The content of the workshop is given in table No: (1). Measurement before and after the training programme (table 2) was done with the consent of the participants, using a ten-point self-administered scale[1],“Knowledge of psychosocial care for children in difficult circumstances”. In addition a demographic data sheet was used for collecting the participant profile. Descriptive statistics and‘t’ test was used for analysis.

Table : 1 Content of the training programme for children in difficult circumstances

Methodology &Activity/topic	Aim of the activity	Expected Outcome	Observations
Game *"Car & Driver"*	• To understand the emotional status of children in difficult circumstances • To understand the role & responsibilities of care takers	• Participants should experience the emotions of the children in difficult circumstances • Understand the responsibilities of a care taker	• Insight into the emotions such as fear, anxiety, tension, uncertainty, etc among children • Protection, motivation to reach the goal, ability to guide, and motivating the child to go forward as responsibilities of care takers
Experience Sharing	• To get a general understanding about the magnitude of the problem	• To open up the discussion on difficult circumstances • Severity of the problem • Different problem situations	• Ventilation of feelings • Clarification of doubts • Creation of a we feeling among members
Group Discussion *Discussion in three groups*	Create awareness about • Who are children in difficult circumstances? • What are the causes/ factors that lead children to difficult circumstances? • What are the Govt / NGO initiatives for such children?	• Comprehensive understanding of children in difficult circumstances	• Live participation • Analysis of the causes/factors • Free listing of Govt / NGO initiatives

Group Discussion *Discussion in three groups*	Impact on the children • Physical • Psychological • Social	Participants understood that • Children can be affected in many ways • Intervention should be multi model (holistic)	Increase in the level of knowledge
Lecture cum discussion *Substance abuse among children & adolescents*	• Enriching the knowledge and awareness of participants	Gained information about • Widely used substances • Symptoms of addiction • Causes • Treatments available	Better knowledge Clarification of doubts
Lecture cum discussion *Commonly seen psychiatric problems in children*	• Enriching the knowledge and awareness of participants	4 major areas • Developmental problems • Emotional problems • Behavior problems • Learning related problems	Gain scientific information
Lecture cum discussion *Child sexual abuse: Identification and Management*	• Enriching the knowledge and awareness of participants on CSA	Enhance the knowledge on the causes, identification, signs &symptoms and management strategies	Improvement in the confidence level of participants to work with CSA

Free listing *Needs of children*	• Improving the knowledge of participants	Identified needs • Food & shelter • Medicine • Love& affection • Empathetic attitude • Support & guidance • Education & entertainments • Encouraging abilities • Trust & respect	Identification of physical, psychological and social needs
Role Plays & discussions *Techniques of psycho social care*	• Learn about psychosocial care techniques	Learnt about skills such as • Observation • Patient listening • Empathy • Resourcefulness • Reassurance • Normalization of activities	Insight into the practical application of the techniques
Group activity *Mediums of psychosocial care*	• Create awareness about different mediums that can be used • How to use each medium	Understand about • Facial expressions • Thematic cards • Family pictures • Drawing • Creative writing • Dolls • Clay modelling	Gained confidence to apply mediums to unearth the suppressed feelings of children

Partners of care *Lecture and discussion*	To build awareness about partners of care	Better knowledge about roles of • Parents • Relatives • Teachers • Community workers	Learned the importance of collaborative work
Participatory discussion *Holistic care*	• What is holistic care • Different aspects involved	Learn about • Law • Health • Education • Family • Finance • Society	Learned the concept of spectrum of care (total care)
Participatory discussion *Dealing with care giver stress*	• To understand the stress among caregivers • To learn the strategies to cope with the same	• Understood that stress among caregivers is a normal reaction • Understood the healthy ways of coping with stress	Internalized the concepts of “sharing with others”, recreation, meditation, yoga, etc. as stress busters
Oath Taking *Maintaining confidentiality*	• To know the ethics of working with children	Learn about • Maintaining confidentiality • Commitment to children and colleagues	Learned on significance of confidentiality, situations to breach confidentiality

Table: 2 Items of the "Knowledge of psychosocial care for children in difficult circumstances" scale[1]

Serial No	Item	Score
a)	I don't know anything about psychosocial care for children in difficult circumstances	1
b)	Providing basic amenities to children is more important than psychosocial care	2
c)	Psychosocial care is not crucial in helping children deal with distress	3
d)	Psychosocial care is needed only for children with mental illness	4
e)	I know the need of psychosocial care for children but know very little of how to provide it	5
f)	I know the importance of psychosocial care and how to provide the same to the children in the general community	6
g)	I know the importance of psychosocial care and how to provide the same to vulnerable group and children	7
h)	I know about psychosocial acre and how to help the CLWs in handholding the activities on the field	8
i)	I understand the importance of holistic care and will be able to provide the same to special groups of children and disabled	9
j)	I am confident that I understand the concepts dealing with psychosocial care for children in difficult circumstances and will be able to train others on the same	10

Results

One among the 31 participants of the workshop had not completed the post assessment proforma and was excluded from the analysis.

Profile of the participants

Gender: Twenty (66.7%) were males and the rest were females

Age: The mean age of the participants was 49.03 (SD=12.02) years. The minimum age was 27 years and maximum was 70 years

Education: The mean years of education of the participants were 14.47(SD=2.27). The minimum years of education of the participants were 10 and maximum was 19 years.

Religion: A little less than half of the (46.7%) participants were Hindus, few (16.7%) were Christians and more than one-third (36.7%) were Muslims

Marital Status: Majority of the (86.7%) participants were married and the rest were unmarried.

Occupational Status: It was seen that 43.3% participants belonged to the category “Government Service / Retired from Government Service”. Remaining 56.7% belonged to the “non-government” category (business, volunteer, nurse, medical representative, trainer, insurance agent and so on)

Prior training participation: Only two (6.7%) participants reported that they had not attended any other training on the same subject prior to the one they are attending. Twentyseven (90%) participants reported that they had attended a training programme on the same subject before. One participant had attended two training programmes on the same subject before.

Volunteer Experience: The mean experience of working as a volunteer was 6.83 years. The minimum reported experience was six months and the maximum was 40 years.

The impact of the psychosocial care training programme

The pre-post analysis of the response of the participants on the ten-point scale showed a significant difference ($p<0.001$) in the level of knowledge before and after the training (Table 3).The initial mean score of the level of knowledge of the respondents on the psychosocial care programme was 4.90 which rose to 8.27 during the post–assessment indicating its effectiveness.

Table 3: The change in the level of knowledge among the participants

Item	Pre Mean±SD	Post Mean±SD	‘t' value	Sig
Level of Knowledge	4.90, 2.1	8.27, 1.4	-9.18	< 0.001

(N=30)

Discussion

The present scenario in India is that even children with families are unsafe and prone to physical, emotional and sexual abuse. Then, one can imagine the heights of vulnerability of those children living in exceptionally difficult circumstances. With some extra assistance, it is possible to bring such children to the main stream of the society. Volunteers attached to various agencies working in the field of child care and protection is a ray of hope to them. They are able to identify the mental health needs and issues of such children. However, they find themselves handicapped due to lack of knowledge and skills to deal with it. It is therefore essential and useful to empower the committed volunteers with the basic knowledge and skills in providing psychosocial care to children in difficult circumstances. It can be a viable model considering the limited well trained mental health professionals in the country.

There was a high representation of males as volunteers in the present study who participated in the workshop. Generally the trend is that females come forward in large numbers to work as volunteers or community level workers. The interest in the male volunteers in the Malabar region of is highly

appreciable and it shall strengthen the psychosocial care programme for children in difficult circumstances to a greater extend.

As reported in an earlier similar study[6] in India, the present study was also found to be effective in enhancing the level of knowledge to a significant level among the volunteers working with children under difficult circumstances. Participants were of the view that the participatory nature of the workshop facilitated better understanding. It's a fact that things learned through activities are more remembered than theoretical points. It sustains the interest and concentration throughout the training programme. Group discussions, modelling, chart discussions, games and mediums also provided room for sharing the personal experiences and wisdom of the participants.

