Papers in
Strengths Based Practice
Papers in Strengths Based Practice

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Introduction

Whatever situation we face, we still have a choice of responses. When adversities strike us, we feel overwhelmed. As these papers were being proof read at the publisher, Cyclone Sandy hit hard, took lives of many in coastal cities in the US and the Caribbean, making the human civilization feel once again, that there is very little that we could do. In fact, our actions do not count at all. That is one way of thinking, sort of fatalist despondency. Strengths based practices offer another.

Those in the growing ranks of helping professions often find themselves at a cross road. One path might despair at the horrific state of affairs of nature, climate, governments, growing apathy in our neighbourhoods, listlessness, powerlessness and continued abuse of our children and elderly in our societies. Another path might bring forth responses of anger and activism and a desire to bring about change. Some may feel that they are ‘stuck’ without skills, responses and resources to actually make that change happen.

So let us interject with a short story

A long time ago a neighbour found Nasiruddin on his and knees near a lamp-post searching for something. The neighbour asked, ‘what are you searching for, Nasir?’ ‘My key’, Nasir replied. Now both men got on their knees to search. After a while the neighbour asked, ‘where did you lose it?’ ‘At home’, Nasir said. ‘Good lord! Then why are you searching here?’ the neighbour asked. ‘Because it is bright here’, Nasir replied.

What does one learn from this story? That, one generally ends up searching for things in the wrong places, or one often looks for solutions in the wrong places, or that solutions are always to be found where problems cropped up.

The kind of response we make and the intrinsic faith we have in our belief systems makes the difference. As editors of these papers, we represent distinctive differences in experience. Two of us have seen more than a quarter century of turbulent times in human services in the west and in the east, amidst the interplay of all kinds of ideologies, bureaucracies, expertises, institutional and de-institutional responses in care of our people with disabilities; those in need of better mental health care and those who require quality of life as they become frail and elderly; and of course our children in need of protection.¹ We have seen days of enlightened leadership in welfare, in small amounts, that allowed us to cherish the darker times when we had to cope more than our clients, as we felt they were being treated unfairly. But, we have not given up. What

¹ Venkat Pulla and Lesley Chenoweth.
Abraham Francis began his career in social work in India, a society with virtually no social security provisions and a society with more collective social obligations towards those in need, and Stefan Bakaj grew up in Slovenia just around the times when balkanisation hit hard and socialism started fading on the canvass. These two had more to cope with and as a result of which have even more to offer today and to the future. Four of us join the rest of the writers in this volume, to appreciate their effort and to salute hope.

These papers confirm our overall perspective that our world is still one of beauty, with a potential and capacity to flourish and proffer in raising a discourse in strengths based approaches. Our focus now has been to see how we strengthen ideas to support our intentions to bring change, to act to play the best part and put the right foot first, whatever form and shape it may be.

The history of strengths approach and its philosophy is certainly longer than the last two or three decades. This is not something that has germinated in one country or society. People have always looked to alternatives, self reliance on one’s own strength and to which one could even add at a philosophical level–looking within, one self, one’s family, society and nation for solutions.

Gandhi, Rabindranath Tagore in India and educators like Heinrich Pestalozzi Maria Montessori and Friedrich Froebel in Europe have been pioneers in reliance on self, communitarian philosophies and recognising the learner’s strengths and aptitudes. There are a number of writings in the field of Psychology from the mid 19th century that of Abraham Maslow, Carl Rogers and Virginia Satir. In western social work, strengths based practices certainly provided a new impetus to understanding the inherent power within the client and questioned the role and seating of expertise in the counseling practices.

This volume entitled “Papers in Strengths Based Practice”, offers a selection of writings that are refreshingly different and begin to explore how we can respond to such challenges especially through strengths based practice. This selection is an endeavour to raise the question of how to keep hope and move beyond mere survival to proactive positive change. Within the practice of social work and human services, these papers to explore some challenges in the broad social and economic contexts, globally.

The authors have addressed similar questions and themes but enriched the discourse through their diverse perspectives and brought us to the understanding that all kinds of obstacles and threats can arise from all kinds of situations for all of us as individuals, groups, communities and nations. If we let these deter or overpower us, we cannot move, we would not see alternatives. It is this quest for solutions that

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1 Abraham Francis and Stefan Bakaj.
humbles us to seek solutions from a variety of perspectives, and raise questions such as how do we dream about alternative futures? How to envision new patterns of social organization that are better than what we have currently or may never have experienced them before? Is there a methodology that allows us to talk about ‘how things could be’ when previously no one has ever actually contemplated about these things? How can our practice in what ever vocation that we belong to be strengthened by the difficult situations that we encounter, just as a bonfire in a strong wind is not blown out, but blazes even brighter.