Another factor that could have contributed to the success of the programme was the introduction of using mediums to work with such children. Participants felt that it would help in unearthing the covert feeling of the children. Information related to staff stress and the strategies to remain mentally healthy was also a new concept for them. The sharing of success stories by the participants has also increased the overall level of confidence.

Implications for Professional Social Work

Professional social workers can play multiple roles in the psychosocial care programme for children in difficult circumstances

a) Plan, design and implement curative, preventive and promotive programmes
b) Coordination and monitoring of the programme
c) Organize capacity building training programmes and sensitization workshops for volunteers, students of schools of social work, other mental health professionals and government representatives
d) To work in coordination with local self governments, health, social justice and educational departments
e) Provide handholding support at the field level and referral for higher inputs
f) Preparation of workbook, reading materials, manuals, pamphlets, etc
g) Reporting, periodical evaluation and modification of the programme
h) Advocacy and policy initiatives
i) Dissemination of the information in seminars, conferences, etc

Limitations

1. Sustainability of the knowledge and skills acquired had to be verified with the participants after an adequate time span

Conclusion

Children are assets to any nation and their care and protection is our duty. Special attention through psychosocial care programme for children in difficult circumstances ensures that no children is left

attended or neglected and that their contribution are very much needed for the progress and development of the country. In moulding and shaping such children to healthy future citizens, the role of caretakers/volunteers is vital. Their level of motivation needs to be sustained with periodical updation of knowledge and sharpening of skills to deal children in difficult circumstances. The effectiveness of the present training programme for the volunteers thus highlights the need for organising such trainings periodically.

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Parental Stress and Support in Families of Children with Autism

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Abstract

Background of the study

Parenting is a wonderful and rewarding experience, is often accompanied by high level of stress. When a child turns out to be disabled or having certain disorders, these stress further increases, ranging from physical adjustment to emotional turmoil as proved by many of the western literature. However there is very limited literature available in Indian context in this area. With this background the present study aimed at assessing the different factors contributing to parenting stress of children with Autism as a means to develop better psychosocial interventions.

Materials and methods

The objectives of the study were to understand the causal factors to the parenting stress of children with Autism and significance of support system in reducing the parenting stress. A case study was conducted with the parents of children with Autism at an integrated school by using an interview schedule as a guideline.

Result and conclusion

Results of the present study revealed that the level of stress among parents of children with Autism is largely depends on extent of availability of support system. Thus understanding the contributing factors for parenting stress and availability of support system is essential as it has implications for Psychiatric Social Work practice to explore the better coping strategies.

Key Words: Parental Stress, Support, Autism

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Introduction

All parents expect a normal and healthy baby. When a child is diagnosed with Autism, parents undergo a series of psychological reactions and stress due to the unexpected demands and challenges, for which they are often unprepared. There is felt disappointment for having given birth to a not perfect child. The feelings of disappointment can be aggravated if the family supports are also lacking. Thus the parenting of children with Autism is a stressful task for the parents, influenced by a number of external and internal factors. A number of studies proved that raising a child with Autism is one of the hardest things a parent will ever have to do.Sharpley, et al (1) in a survey of 219 parents of children with Autism found, Concern over the permanency of the condition, poor acceptance of autistic behaviors by society and often, by other family members and the very low levels of social support received by parents; are the three major stressors related to the parenting a child with Autism. In a study on 'Family perspectives of raising a child with Autism', Schall (2000) stated that, 'family burden of a child with Autism increased by a combination of the rejection from family members and the stigma felt from members of the community'(2). Often parents of a child with autism describe relatives as cold, distant, and generally unhelpful.Greater the support perceived by mothers of children with Autism from the other parents of children with disabilities and the persons with whom they are emotionally attached, lesser is the stress experienced; as found by Bristol (1984) in his study on 'Psychosocial environment of families of children with Autism'(3).

Thus studies have highlighted the stress parents experience when they have children with Autism. Understanding the contributing factors for the parental stress is essential as it has implications for Psychiatric Social Work practice. This Research explores a basis to study new directions required to meet the needs of parents coping with such demands, which in turn will help professionals in the field to derive at a module to help parents of Children with Autism and there are very limited adequate literature or studies available relevant to the study undertaken, especially in the Indian context. Thus this study will also serve as a material for further researches in similar areas in Indian context.

Methods

The paper aimed atassessing the different factors contributing to the stress in parents of children with Autism as a means to explore better coping strategies. Primary objectives of the study includedassessment of the factors contributing to the parental stress in the children with Autismand understanding the significance of support system in reducing the parenting stress.Used case study method of research to explore problem areas, which influence the stress among parents of children with Autism.Five parents of children with Autism residing in Mangalore and who were under training at SDM Integrated School Mangalajyothi, Vamanjoor were selected purposively in the study.An interview guide prepared by the investigator including some important aspects derived from 'Family Assessment Schedule' (FAS) (4)related to the factors contributing to parental stress

has been used as a guideline for this study. An Informed Consent was taken from the respondents prior to the interview.

Discussion and Findings

Case Summaries

Case 1: The child was diagnosed with Autism when he was 5 years old. The parents experienced a number of barriers such as need forextra inputs for care, decreased leisure time, altered social life, social embarrassment and personal distress. They got primary and secondary (internal) support from their family but there is no tertiary (external) support is available.

Case 2: When the child was 3 years, he was diagnosed with Autism. They feel that the need for extra input for care of this child, disturbed behavior of the child, decreased leisure time, financial implications and social embarrassment made them distressed. There is neither family support nor external support available for them.

Case 3: The parents got to know that the child has Autism when he was 4.5 years old. They have a supportive family, at the same time they don't get any sort of external support. Somewhere they felt that they need extra inputs for care for this child, hence their social life has been altered, they cannot concentrate on others, feel social embarrassment and get distressed thinking about the future of the child.

Case 4: Thechild was suspected to be having Autism when he was 4 years of age. They experience a number of personal barriers because of this child such as personal distress, financial burden, need for extra inputs for care, social embarrassment and role burden. No external and family support is available.

Case 5: The child wasdiagnosed with Autism when she was 4 years old. They have a good supportive family but there is no external support available. They feel that they need to put extra inputs for care, they get embarrassed when people question about the child which makes them distressed at times.

Even though there are 5 different cases, there are some similarities in the stress experienced by parents of children with Autism. The results of the case analysis also show the specific areas of stress among parents and the impact of support system to reduce the stress. The *barriers experienced and support available* determined the level of stress experienced by the respondents. An in depth understanding into the same can be achieved through the discussions below.

Factors Associated with Parenting Stress:

1. **Barriers Experienced:**

Extra Inputs for Care: All the respondents felt that they had to spend a lot of time caring for their child than any other personal work. Therefore they were not able to give proper amount of time to

other children and family members because of the time they spend with this child. Following experiences shared by the respondents further illustrate this;

Case 1: *'It is very difficult to balance all the other work along with taking care of this child'.*

Case 2: *'..at the end of the day I get exhausted but being a mother I need to tolerate this and continue with my routine..'*

Case 3: '*At times we feel we are not able to give proper amount of time to other family members nowadays'.*

Case 4: *'If all the time I am behind him who is there to look after other concerns..'*

Case 5: *'I feel that we spend more time caring for this child than anything else'*

Personal Distress and Social Embarrassment: All the respondents feel that, they often find themselves at home looking after the child. They get worried thinking about the future of the child. They often experience the social situations where people stare at the child and pass comments looking at the strange behaviors. They get distressed and feel embarrassed at that moment. This is evident in the below mentioned statements made by the respondents during the interview;

Case 1*: 'I spent so many sleepless nights thinking of his future…I get irritated and feel sad when people probe about the child even though they are aware of his problem'.*

Case 2*: 'I feel guilty and embarrassed when people stare at him and enquire about him…if God's wish is so nobody can help it. We just have to walk in the path he shows..'*

Case 3*: 'Frequently we face situations where others stare and pass comments on our child, this makes us angry and feel insulted…because of my destiny my child became like this'*

Case 4*: 'I feel very uncomfortable and get humiliated when people enquire about the child…there is nobody to help me out with this'*

Case 5: *'In spite of knowing the reality when others ask about her we feel sad. So we just try to avoid such people..we are worried of her future'*

The finding on Parents' distress and feeling of social embarrassment from this study goes along with the study (5)on 'Ten years on: a longitudinal study of families of children with autism', where he observed that "the period of early childhood is one of the most stressful times for parents of children diagnosed with autism. Possible reasons for the increased distress include more time spent caring for a highly challenging child, less adult interaction, social embarrassment and reduced income associated with increased financial worries".

2. Availability of Support:

All the respondents are receiving primary support (internal) especially from their spouse. And majority (3) of the respondents are also getting secondary support (internal) from their extended family, which has helped them to cope with the situation. For the respondents who are living in a joint family, the internal support is more than that of the respondents who live in a nuclear family. On the other hand other than Mangalajyothi there was neither tertiary support (external) available for all the respondents nor were they aware of such support. Similar to this in a study on 'Psychosocial environment of families of children with autism' by Bristol (3)found that "mothers in the low-stress group reported greater perceived support from their spouse, relatives, and other

parents of children with Autism, and more than half of the respondents reported that social support from more formal sources, such as parent groups, social clubs, and day care centers, was unavailable".

Becoming a parent fundamentally changes one's life, making it more complex. Parenthood often leads to reassessing the purpose and meaning of life. During a child's early development, after the realization that 'something is not right with their child', parents go through a period of intense stress that vary from physical adjustments to emotional turmoil as a result of watching their child's problems become more pronounced in comparison to their normally developing peers.

Some of the limitations of the study are:

- The researcher had to rely only on the single source of information for this study.
- There are chances of bias being affected with the response given by the respondents.
- Due to time constraint data from more respondents could not be collected.
- Few respondents were not cooperative with the investigator as it involved emotional and sensitive issues
- Many of the Special Schools and the respondents did not consent the researcher for data collection

Thus these limitations need to be addressed in the future research studies on the subject.

Conclusion

The study found that the period of parental stress builds over time as parents go through the process of seeking an accurate diagnosis and trying to obtain treatment for their child. As explained above the factors contributing for the increased distress of the parents include; more time spent caring for the child, less adult interaction, altered social life, societal reaction to the child, disturbed behavior of the child, personal distress and poor internal and external support available to them.Psychiatric Social Workers play an important role in this area. In addition to rendering psychoeducational services there is scope for therapeutic interventions with parents to enhance their coping. The Parents are also found to benefit from the support groups as it would also help in reducing the effects of stigmatization through shared experience and the realization that they are not alone in their struggles.

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Socio-demographic characteristics and Self-esteem among Transgender persons in Southern part of India: A Descriptive study

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Abstract

Background of the study: Transgender persons are those who exhibit gender variant behavior and roles in the society and are the most visible and exploited sexuality minorities in India. The current study is an effort to understand more about this population.

Materials and methods: The study adopted descriptive research methodology and conducted in Bengaluru city. 60 Male-to-female transgender subjects selected for the study by using consecutive sampling method. The subjects were contacted through Sangama, the NGO working for this community.

Results: Half of the Transgender persons are migrated from other states and having no support from family and friends. Sex work and begging are the main sources of their livelihood. They spend all their earnings mostly on substances and other day-to-day commodities and have no practice of saving for future. Many of the respondents are not satisfied with the life they are living. Those who are educated in high school and above and those who are staying in their family of origin have scored high level of self esteem.

Conclusion: Transgender persons are stigmatized and minimally understood from the wider part of the society. Hence, there is an urgent need to bring about awareness among the society and mainstreaming this population. In this regard, the social workers have a major role to play in terms of bringing change in their life.

Key words: Transgender persons, Socio-demographic Characteristics, Self-esteem

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Introduction

The word 'Transgender' is a general term applied to a variety of individuals, groups, behaviors, and appearance involving tendencies to vary from culturally conventional gender roles of the society[1, 2]. In other words, Transgender is the state of one's gender identity (self-identification as woman, man, neither or both) not matching one's assigned sex (identification by others or society as male, female or intersex based on physical or genetic sex)[3]. The term 'Transgender' does not imply on any specific sexual orientation[1]. However, Transgender persons may identify themselves as Homosexual, Bi-sexual, Female to Male, Male to Female, Lesbian and some of them may consider conventional sexual orientation labels inadequate or inapplicable to them[2, 3].

Since, the Transgender persons exhibit deviant gender expression against the social norms and values[2] they are subjected to ridicule, discrimination and harassment by others including from their own family members, parents and friends[4]. Hence, they have been segregated in the society as most visible and exploited sexuality minorities in India[2]. It is important for social workers to understand this group of people and respond to their problems.

Materials and methods

The aim of the study is to understand the socio-demographic characteristics and self-esteem among Transgender persons. Hence, a Descriptive method of research is adopted. A total of 60 respondents who identify themselves as 'Hijra' or 'Transgender women', were recruited for the study by using consecutive sampling method. The respondents are contacted with the help of a Non-government Organization (NGO), which is actively working for the rights and mainstreaming of the Sexuality Minorities in southern part of India. The respondents are interviewed by the researcher at the NGO by using a semi-structured Socio-demographic Datasheet and Rosenberg Self Esteem scale –a structured questionnaire. Rosenberg Self Esteem scale is a ten items, Likert scale, each item answered in a four point scale –ranging from strongly agree to strongly disagree. The total score range from 10-40; Higher the score higher the self esteem; score 25-35 denotes normal level of self esteem, below 25 denotes low self esteem. The scale can be used without explicit permission from the author[5]. The respondents were contacted in the NGO, explained them about the study and requested for their participation. The first 60 persons who signed the written informed consent forms were included in the study. The data was collected by the researcher by using interview method.

Results

Socio-demographic characteristics

The Transgender persons who are residents of the research-universe mostly belong to young adult age and adult age(28.27±6.804) (range=20-52); half of them are migrated from other states of the country and mostly living in the Transgender community -away from their family and friends. Most of them are educated at primary level and high school level; they speak multiple languages, engaged in sex work or begging or both for their livelihood. Quarter of the respondents are in intimate relationship and some of them are consider themselves as married. Three out of four of the

respondents are using or abusing substances and majority of them have no practice of saving money. The results are depicted in the table-1.

Table 1: Socio-demographic characteristics of the respondents.

Characteristics		Frequency	Percentage
Age (years)	20-27	32	53.3
	28&above	28	46.6
Educational Status	Primary (1-7th std.)	16	26.7
	High School (8-10th std.)	28	46.7
	Pre University	8	13.3
	Graduation and above	2	3.3
	Illiterate	6	10.0
Languages known	Single language	4	6.7
	Two or more than two	56	93.3
Marital Status	Married/in romantic relationship	14	23.3
	Unmarried	46	76.7
Domicile (state)	Karnataka	30	50.0
	Other than Karnataka	30	50.0
Living Arrangement	In family of origin	5	8.3
	Transgender Community	43	71.7
	In the mainstream (rented house)	12	20.0
Source of Livelihood	Begging/ Sex work or Both	52	86.6
	Other than Begging / Sex work	8	13.3
Substance Use/abuse	Present	44	73.3
	Absent	16	26.7
Practice of saving money	Present	17	28.3
	Absent	43	71.7

Self-esteem among Transgender persons

As the following table depicts, most of the Transgender persons have normal level of self esteem and 1/5th of them have low level of self esteem.

Table 2: Level of Self –esteem of the respondents

Self Esteem –Levels	Frequency	Percentage	Mean	SD
Low Self Esteem	12	20.0	16.7000	2.28703
Normal Level of Self Esteem	48	80.0		
High level of Self Esteem	0	0		
Total	**60**	**100.0**		

Differences in the level of Self-esteem among Transgender persons based on the selected Socio-demographic variables

In order to understand the difference in the level of self-esteem among the respondents based on certain socio-demographic characteristics, 'Kruskal Wallis test' been performed. The results showed that the difference in the level of self-esteem is almost statistically significant ($p=.057$, $p<.05$) as far as their living arrangement is concerned which is shown in the following table. It depicts that the Transgender persons who are staying in their family of origin are having better self-esteem compared to those who are staying in Transgender community and in mainstream of the society. The other socio-demographic domains such as source of livelihood, status of substance use/abuse, education status, domicile, languages known etc. did not show any statistical significant differences.