Our ability to be connected and to continue to draw on personal strengths and desire to conquer the demands placed on oneself brings with it an opportunity to think beyond the individual needs and to generate collective thinking about humanity. This world privileges and exposes human services professionals to challenges and actions in social justice and human rights arena. Common concern of individual and social good in various countries is influenced by theoretical frameworks, cultural and political histories. That diversity is also reflected in the idioms, tools and practice frameworks of the current authors in this collection. Social work and human services colleagues have reflected on their current practices and brought forward inspiration.

Our Methodology

The “Papers in Strengths Based Practice” have been double blind peer reviewed by colleagues and experts from around the world. We are grateful to colleagues in social work practice and in academia for having given their time to assist with abstracts and peer reviewing the papers. It is after this process, the editors assumed the responsibility to bring forward a modest selection of papers that support, celebrate and or suggest alternative strengths based approaches that either supplement current conventional approaches or replace them for better results.

This volume is cross cultural and collaborative and has papers from a number of scholars describing various native traditions, indigenous experiences, case studies and research outputs around strengths approach. Scholars who have reflected, and whose papers have been included here, come from Uganda, Philippines, Kenya, Lapland, India, Australia, Slovenia and Nepal.

Beyond this Volume

We recognize that the world is changing fast. With vast development in science and technology that has heralded quality of life for the mankind, there is an ever increasing gulf between the poor and the rich in every nook and corner of this world. Wars, terrorisms, conflicts, tensions and economic crisis have slowed down the process of advancement and deepened the wounds of injustice and exploitation.
among nations and communities. Putting ‘humanity’ into our humanness today is not that easy. Materialism, greed and overexploitation of nature and of the fellow humans perhaps are the obstacles that we need to confront. The recipe that we would like to promote is “meeta bhavana” an understanding that the delicate interdependence on one another is crucial and that finding a meaningful relationship in our interactions will not only foster the strengths based practice but will perhaps pave a way for world peace.

Although we are all working for this cause but Venkat Pulla has shown extraordinary passion and yearning, and with him around there is certainly no looking back.

22 November 2012
Kathmandu, Nepal

Venkat Pulla
Lesley Chenoweth
Abraham Francis
Stefan Bakaj
Acknowledgments

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Individually, each of us owes a debt of gratitude to our spouse/partner for her/his understanding, and to our families that bear the brunt and continue to support our volunteering efforts.

22 November 2012

Venkat Pulla
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What are Strengths Based Practices all about?

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When people used to offer to join Mother Teresa in her work with the needy of Calcutta, she would often respond: “Find your own Calcutta”.

Wanderer, your footsteps are the road, and nothing more; wanderer, there is no road; the road is made by walking. By walking one makes the road, and upon glancing behind one sees the path…..

—Antonio Machado (1979)

ABSTRACT

Strengths Based Practices (SBPs) concentrates on the inherent strengths of individuals, families, groups and organizations deploying peoples’ personal strengths to aid their recovery and empowerment. SBPs are empowering alternatives to traditional methods with individuals, group or organizational work. SBPs refrain from allowing crippling, labeling and stigmatized language. Descriptions and pathology owned by persons’ groups and organizations that suggest acceptance of their condition as hopeless or helpless to change are constructively challenged through SBPs. Strengths based strategies build and foster hope from within by focusing and working with precedent successes. SBPs strategies facilitate change by assisting to look at/what has worked? What does not work? And what might work presently making it important for facilitators and those desiring change to be integral to this process of change. This introductory paper provides a bird’s eye view of the assumptions, and discuss its core elements.

Keywords: Resilience, Strengths Based Practice, Strengths Approach, Social Work.

Introduction

In tune with the ‘Positivity Wave’s) that are currently sweeping the planet, several exciting and new approaches are being forwarded in all practices that involve human interactions. ‘Strength based practice’ in simple terms present approaches that promote resilience as opposed to dealing with deficits’ (Pulla V., 2006). Strength based practices are gaining impetus globally in diverse fields of human services management, health
care, education and training reminding that all environments have resources and that in every society individuals, and institutions are willing to assist each other to cause human well-being. The principles of caring and caretaking, nurturing and ensuring that members of our society and our organisations in turn become resilient and hopeful is clearly within the scope of strengths approaches.