Table 3: Differences in the level of Self-esteem among Transgender persons based on their living arrangement

Domain		**N**	**Mean Rank**	**Chi-square (H)**	**p' value**
Living Arrangement	Family of origin	5	47.4	5.733	0.057
	Transgender community	43	28.14		
	In mainstream of the society (rented home)	12	31.92		

Discussion

The study highlights that the Transgender persons who are living in the research area (an urban area of southern part of the country), majority of them are migrated either from other parts of the state or from other states. Majority of them are educated at primary level or high school level; they are not occupied in any of the mainstream jobs for their livelihood and mostly stay in their own community. Very few of the respondents are staying in their family of origin and in the mainstream of the society. Majority of the respondents are involved in substance use/abuse behavior and majority of them are not concerned about saving money for their future.

Though the results highlight, majority of the respondents are having normal level of self-esteem when it is cross examined with their type of living arrangements, those who are living in their family of origin have got better self esteem compared to other two groups.

As reported in other studies, the Transgender persons are socially excluded where they are ridiculed, harassed and discriminated[6] by their own family members, friends and neighborhood

and they receive no support from family and friends; they are deprived of the education and livelihood opportunities because of which they are dependent on sex work [4, 7-9] and begging. The results of the current study also found similar where majority of the Transgender persons are migrated from various places to the urban area –research universe, they are living in a separate Transgender community away from their family and friends and having very limited transactions with the mainstream of the society. The results of the current study also corroborate with poor education status and deprived of livelihood opportunities.

It was found in the other studies that, the transgender people have low self-esteem[10, 11] and depression[12] which have made them to be so pessimistic about their life[13]; majority of the Transgender persons also involved in Substance use and abuse behaviours[6, 14]. The results of the current study also corroborated with the above, where majority (73%) of the respondents are using or abusing substances, they (72%) have no practice of saving money for their future and overall 20% of them and those who are staying (majority) in the Transgender community and in the mainstream of the society are found to be having low level of self-esteem. All these indicate pessimistic ideas towards life, no purpose in life, no respect towards oneself, feeling lonely and so on.

As the studies strongly suggest that, in order to deal with the psycho-social problems faced by the Transgender persons and achieve their welfare, they should be accepted by the family, friends and the community, brought to the mainstream[4], provided with equal educational, livelihood, health and other public welfare services[6, 15], the current study also shows that the Transgender persons who have accepted or staying in their family of origin are having better self-esteem compared to those who are staying in the Transgender community and in mainstream of the society. This indicates the family acceptance of Transgender persons would bring positive changes in their life and further it would lead to security to the life, reduction of the discrimination and help to avail the educational, livelihood and other welfare services.

Limitations of the study

The small sample size and the sampling method would bring great limitations to the study in terms of no proper representation of the population and no scope for generalization of the results. Since, the respondents are recruited to the study through the NGO this may not be the representation of whole population of the research-universe and the results may vary if the study would have been

conducted in the Transgender community directly. Due to lack of availability of time, stigma, legal complications, lack of place to meet the respondents and other practical difficulties the study could not be conducted in the Transgender community directly.

Conclusion

Though there are lots of limitations to the current study, it describes the socio-demographic characteristics of the Transgender persons along with their level of self-esteem and its status with regard to different socio-demographic domains. The study highlights the need for more research studies in this area and need for accepting the Transgender persons in the families, friends and the community groups which will help them in mainstreaming, achieve welfare and reduce their unique psycho-social problems. In this regard the Social workers have a lot to do in helping the families, friends and community members in accepting them, tackling with the stigma, bringing about awareness and sensitizing the professionals and service providers.

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Reaching the Unreached; De -Professionalization of Social Work Education

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Abstract

Background

Lack of professional services in rural areas is a major problem in reaching the unreached populations in difficult circumstances. Social work as per the IFSW and IASSW emphasizes "A practice based profession and an academic discipline that promotes social change and development, social cohesion and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. This can be facilitated by de- professionalization which emphasizes on training of community level workers in providing psychosocial services for children in difficult circumstances.

Materials and method

Through seven years of systematic assessments, planning, implementation and evaluation NIMHANS has developed a community based social work approach to work with children in difficult circumstances by educating community level workers. A need assessment was conducted to develop a five tier approach followed by developing training and education materials and intervention kits for children to provide preventive, promotive and curative psychosocial and mental health services.

Results and conclusion

These services were provided to a total of 15878 children through 1645 community level workers and 361 master trainers. The result of the de-professionalization of social work confirms that the approach would help to materialize the professional and academic goals that have been propagated by the International Federation of Social Work and International Association of Schools of Social Work.

Keywords: De-Professionalization, Social, Work Education, Psychosocial Care, Children in Difficult Circumstances, Community based intervention

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Introduction

The Census of India (2011) reports 30.8% of population below the age of 14 years (1). India is the country with the highest number of child population in the work with 19% of world children. This figure shows that India is rich with human resource that can contribute to the nation's development. This can be achieved only if these children grow up as responsible individuals for whom a conducive environment is essential. People especially in various social epi-centers are discriminated due to socio economic political and cultural factors. Children in such epi-centers are at the threat of developing psychosocial problems that hinders their development as responsible individuals. Though there are government programs for these children reaching out to rural unreached population remains a challenge due to lack of resources. There is a need to build up local resources to reach out to this population to ensure their psychosocial development through de-professionalization.

Psychosocial problems among children in difficult circumstances

Children in difficult circumstances refer to a wide group of children who experience specific difficulties in their life that interferes with their normal psychosocial development. "*Children in especially difficult circumstances are those children who are for shorter or longer periods in their lives, exposed to intense multiple risks to their physical and mental health. A common characteristic of these children is that they lack proper adult care and protection and that they lead their lives outside mainstream society*"(2). Skinner et al., and Mock &de Buhr brings out the pathetic condition of children in difficult circumstances that highlights their vulnerability to be exploited, be out of family and highly getting exposed to violent situation, poor health due to malnutrition and poor availability of services(3, 4). A study conducted by NIMHANS revealed 24 various difficult circumstances among children in the southern states of India (5). Children in difficult circumstances experience psychosocial problems such as frequent recall of negative/violent experiences, anxiety and fear of the future, frustration/anger, depression/loneliness, distrust, sense of fear of being rejected or neglect (6).

Mental health services in India

Lack of country centric mental health programs, plans and policies pertaining to children as well as lack of human resources is highlighted by Russell, Mammen, Nair, Russell, & Shankar, as cause for the unmet mental health needs of children in the country(7). Mental health services in India is provided by State and private sectors of which State provides services only to 2.05% and rest 98.95% of population avail services from own expenses due to lack of available social welfare systems (8). WHO brings out the lack of human resource in India as 0.2 psychiatrists, 0.05 psychiatric nurses and 0.03 psychologists and social workers for 100000 population(9). Reasons for the poor availability of mental health services in rural India as reported by Kumar were economic, disasters, poor social support systems as well as individual factors(9, 10). WHO identifies challenges in reaching out to rural India as challenging that need correction in existing infrastructure, program and architecture of NMHP and DMHP(11). Apart from this, there are major barriers that prevent rural population from seeking professional help for mental illness such

as non availability services, poor literacy, socio-cultural and environmental factors as well as stigma and discrimination.
The statistics of children with mental health issue as reported by Shastri shows an alarming figure as 10% of children below 15 yrs have diagnosable mental health disorder and 20% of adolescents have severe disorders. The study also reports that 90% of children with mental health disorders do not receive professional support through mental health services(12). The reasons listed out in the study were lack of accessibility and poor infrastructure. WHO confirms that across the world children and adolescents who are in need of professional services are not accessing it due to personal and social reasons as well as lack of accurate information(9). Saxena, Thornicroft, Knapp, & Whiteford, confirms that all these factors affects persons from seeking help for mental health problems(13).

Scope of the study

Lack of professional services in rural areas is identified as a major problem in reaching the unreached populations in difficult circumstances in major national and international studies. To bridge this gap and provide mental health services to children in difficult circumstances social workers can play a major role. The definition of Social work as per the IFSW and IASSW(14) emphasizes "A *practice based profession and an academic discipline that promotes social change and development, social cohesion and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work"*. A community based approach by de-professionalising the psychiatric social work services would help in reaching out to the unreached population in the community. This approach utilizing the community resources would build community resource there by developing knowledge among the population on mental health. Developing community resource would facilitate identifying probable cases of mental health problem and refer to appropriate professionals. This approach would educate the people on mental health problems and professional services available thereby ensuring professional services for the unreached and justifying the definition of social work as defined by IFSW and IASSW.

Methods

A community based intervention model was developed in three stages to develop community resource to provide psychosocial care for children in difficult circumstances. The first stage being sensitisation and need assessment, the second stage was developing the intervention modules, pre testing, standardizing, NGO capacity building, community resource building followed by the third stage that focused on institutionalising psycho social care in NGO's and identifying and providing psychosocial services for children in difficult circumstances. The population for the study consisted of the children attending the child care activity centre's, NGO staff and teachers of the child care activity centre's run by the 7 NGOs supported by NIMHANS through the project. Based on the results of the need assessment intervention modules were developed, pretested, standardized and implemented among children.

Developing the community based intervention model

Community based intervention was developed as a five tier program consisting of sensitisation of the key persons in the community, NGO resource building, community resource building, implementation of the program with children and referral. The five tier program was carried out in three stages.

Stage-1: Understanding psychosocial problems among children

Sensitization of NGO heads: A two day sensitisation program was conducted for the NGO heads, key stake holders and volunteers from the community on the psychosocial problems among children in difficult circumstances through an interactive program with NGO heads and the technical experts from NIMHANS. The program sensitized the key persons on the need of psychosocial interventions for children in difficult circumstances

Need assessment: A need assessment was conducted through both qualitative and quantitative method to identify psychosocial problems among children in difficult circumstances. The qualitative research through case studies, key informant interview and focus group discussions identified 24 various difficulties among children. The quantitative study among 338 children identified that 49% of children reported moderate stress and 7.1% reported severe stress due to impact of difficult circumstances. Behavioural problems were reported by 72% of children (Antisocial- 48.5%, Neurotic- 15.1%). Parents reported probable mental health problem behaviour among 85.5% of children. Adjustment in general was reported to be poor among 63.6% of children. Negative adjustment was prominent in the areas of adjustment with teacher as well as in school. The self esteem among the children in difficult circumstances reported average self esteem among 62% of children(15).

The results of the study identified that the difficulties experiences by children leads to higher stress, behaviour problems, poor self esteem and adjustment. Curative, preventive and promotive programs are essential for these children to ensure their psychosocial wellbeing.

Stage-2: Developing intervention modules and resource building

The results of the study identified higher psychosocial problems among children that warrant psychosocial intervention. Four programs were designed to address psychosocial needs of children i.e., Psychosocial care for children in difficult circumstances that focus on the curative aspect, Life skills education for children in difficult circumstances that address the preventive aspect, Student enrichment program and Enriching family life that address the promotional aspects of mental health. Apart from the basic four modules 4 more intervention modules were developed and standardized as the need arose from the community during the intervention. The modules were: 1) Community based education program on ill effects of substance use, 2) Adolescent girls mental health program, 3) Psychosocial care for adolescent girls rehabilitated from Sumangali scheme and 4) Mental health problems of children in difficult circumstances(16-19).

2.1 Developing psychosocial intervention modules and materials

The intervention modules and materials were developed in a simplified manner to facilitate intervention by the community level workers. Materials developed mainly served three major activities of psychosocial intervention.

- Training- Work book, Manual, Facilitator manual
- Implementation- Intervention kit
- Information dissemination- Pamphlets and brochures

Materials were developed to impart information at various levels of service providers such as NGO heads, staffs, managers and stake holders, and a kit to work with children.

2.2 Pretesting and standardizing

The psychosocial intervention modules and materials developed were pretested with the master trainers as well as community level workers through training. A pre and post assessment was conducted to understand their level of information before and after the training. This process was followed by peer review of the materials by the professionals and necessary changes were made in the content of the module according to the responses for the trainees and suggestions by the peer reviewers. The modules developed were pretested with two batches of the master trainers and standardized. The modules were implemented with children later.

Table 1: Modules and materials developed

Modules	Materials developed
Psychosocial care for children in difficult circumstances	Work book Manuel Facilitator manual Intervention kit Brochure Pamphlet
Life skills education for children in difficult circumstances	Work book Manuel Facilitator manual Intervention kit Brochure Pamphlet
Enriching family life	Work book Manuel Facilitator manual Brochure Pamphlet
Student enrichment program	Work book Manuel Facilitator manual Intervention kit Brochure Pamphlet

Table 2: NGO capacity building

	Programme	Trainings	Master Trainers	Pre	Post
1	Psychosocial care	4	95	3.18	8.55
2	Life skills education	4	75	3.42	9.54
3	Enriching family life	4	88	3.41	9.29
4	Student enrichment program	4	111	3	9.36
	TOTAL	**12**	**361**		

As part of NGO capacity building, Master Trainers were trained through five days TOT at NIMHANS to enhance the knowledge and skills, in understanding the issues of children in difficult circumstances and to train the community level workers on the four modules in their respective NGOs. Each of the master trainers has undergone 200 hours training spread across 20 days. Knowledge assessment was conducted among the master trainers that showed a significant increase in the knowledge after the program for all the four programmes. The NGO capacity building program was conducted in two phases the 1st phase extended for 2 years where the master trainers were trained once in 6 months in one module. New set of master trainers underwent the 5 days master trainers TOT program once in three months for one year the assessment conducted revealed a significant improvement in knowledge among the master trainers after the training.

2.3 Community resource building

The trained master trainers organised three days training for the community level workers at NGO level where 16 hand holding trainings were organised. A total of 2039 community level worker was trained for 96 hours spread across 12 days. Community resource building was thereby achieved through the program. These trained community level workers worked with children in difficult circumstances through the Child Care Activity Centre's i.e., evening tuition centres for children run by the NGOs The community level workers were trained in three phases: the first phase was once in 6 months on a module for two years followed once in three months on one module that continued for one year. . One day refresher program was carried in the NGOs on a monthly basis. The child care activity centres are grouped in to various clusters. Cluster level refresher training programs were conducted in one module every month.

Stage-3: Institutionalizing psychosocial care in NGO

Institutionalization of psychosocial care in the NGO was achieved by appointing trained psychosocial counsellors in the NGOs to carry out the psychosocial care activities. The psychosocial counsellors were provided intensive training for twenty days in the first year followed by 10 days refresher training the second year. 10 psychosocial counsellors were trained and placed in the NGO's. Psychosocial counsellors supported the CCAC teachers to implement psychosocial mediums among children repeatedly in stages to express their difficulty and gain mastery over the

event to facilitate normalization followed by provision of spectrum of services. Life skills education program was carried out among children once in a week through activity based approach involving role plays, discussion, quizzing, debate, self analysis that facilitated children to develop better understanding about the situations and incorporating life skills in such situations. Interventions at family level were carried out by the CCAC teachers, community level workers supported by the psychosocial care trainers. Student enrichment program aimed to support the first generation learners focused to improve the physical and mental health among the students as well as developing study habits, preparation for examinations, and various methods of learning which was incorporated in the regular education support program. The programs were recorded and reported through systems developed and implemented.

Provision of psychosocial services for children in difficult circumstances

Psychosocial interventions were carried out in two phases. The first phase of intervention from 2009 to 2012 was an ongoing process in the child care activity centre's where psychosocial care was provided using mediums to children attending the centre along with life skills education and student enrichment program. The program reached out to 16, 281 children in 10 districts through 9 NGO's.