There is something very inward looking about this practice. Teachers in the schools are seriously considering how best to make their students understand what they really want them to understand. HRD Managers have started thinking about strength based performance appraisal while dealing with their employees. Community groups in Asia and the Pacific region have been dealing with self-reliance and indigenous development for several decades. Some of these self reliance experiences can be tweaked to reflect in strength based practice’ (Pulla V., 2006).

Strengths Based Practices (SBPs) concentrates on the inherent strengths of individuals, families’ groups and organisations deploying peoples’ personal strengths to aid their recovery and empowerment. SBPs are empowering alternatives to traditional methods with individuals, group or organizational work. SBPs refrain from allowing crippling, labeling and stigmatized language. Descriptions and pathology owned by persons’ groups and organizations that suggest acceptance of their condition as hopeless or helpless to change are constructively challenged through SBPs. Strengths based strategies build and foster hope from within by focusing and working with precedent successes. SBPs strategies facilitate change by assisting to look at/what has worked? What does not work? And what might work presently making it important for facilitators and those desiring change to be integral to this process of change.

In 2006, the author of this paper launched the first international conference on strengths based practice in India, the land of Gandhi (Pulla, V, 2006, pp. 120–126). The core values of Gandhian way of development have been being fair and respectful to all, focusing on strengths, assisting a self directed transformation to bring forward changes that are meaningful and significant to people and to reflect on how they want their situation to be (Pulla, V., 2006). Gandhian mantra may sound a shade simplistic description of what is being canvassed as strengths approach today, but the core elements that he deployed in the context of communities and ensuring sea change in the fabric of Indian society undoubtedly provides the fundamental context for community engagement practice in the western world today.

It is a tribute to Gandhi that he applied only positive thoughts and positive strategies across a wide range of social institutions including the British raj that had India and several other colonies in its grip. Resonating constitutes the basis of strengths based practice everyone has strengths. We have experiences, abilities and knowledge that assist us in our lives. If we are lucky, we also have a variety of people around us who act as a support network for us. A Strengths based Approach allows people to identify
What are Strengths Based Practices all about?

and build on their strengths so that they can reach their goals, and retain or regain independence in their daily lives. Why work in this way? Long-term studies in strength-based care have proven that the approach improves self-care abilities, confidence, and self-esteem of clients allowing them to independently carry out daily living activities.

The Strengths Approach

A strengths based approach operates on the assumption that people have strengths and resources for their own empowerment. Traditional teaching and professional development models concentrate on deficit based approaches, ignoring the strengths and experiences of the participants. In strengths based approach the focus is on the individual not the content. Drawing on appreciative inquiry, strengths based methodologies do not ignore problems. Instead they shift the frame of reference to define the issues. By focusing on what is working well, informed successful strategies support the adaptive growth of organisations and individuals. A belief and an approach that every individual, group, organisation and community has strengths allows us to focuses on identifying, mobilizing, and honouring the resources, assets, wisdom, and knowledge that every person, family, group, or community has. This processes of re-discovery with the community or individual’s helps, assists in healing and ensuring that their full potential is brought out for creating meaningful patterns that can see as being useful. An opportunity therefore is offered to fathom their inner strengths. The Strengths Perspective recognises that for the most part of life, people face adversity, become resilient and resourceful and learn new strategies to overcome adversity. It would be pertinent to consider resilience in the context of strengths perspective 'as the opportunity and capacity of individuals to navigate their way to psychological, social, cultural, and physical resources that may pull together during crisis and provide them an opportunity and capacity individually and collectively to negotiate for life following adversity in appropriate and culturally meaningful ways' (Pulla, V., 2012). Thus using client’s personal strengths and in discovering resources in the environments to fulfil the client’s needs and to enhance the client’s resilience (Norman, 2000). In fact the environment is conceptualises as “the helping environment”, in a strengths based practice (Early and GlenMaye, 2004, p. 113). As a practitioner and facilitator of strengths approach, people told me that at times their negative experiences bring them down, at the same time I saw as the process work commences people recognise that even in their most adverse situation they have displayed their strengths.