Table 3: Problems among children identified

	Problems identified	**Total**	
		Identified	Supported
1	Drop out &Education problem	297	181
2	Learning difficulties	477	457
3	Mental health problems	144	98
4	Mental retardation	82	60
5	General Health	31	19
6	speech and hearing	11	10
7	Disability	29	27
8	Social Problem	27	21
9	Others	96	62
	TOTAL	1194	944

The second phase of the intervention was initiated in 2012 by assessing the children attending the CCAC using scientific scales: Family schedule, Child Behaviour Questionnaire, Reporting Questionnaire for Children. Children with behaviour problem and probable mental health problem behaviours were identified and referred for higher level interventions (20-22).

Spectrum of services through referral

Children were supported through the spectrum of services such as support to families and children through various government programs carried out through social welfare board, department of education, women and child welfare, department of health and legal support.

Table 4: Spectrum of services provided:

Spectrum of services provided	Number of children supported
Linkage to social welfare board	56
Health assistance	212
Referral for healthcare	210
Education support through hostel/scholarship	99
School Re enrolment	144
Economic support	27
Legal	34

Conclusion

Major challenge to reach out to the unreached population is the lack of professionals especially in the rural areas. There is a need to reach out to the general population especially to the rural population who are highly vulnerable towards developing mental health problems due to social, cultural and economic conditions. Poor human resource in the area of mental health can be addressed through developing resources within various community organizations, institutions, government and non government departments. Integrating the psychosocial services with education is found to be successful model to reach out to children in difficult circumstances. This can be achieved by training and supporting teachers in schools to impart psychosocial care for children in schools. Children spend most of their time in school. Sensitizing teachers on psychosocial problems among children would help them in identifying the problems among children early and support by providing appropriate interventions to curb the issues at the early stage thereby preventing adverse effects. Policies need to be formulated at government level to incorporate psychosocial services in schools through trained teachers and school social workers. An integrated approach involving various service sectors such as education and health, government departments that work directly with the community especially children such as ICDS, Department of Social Welfare, Department of Women and Child Development in provision of psychosocial care for children in difficult circumstances would ensure better reach. Training community workers such as ASHA workers, ANMs would further ensure reaching to the rural population.

The current model of de professionalization of social work that integrated psychosocial care activities along with the educational activities where the curative, preventive and promotive programs are carried out simultaneously along with the spectrum of services by the trained

community level workers proved to reach out to the unreached and ensure professional services to them. De professionalization approach of social work confirms that the approach would help to materialize the professional and academic goals that have been propagated by the International Federation of Social Work and International Association of Schools of Social Work.

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Family Interaction Pattern of Adolescents with Absent Fathers and Their Adjustment at School

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Abstract

Background: Family has an undeniable effect on the development of a child. The roles played by family members help in determining the child's adjustment at home and in other surroundings. This study has picked out one of these aspects, the role of the father in child development and in turn, its impact on the child's adjustment levels as he/she grows up to be an adolescent.

Methodology: The objectives of the study are to assess the Family Interaction Pattern of adolescents with fathers and those without, and also to verify whether or not the absence of a father has an impact on the child's adjustment in schools. Case-Control Study method has been used for this study where the Case Group consists of 30 adolescents whose fathers are absent either due to divorce, separation, migration or death and the Control Group comprises of 30 adolescents who have had the privilege of growing up with fathers. The study exposed a number of aspects of family and society which have an influence on adolescent adjustment, apart from the father's involvement. These included nature of family, place of birth and financial background.

Result and conclusion: The study highlights that adolescents from nuclear families have a higher score in dysfunctionalism. As for the adjustment of adolescents in their schools, it was confirmed that a father's absence affects their social development. This explains the need for preventive and promotive school social work services.

Key words: *Adolescent, Adjustment, Father, Family*

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Introduction

"Family is not an important thing. It's everything" words said by Michael J. Fox, a Canadian-American actor, author and advocate. Families are our most intimate social environment. It is the place where the vital process of socialization of children, teaching them and learning the ways of surviving and thriving in this world is initiated (1). Family influence on personality is greatest when the major part of one's time is spent in the home with family members. The amount of time one spends with a person is one of the chief determinants of how significant that person will be in his/her life (2).

Adolescence is the state of growing up from childhood to manhood or womanhood, youth or a period of life between puberty and maturity, generally considered to be, among the male sex, from fourteen to twenty-one and in the female sex, from twelve to eighteen. A study conducted by John Bowlby in 1969 found that most adolescents who are successful and well adjusted come from homes where a wholesome relationship existed between them and their parents, whereas adolescents, who were discouraged and rejected at home, lacked concentration in their work.

Child and adolescent adjustment problems relate to behavioural and emotional problems in adolescents. Adolescents show adjustment problems in the form of hyperactivity or conduct problems. Conduct problems refer to a range of acting out, defiant, aggressive and anti-social behaviours (3). The development of conduct problems and antisocial behaviour is related to a number of individual risk factors such as difficult temperament, verbal deficit, or psychopathy and family influences such as inadequate parental discipline, parental psychopathology, and parental discord (3).

A father in the home is a strong protective factor for children.Rough-housing with the father, for example, can teach children how to deal with aggressive impulses and physical contact without losing control of their emotions. Generally speaking, fathers also tend to promote independence and an orientation to the outside world. Fathers often push achievement while mothers stress nurturing, both of which are important to healthy development. As a result, children who grow up with involved fathers are more comfortable exploring the world around them and more likely to exhibit self-control and pro-social behaviour. They were also found to be less likely to experience depression, to exhibit disruptive behaviour, or to lie (4).

"When fathers play with their toddlers, they are not just entertaining them. They are providing a safe, yet challenging arena for toddlers to learn how to interact with the world and with others. Through rough-and-tumble play, fathers create obstacles for their children and demand respect for limits and boundaries. At the same time, they challenge their children and encourage them to explore their own strength, their ability to do new things, and their impact on the world around them. Toddlers who must work out for themselves how to achieve goals-such as retrieving a ball that is just out of reach in their father's hand or wrestling their father to the ground-are practicing important problem-solving skills. In fact, when fathers are good at playing with their young children, these children score higher on tests of thinking and problem-solving skills." (Radin, 1994)

Materials and Methods

The main aim of the study is to address the rising problems faced by adolescents in recent times. One of the reasons adolescents these days are having trouble adjusting in their surroundings could be due to their family interaction patterns.

Objectives of the Study

1. To assess the Family Interaction Pattern of adolescents with and without fathers
2. To assess the impact of Family Interaction Pattern on the adjustment of adolescents in their school environment

Need for the Study

This study has covered school going girls and boys between the age group 12-18, living in Mangalore. Most of the mental health disorders take their start in childhood and adolescence (3). Children and adolescents experiencing difficulties with mental health also tend to have problems with physical health, relationships with family members and peers as well as with functioning at school (Jane-Llopis&Braddick, 2008 as cited in Narusyte, 2009). There is a strong consensus concerning the recognition of early detection of behavioural problems as an undeniable component of successful intervention programs (3). The outcome of the study can help in early identification and detection of adjustment problems among adolescents.

Research Design

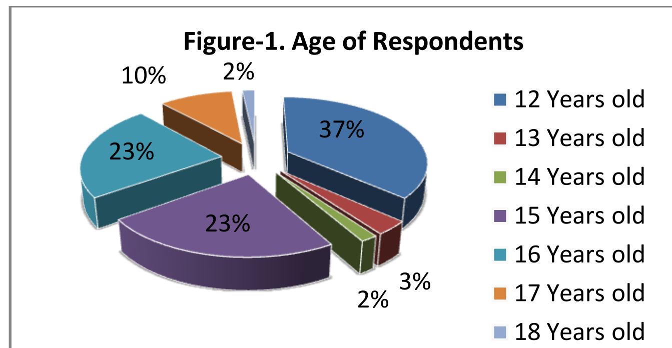
This followed the design of a Case-Control Study. Case-Control is a type of epidemiological observational study in which the subjects are not randomized to the exposed or unexposed groups, rather the subjects are observed in order to determine both their exposure and their outcome status.

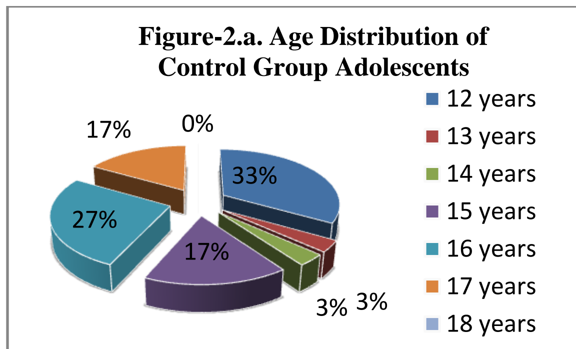
In the current study, the 'disease' is the absence of paternal bond/relationship in an adolescent's life, while a group of adolescents who have a father figure in their lives will be the reference group. Researcher will be taking two groups of thirty members each, between the age twelve and eighteen. One group will be of those adolescents who do not share a good relation with their fathers either because of their separation from family, migration or passing away. On the other hand the second group, or the reference group, will include thirty adolescents who have the pleasure of growing up with a father figure in their life. The main focus of this paper is on the Family Interaction Pattern of adolescents and their adjustment in their school environment.

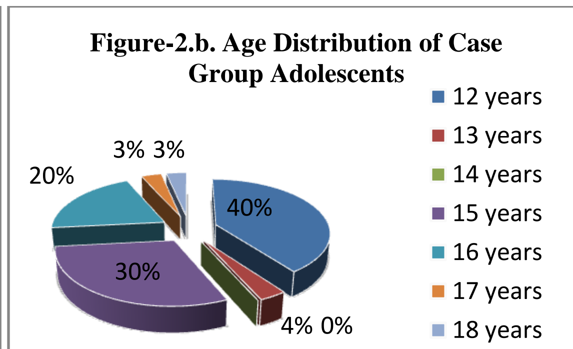
Results and Conclusion

The demographic profile of adolescents between the age group twelve and eighteen was studied.

☙ *Age*

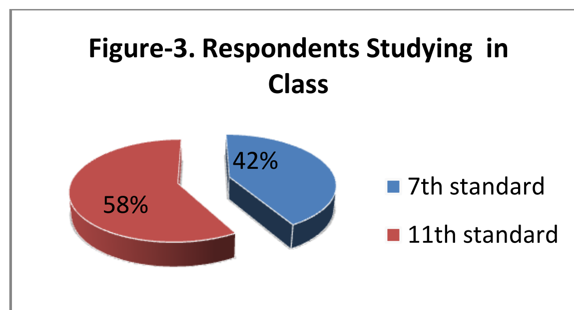


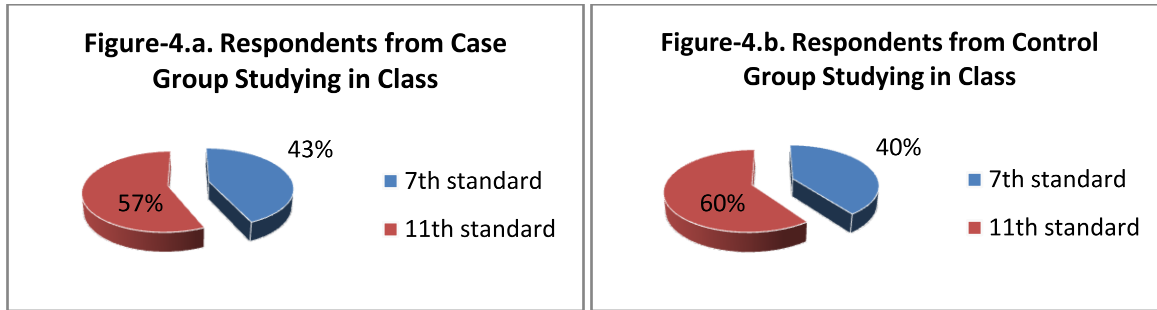




Of the total respondents, majority were from the age groups twelve, fifteen, sixteen and seventeen while a very few respondents belonged to ages thirteen, fourteen and eighteen. 40% of the respondents from Case Group were in the age group 14 and below and the remaining 60% were above age 15 (Figure-2.b). Same goes for respondents from Control Group where 44% were 14 years and below and remaining 56% were 15 years and above (Figure-2.a).

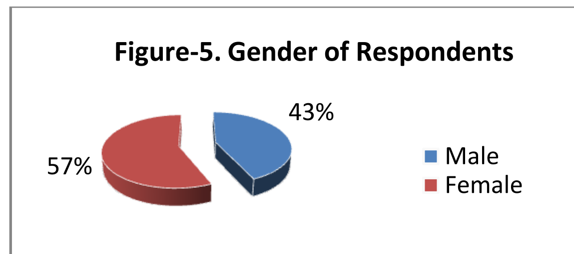
☙ *Class*

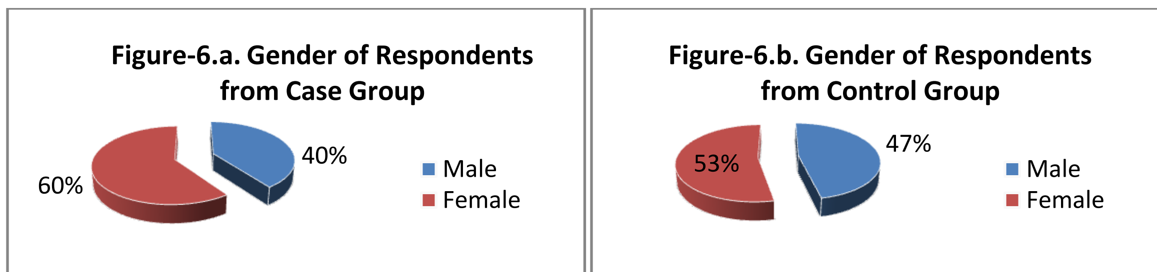




Majority of respondents from both groups were studying in 11th standard and rest were in 7th standard. Even when the groups were taken separately, 57% of Case Group adolescents and 60% of Control Group adolescents were in 11th standard (Figure-4.a & 4.b).

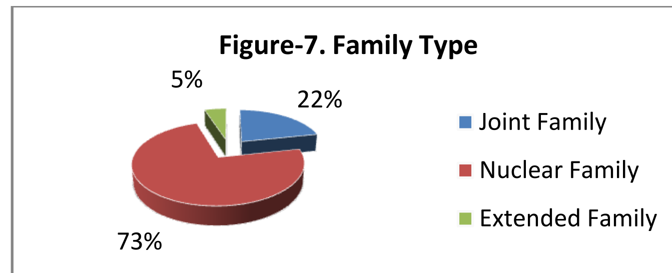
Gender





Of the total respondents 57% were females and 43% males. From the Case Group 60% were females as compared to the Control Group which has 53% as shown in Figures-6.a and 6.b. Similarly, more male respondents come under the Control Group, i.e., 47% as compared to Case Group which has 40%.

Family Type



As seen in Figure-7, 73% of adolescents belong to nuclear families and 22% come from joint families. A very small number of adolescents come from extended family type. The fact that majority of the respondents hail from nuclear families could be due to the present trend in the society where most joint families are being broken down into smaller units for simpler, easier lifestyle and social causes.