The emphasis is certainly on ‘getting up’ to see opportunities to growth and development. It would be naive to think that a strengths perspective allows social workers to casually taciturn the real pains and troubles that affect our clients and our societies. It is widely acknowledged that poverty, child sexual abuse, and violence
towards elderly, torture and racism all these are ‘real problems’ and they exist. Saleebey articulated the central belief systems that strengths perspective entails in his first published article on ‘Power in the People: Strengths and Hope’ in the year 2000 as follows:

‘The strengths perspective does not require one to discount the grip and thrall of addictions or the humiliating, frightening anguish of child abuse, or the unbidden disorganization and confusion of psychosis. But from the vantage point of a strengths perspective, it is as wrong to deny the possible just as it is to deny the problem. And the strengths perspective does decry the intemperate reign of psychopathology and illness as the central civic, moral, and medical categorical imperative. Adherents of the strengths perspective do not believe, with good reason, that most people who are the victims of abuse or their own rampant appetites, or that all people who have been traumatized inevitably become damaged goods’ (Saleebey, 2000).

Clearly we are unaware of the upper limits of human capacity to grow and change, therefore the message is to take the individual, group, and community aspirations seriously. Strengths Approach allows us as human service workers to go beyond the assessment, diagnosis, or profiling and presenting verdicts on people’s lives. If we aim social work to be a profession that work with people to build their hopes, values, aspirations, and visions, then strengths approach obviously lets us deal with all those possibilities through a collaborative pathway. For this to happen we need to be open to the idea that our clients do have the wisdom, knowledge, and experience that they bring with them and that in combination with the specialized skills and experience that the facilitator may have a valuable outcome can be created. This could not happen if the end user voice is not heard and valued at all levels of management of change.

Some Common Myths about Strengths-Based Practice

- It is just a glorified version of positive thinking.
- It’s really about reframing people’s perception to find good even in the worst situation.
- It basically re-labels weaknesses as strengths.
- It ignores the reality that serious symptoms and problems do exist and continue to persist.
- Strengths-Based Practice assesses the inherent strengths of a client’s people, employees or family, and then builds on them.
What are Strengths Based Practices all about?

Why Use It?

It is an empowering alternative to traditional human resource development methodologies that tend towards describing or diagnosing human motivation and human competencies functioning in terms of deficits and may offer un-related alternatives. Strengths approach avoids the use of stigmatising terminology, which people in need may have got used to and eventually accept, and feel helpless to change and contribute their future. It fosters hope within people by focusing on what is or has been historically successful for them in their personal, professional and or even career contexts, thereby exposing precedent successes as the groundwork for realistic expectations. It inventories the positive building blocks that already exist in the environment of the change seeker which can serve as the foundation for future growth and change for him or herself and it reduces the power and authority barriers in number of situations such as employees and their managers or the clients and their therapists, the communities and the social worker by,

- Promoting the client to the level of expert in regards to what has worked, what does not work, and what might work in their personal, professional and work group situation.
- Placing anyone in power or expertise in the role of facilitator, partner or guide.
- And lastly—it works (Pulla, V., 2006).

Empowerment, Ecosystem and the Strengths Based Practices

The strengths perspective originated in response to criticism of the deficit-oriented psychotherapeutic model that dominated social work practice (Guo and Tsui, 2010; Saleebey, 1992). Different strengths based approaches to practice emerged in late 1980s as alternatives to the dominant models. The impetus for strengths based social work practice arrived at a time in US when helping professions were saturated with psychosocial approaches based on individual, family, and community pathology, deficits, problems, abnormality, victimization, and disorder (Saleebey, 1996, p.296). The strengths perspective is rooted in ecosystem and empowerment theories with underpinnings of humanistic philosophy. According to Johnson (1998), ecosystem theory provided a foundation for the integrated, generalist social work practice model and revived the core concept of ‘person-in-environment’ or “how people and their environments fit” (Miley, O’Melia, and DuBois, 2004, p. 33). In fact, Weick and colleagues (1989), in a seminal article about the strengths perspective, stated that the personal history and unique composite of personality characteristics of individuals interacts constantly with the political, economic, social, and natural forces in society (Weick, Rapp, Sullivan, and Kisthardt, 1989, p. 353). Because of their affinities, the combination of strengths based practices and new ecosystem approaches is increasingly being used in social work practice. Therefore, Guo and Tsui (2010)
advocate for the adoption of a reflective practice model that creates “a strengths based social work practice model that promotes not only the strengths of service users but also the capacities of the social work profession” (p. 234).

“Empowerment as a proactive process in which individuals and groups gain power, access to resources, and control over their own lives is central to strengths approach (Robbins, Chatterjee, and Canda, 2006, p. 94). Personal empowerment and social empowerment are two interdependent and interactive dynamics achieved simultaneously which characterize client empowerment. Personal empowerment recognizes the client’s uniqueness and it is analogous to self-determination; that is, clients provide direction to the process, take control of their lives, while client social empowerment provides him or her resources and opportunity to play an important role in his or her environment and in the shaping of that environment” (p. 263).

Empowerment theories identify and help individuals and communities to recognize barriers and dynamics that allow oppression to persist as well as circumstances and actions that promote change, human empowerment, and liberation. Considering that the Strengths Perspective is used to build on people’s aspirations, strengths, resources, and resiliency and to engage in actions pursuing social justice and personal well-being (Robbins et al., 2006), it can be considered a theory of empowerment. The strengths perspective is committed to promoting social and economic justice considering that social work practice deals with transactions between person and environment in which the dynamics of power and power are embedded. Client empowerment is central to a strengths based practice and the discovery of client’s strengths nurtures that empowerment (Cowger, 1994).

In addition, the Strengths Perspective has emphasis on positive qualities and attributes, including talents, knowledge, abilities, and aspirations to reclaim personal power in their lives (C.A. Rapp and Goscha, 2006; Saleebey, 1997, Weick et al., 1989).

Strengths based practices such as solution-focused therapy (Berg and De Jong, 1996), the individual placement and support model of supported employment (Becker and Drake, 2003), positive youth development and resilience approaches (Benard, 2004), and asset-building model of community development (Kretzmann and McKnight, 1993), and several writings from the Kansas School of Social Work, (Chamberlain, 1991; Chamberlain and Rapp, 1991; C.A. Rapp, 1993; Saleebey, 1992; Weick et al., 1989) field studies in areas such as people in poverty (Jones and Bricker-Jenkins, 2002), physical and sexual abuse (Anderson, 2001, 2010), older adults (Fast and Chapin, 2002), family violence (Postmus, 2000), secondary trauma (Bell, 2003), spirituality (Canda and Furman, 2010), and substance abuse (R.C. Rapp, 2006) have contributed to the development of strengths approach in social work.
The strengths perspective is impacted by a variety of concepts and perspectives. According to Saleebey (2001a), “the ideas about healing, wholeness, and wellness that challenge the medical model; the empowerment and liberation movements within and outside of social work; the evolving resilience research and practice; the assets-based community building approaches; the power of mind and health organization approaches to individual and community change; solution focused and narrative approaches to therapy; the research on hope, positive expectations and possibility; all of these extend links to, and embolden the strengths perspective” (p. 221).

However, the strengths perspective does not consist of “only a positive reframing” of a problem, “being nice”, or compiling a list of strengths (Early and GlenMaye, 2004; Saleebey, 1996). It refers to a “consistent focus on identifying client strengths and resources and mobilizing resources that directly or indirectly improve the situation” (Early and GlenMaye, 2004, p. 123).

With the purpose of clarifying what constitutes a strengths based practice, Rapp, Saleebey, and Sullivan (2005) identified six hallmarks that characterize strengths based practices:

1. It is goal oriented: social workers invite clients to define goals for their lives. Client-set goal attainment is the indicator social workers can use for evaluation purposes.

2. Systematic assessment of strengths: strengths based practice uses a systematic set of protocols for assessing and documenting strengths, with an emphasis on the present (although past resources and strategies can also be useful).

3. The environment is seen as rich in resources: the natural community is the main source of opportunities, supports, resources, and people. “a central notion is that the path to goal attainment is the matching of client desires, strengths, and environment resources” (C.A. Rapp et al., 2005, p. 82).

4. Explicit methods are used for using client and environmental strengths for goal attainment. For instance, in strengths case management, the strengths assessment is used to help clients set goals, elicit resources, set short-term goals and tasks, and guide role and responsibility assignments (C.A. Rapp and Goscha, 2006).

5. The relationship is hope-inducing: the relationship is clearly focused on increasing the hopefulness of the client through an empowering relationship.

6. The provision of meaningful choices is central and clients have the authority to choose: the social worker’s role is to extend the list of choices, clarifying them, and supporting the clients to become confident and to take the authority to direct the process.