Family Interaction Pattern

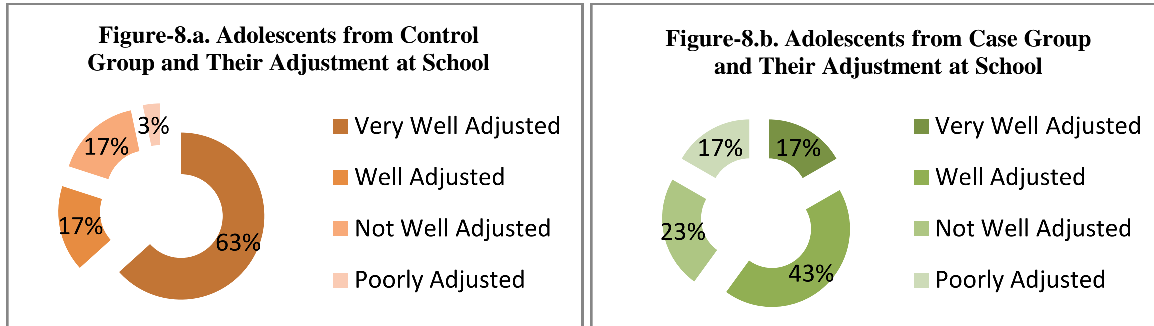
Table-1. Family Interaction Pattern

Family Status	No. of Adolescents From Case Group	No. of Adolescents From Control Group
Well Functioning Family	NIL	NIL
Functional Family	2 (6.7%)	8 (26.7%)
Dysfunctional Family	20 (66.6%)	19 (63.3%)
Highly Dysfunctional Family	8 (26.7%)	3 (10%)
Mean Value	**3.2**	**2.83**

The family interaction pattern of 60 adolescents from both groups was studied through the Family Interaction Pattern Scale developed by Bhatti et al (1986). Table-1 shows the number of respondents belonging to different categories that vary from well functioning family to poorly functioning family. Researcher found most of the respondents to be coming from dysfunctional families. This could be due to the various contributing social factors such as age, gender, family type, family income, place of birth etc.

Majority of the adolescents from Case Group came from dysfunctional and highly dysfunctional families when compared to a slightly smaller number of adolescents belonging to Control Group. This finding supports that absence of fathers causes dysfunction in families. Altogether 83% of the total respondents came from dysfunctional families, suggesting that there are various factors other than an absent father that affects the functionality of a family.

Adjustment Level of Adolescents



Figures-8.a & 8.b represent the number of respondents and their adjustment level at their school.

Table-2. Adjustment Levels of Adolescents

Adjustment at School	Case Group	Control Group
Very Well Adjusted	5 (16.7%)	19 (63.3%)
Well Adjusted	13 (43.3%)	5 (16.7%)
Not Well Adjusted	7 (23.3%)	5 (16.7%)
Poorly Adjusted	5 (16.7%)	1 (3.3%)
Mean	**2.6**	**3.4**

Table-2.indicates more number of adolescents from the Control Group to be 'Well Adjusted' and 'Very Well Adjusted' as compared to the Case Group members whose majority were in the category 'Not Well Adjusted' and 'Poorly Adjusted'. On comparing the mean values, it was clearly seen that control group members were better adjusted in their school environment.

Fathers play a major role in building his child's social behaviours. Supporting Researcher's finding DittaOliker (2011), in her article titled *The Long Reach of Childhood* in the periodical *Psychology*

Today highlighted the importance of the impact father's playfulness with children has on his child's emotional and social development. She reports that right from birth, children who have an involved father are more likely to be emotionally secure, be confident to explore their surroundings, and, as they grow older, they tend to have better social connections. Of all adolescents, those with fathers had better interactions with peers and teachers than those whose fathers were absent.

Family Interaction Pattern and Adolescent Adjustment at School

As mentioned earlier, a vast majority of respondents come from dysfunctional families. It was found that adolescents who came from functional families were well adjusted at home and at school. But a large number of adolescents from dysfunctional families were also fairly well adjusted in their surroundings.

Table-3. Family Interaction Pattern of Adolescents from Case Group and Control Group and Their Adjustment at School

Adjustment at School	Family Interaction Pattern							
	Well Functioning Family		Functional Family		Dysfunctional Family		Highly Dysfunctional Family	
	Case	Control	Case	Control	Case	Control	Case	Control
Very Well Adjusted	0 (0%)	0 (0%)	2 (6.7%)	6 (20%)	3 (10%)	12 (40%)	0 (0%)	1 (3.3%)
Well Adjusted	0 (0%)	0 (0%)	0 (0%)	1 (3.3%)	9 (30%)	3 (10%)	4 (13.3%)	1 (3.3%)
Not Well Adjusted	0 (0%)	0 (0%)	0 (0%)	1 (3.3%)	5 (16.7%)	3 (10%)	2 (6.7%)	1 (3.3%)
Poorly Adjusted	0 (0%)	0 (0%)	0 (0%)	0 (0)	3 (10%)	1 (3.3%)	2 (6.7%)	0 (0%)

In order to understand the importance of family and the role it plays in the development of an adolescent and his/her adjustment, the Family Interaction Pattern of respondents from both groups was put side by side with their adjustment at school as shown in Tables-3. Most adolescents from both groups come from dysfunctional and highly dysfunctional families. It is seen that adolescents coming from functional families are well adjusted in their schools as compared to those belonging to dysfunctional families. Although coming from functional family improves that quality of

adjustment of the adolescent, coming from dysfunctional family doesn't always have to hamper his/her adjustment levels. This is inferred from the fact that majority of adolescents from Case Group as well as Control group hail from dysfunctional families.

Comparing both groups, it is observed that more adolescents from Case Group belong to dysfunctional families and are poorly adjusted at their schools. The absence of adolescents from a well functioning family goes to show that due to various societal changes, families are not functioning as they are meant to be and are failing to provide enough support and guidance to its members. Despite the functional attribute of families, Control Group members, are better adjusted at schools as compared to members of Case Group.

It is seen that the impact families have on adolescents has reduced maybe due to the fact that mothers these days prefer to leave their children in the care of others while they go to work. The relationship children develop with family members is not as strong as it used to be. The affect families used to have on a child's development has declined considerably over the years. In 1969, John Bowlby in his study *'Attachment and Loss'* had established that most children who are successful and well adjusted come from homes where a wholesome relationship existed between them and their parents, whereas children who were discouraged and rejected at home, lacked concentration in school work. Contrary to Bowlby's study as well as Hurlock's, Researcher found that the impact of family interaction on child's adjustment is not very significant.

Suggestions

- ***In Schools***

i) Recreational activities should be held in schools. This plan will help students socialize with their classmates and have good and fruitful experiences with their peers

ii) The findings of this study can help teachers in early identification of adolescent problems. Teachers must be given training in recognizing, intervening and rectifying the problems faced by the student.

iii) Having a counselor should be a must in every school.

iv) Parent-Teacher conferences should be organized at least twice a year so that the parent and teacher along with counselor can have a meaningful conversation about the student in question.

v) Group therapy can be given to adolescents who do not share healthy bonds with their fathers. Group discussions, activities and therapeutic interventions can be a part of the programme that helps them adjust better in their domains.

- ***At Homes***

i) As with teachers, even parents have to be aware about how to identify a problem in their adolescent child. For this purpose, awareness programmes should be given in schools and communities.

ii) Awareness on the importance of parents' involvement in their child's life should be given by school counselors.
iii) Couple enrichment courses and activities could be organized to develop a strong bond between the husband and wife.
iv) Bonds needn't necessarily be established only through close proximity. Keeping up to date with the things going on in his child's life through regular phone calls, visits, postcards etc., can help in the foundation of a healthy bond between father and child.

In Communities

i) Timings should be flexible at workplace encouraging and allowing parents to spend quality time with their children.
ii) Creating a community atmosphere where attending enrichment classes for individuals and couples are considered an accepted norm (DeFrain, 2008).

This study has brought out one of the root causes for adolescent problems – *lack of family support*. It was found that most adolescents facing adjustment issues hailed from nuclear families and majority of those hailing from joint families did not have any adjustment problems. The rise we see in nuclear families and disintegration of joint families could be one of the factors causing adolescent problems that have taken a dive for the worse in terms of their academics and relations. Most of the adolescent population in the study belongs to dysfunctional families and among these majorities are adolescents whose fathers are absent due to separation, migration, divorce or death. The fact that a very few come from functional families is a proof that the society today, due to various trends and modifications, has become less consistent in providing care, support and guidance to its members. Family is the basic unit of society. Dysfunctionality in the family setting is a sign of a society that cannot fulfill needs of an individual. The weakening of family system in our Indian Society is a cry for help because this society bases all values on norms that are imparted through family customs.

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