While the strengths perspective encourages the exploration of possibilities and resources, it does not overlook the problems that clients bring. Yet, a strengths based practitioner will spend little time trying to understand the causes of the problem or
labeled labeling it (Early and GlenMaye, 2004). This perspective acknowledges and takes problems, needs, and challenges in consideration. Often, these problems, situation, and challenges are where clients begin, what is most urgent, what they are compelled to talk about. However, the strength based practitioner goes beyond the challenges ahead and does not make them the priority or sole focus of intervention. Indeed, the strengths perspective believes in a resilient and self-righting capacity, opening the possibility of a fulfilling life:

“The strengths perspective does not deny the grip and thrall of addictions and how they can morally and physically sink the spirit and possibility of any individual. But it does deny the overweening reign of psychopathology as civic, moral, and medical categorical imperative. It does deny that most people are victims of abuse or of their own rampant appetites. It denies that all people who face trauma and pain in their lives inevitably are wounded or incapacitated or become less than they might” (Saleebey, 1996, p. 297). In consequence, the strengths model allows us to see possibilities rather than problems, options rather than constraints, wellness rather than sickness, which, once seen, can be achieved.

**Underlying Assumptions**

Given its humanistic roots, at the core of the Strengths Perspective is the belief that humans have the capacity for growth and change (Early and GlenMaye, 2004). In addition, believing that people are capable of making their own choices and taking charge of their own lives promotes empowerment. It means that human beings have the potential to use their strengths and overcome adversity as well as to contribute to society (Cowger, 1994). It implies a belief that people are doing the best they can (Weick et al., 1989), as is reflected in the following underlying assumptions:

- Every individual and every environment has strengths and resources, *i.e.* Knowledge, talents, capacities, skills, and resources to mobilize in order to pursue their aspirations (Saleebey, 2009).
- People who face adversity typically develop ideas, capacities, and strategies that eventually serve them well (Saleebey, 2009). In other words, every individual is resilient.
- All human beings have an innate capacity for health and self-righting, which is a drive, a life force (Weick, 1992), that heals and transforms.
- Almost always, people know what is right for them. This requires a non-judgmental attitude; “instead, the principles of knowing what is best and doing what is best places the power of decision where it should be—with the person whose life is being lived” (Weick et al., 1989, p. 353).
- A personal, friendly, empathic, and accepting relationship provides the atmosphere for healing, transformation, regeneration and resilience.
What are Strengths Based Practices all about?

• A positive orientation to the future is more useful for healing and helping than the preoccupation with the past.
• It is possible to find the seeds for health and self-righting, even in maladaptive responses or patterns of behavior, since individuals may be trying to satisfy some need for respect, connection, affection, or control.

How to Find Strengths?

The strengths perspective provides content and structure for the assessment of achievable alternatives, the mobilization of competencies to promote change, and the building of self-confidence to promote hope (Kirst-Ashman and Hull, 2002). According to Saleebey (2006), almost anything can be considered as strength under certain conditions (p. 82). Central to this finding is where they do emerge from. For instance, a person who is agreeable may be engaging and attractive to play a role in building relationships. Certainly if he or she is disposed to being always agreeable and does not have any boundaries to the others it could be due to their fear of losing them. Facilitation in those situations requires that the individual is made aware that he or she needs to work toward his or her own goals or aspirations as well.

A strengths based practice working tool is its assessment with no rigid boundaries. It is constantly updated through the partnership and collaboration between client and social worker or the organisations and the facilitator, thus a strengths based assessment is both—a process and a product. It is a process because through an assessment, strengths based facilitator help clients define their situations, evaluate, and give meaning to those factors that impact their situations. The assessment process helps clients to tell their stories, according to their unique socially constructed reality and thus, this process is multicausal, interactive, and constantly changing (Cowger, 1994).

Strengths based practitioners need to explore the client’s experiences in order to find:

• What people have learned and known about themselves, others, and their world (Early and GlenMaye, 2004; Saleebey, 2006, 2009).
• Personal qualities, traits, talents, and virtues that reside in people; display of some of them during crises and after trauma, survivors discover inner strengths, utilize the ones that they know, and also develop new ones (Early and GlenMaye, 2004; Saleebey, 1997; Weick et al.
• Cultural and personal stories and lore, which have been a deep source of strength for human kind providing guidance, stability, heritage, belonging, or transformation.
• People’s sense of pride, defined by Wolin and Wolin (1993) as the “survivor’s pride” in overcoming the odds.
• Personal and familial narratives of survival and redemption can provide strategies, tools, symbols, and metaphors for rebound.
Researching and re-discovering the community and its different resources, which are frequently overlooked during presenting crisis.

Family traditions, rituals, and the combination of the strengths of the nuclear and extended family members (Early and GlenMaye, 2004).

Spiritual and world views that provide with clues around essential holistic quality of being.

Personal hopes and dreams, which, with help, can be recovered and revitalized.

For this perspective, social workers have an opportunity to create enabling niches, as they assist people transform their lives by individually tailoring case management to each person’s unique needs and by “identifying, securing, and sustaining” the personal and environmental resources needed (C. A. Rapp and Goscha, 2006, p. 54). Evidently, this perspective underscores the human capacity for resilience (Robbins et al., 2006). Indeed, a strengths based assessment should follow these guidelines (Cowger, 1994; Saleebey, 1997, 2009):

- Give preeminence to the client’s understanding of the facts: The central focus of the assessment is the client’s view of the situation as well as the client’s feelings and meanings about it. Cognitive, mental or intrapersonal assessments of the client are only relevant if they clarify the current situation or if they can help us identify strengths to use with the situation. Indeed, the process of empowerment begins by who defines the situation:
  
  “Many alienated people have been named by others—labeled and diagnosed—in a kind of total discourse. The power to name oneself and one’s situation and condition is the beginning of real empowerment” (Saleebey, 1996, p. 303).

- Believe the client: The belief that clients are trustworthy is central to the Strengths perspective (Early and GlenMaye, 2004). Social workers need to review their attitude, that is, they need to suspend their initial disbelief in clients. Thus, it takes courage and diligence on the part of social workers to regard professional work through this different lens (Saleebey, p. 297, 2009).
  
  - Discover what the client wants.
  - “Move the assessment toward personal and environmental strengths: solutions to difficult situations typically lie in strengths. This is not as easy as it would seem, as the proposition is that client strengths are central to the helping relationship is simple enough and seems uncontroversial as an important component of practice. Yet much of the social work literature suggests otherwise” (Cowger, 1994, p. 262).
  - Make assessment of strengths multidimensional: both internal and external strengths are necessary to solve a situation, as well as the examination of power relationships in person-environment transactions.
What are Strengths Based Practices all about?

- Discover the client’s uniqueness: assessment must be individualized to understand the client’s unique situation.
- Use the client’s language: the product of the assessment should use a language that the client can understand (Weick et al., 1989, p. 354). The feeling of “ownership” is only feasible when the assessment is open, transparent, and shared.
- Avoid blame and blaming: blaming typically leads nowhere; it only deters motivation to solve the situation and increases learned helplessness.
- Avoid cause and effect thinking because they are usually based on simplistic cause-effect relationships that do not consider the multiple dimensions and complexity of the client’s realities.
- Avoid diagnosing: “diagnosis is understood in the context of pathology, deviance, and deficits”.

Saleebey (2006, p. 87) identified several questions that may be useful to identify strengths: survival questions (e.g., “How have you managed to survive this far given all the challenges you have had to contend with?”); support questions (e.g., “Who are the special people on whom you can depend?”); exemption questions (e.g., “When things were going well in life, what was different?”); possibility questions (e.g., “What are your special talents and abilities?”); esteem questions (e.g., “When people say good things about you, what are they likely to say?”); perspective questions (e.g., “What are your ideas about your current situation?”); change questions (e.g., “What has worked in the past to bring a better life for yourself?”); among others. These questions are not presented as a protocol and are intended to direct the helpers’ attention during conversations with clients (Saleebey, 2009).

What Makes Change Possible?

A strengths based practitioner attempts to understand a client in terms of her or his strengths. This involves a systematical examination of the client’s knowledge, resources, skills, and aspirations (Early and GlenMaye, 2004; Saleebey, 2009). By actively listening to the client’s stories and narratives, a helper can discover the client’s assets, abilities, and resources, as well as his or her concerns and challenges (Saleebey, 2006). Strupp (cited by Saleebey, 2006), who has been researching psychotherapies and positive change for decades, has repeatedly found that the most important factor across schools of psychotherapy is the quality of the helping relationship.

If we take into consideration that human beings build themselves into the world only by creating meaning, which is embedded in culture and environment, then we can understand the relevance of understanding the situation from the client’s perspective. Indeed, oppressed peoples typically have their stories buried under the stereotypes.
Removing oppression and emancipating the visions and hopes of the oppressed involves a process of reconstruction, which ultimately is our role as social workers. Thus, “it is a part of the work toward liberation to collaborate in the projection of peoples’ stories, narratives, and myths outward to the institutions that have ignored or marginalized them” (Saleebey, 1996, p. 301).

When clients seek help, they are usually in a vulnerable position; they have relatively little power which is often associated with the reason why they seek help. The strengths perspective provides for a balanced power relationship between social workers and clients, by reinforcing client competence and thereby mitigating the significance of unequal power. To minimize the power imbalance between worker and client, it is also important to make assessment a joint activity in which the worker inquires, listens, and assists client in discovering, articulating, and clarifying whereas the client provides direction to the content of the assessment.

A positive relationship between the social worker and the client is a key factor in the process of recovery. The most important features of an effective helping relationship, according to Rogers (1961), are empathy, congruence, and unconditional positive regard. These attitudes have been found essential for the healing process since it involves a nonjudgmental approach and a strong belief in the positive nature of human beings. Saleebey (2001b) includes expectancy, hope, and the placebo effect, as they are associated with positive expectations (the helper believes in the client’s inner power to transform his/her reality). This expectation mobilizes hope and the possibility of a different future (Saleebey, 2001b).

For strengths based practitioners, collaborating and partnering to achieve the client’s dreams and aspirations is crucial. A personal, empathic, and accepting relationship provides the atmosphere for healing, transformation, regeneration, and resiliency (Saleebey, 2006). Rapp (cited in Saleebey, 2006), considers an effective helping relationship “as purposeful, reciprocal, friendly, trusting, and empowering” (p. 80), and with positive expectations. Indeed, as Saleebey (1997) states, the role of the social worker is to help to create a dialogue of strength, in which the strengths based practitioner “becomes a translator who helps people see that they already possess much of what they need to proceed on their chosen path” (Weick et al., 1989, p. 354).

A growing body of literature shows that the client is actually responsible for the changes that take place in this process (Blundo, 2001). What changes and how it changes depend on what the client brings; in other words, what has been called the “extra therapeutic change” accounts for 40% of the change in the client’s outcomes. The collaborative and empathetic relationship (warm, accepting, understanding, and encouraging worker as perceived by the client) accounts for 30% of this change. The placebo effect accounts for 15% of this change; this means that the belief in the possibility of change, the increase in hope for a different situation is change-inducing.
What are Strengths Based Practices all about?

Repeatedly, studies have shown that our techniques or clinical interventions only account for 15% of the change in client’s outcomes (Blundo, 2001). Consequently, our focus should move to understanding how clients make these changes and supporting them in their unique circumstances (Blundo, 2001), with their unique resources and strategies, working toward their unique dreams, hopes, and aspirations.

Evidently, language matters in social work practice. The kind of rhetoric social workers use preserves or annuls the possibility and promise of their clients. Certain words are central to the strengths perspective: Empowerment, resilience, membership, health and wellness, and the like (Saleebey, 1996). People are competent, resilient, and responsible and valued members of a group or community. Strengths based practitioners appreciate believe in the restorative powers intrinsic to human beings and their bodies; emotions can have a profound impact on the overall health and wellness of individuals. Thus, believing in the hardiness and wisdom of the human body implies the belief in the possibility of overcoming adversity inherent to all individuals (Saleebey, 1996).

The strengths perspective demands social workers to change from a pathology-focused paradigm to a possibility-focused paradigm. This shift is more than theoretical; it demands a deep inner transformation. As Saleebey (2001b) insists, “to embrace a resilience/strengths model is not just a matter of acquiring some new techniques or a different vocabulary… it is a matter of changing one’s heart and mind—a personal paradigm shift” (p. 13). The real belief in the client’s capacity for change is what makes the difference. Indeed, the strengths perspective demands practitioners to adopt a different way of looking at individuals, families, and communities:

“All must be seen in the light of their capacities, talents, competencies, possibilities, visions, values, and hopes, however dashed and distorted these may have become through circumstance, oppression, and trauma. The strengths approach requires an accounting of what people know and what they can do, however inchoate that may sometimes seem” (Saleebey, 1996, p. 297).

Discussion

As the literature reports, as clients recognize and develop new strengths, they continue to gain power and growth. An emphasis on the individual and environmental strengths seem to act as a stimulus for further growth and development, leading individuals to contribute, not only to their personal goals and dreams, but also to the development and growth of their families and communities (Early and GlenMaye, 2004; C.A. Rapp and Goscha, 2006; Saleebey, 1996, 2006, 2009; Weick et al., 1989). Indeed, “the interplay between being and becoming and between what a person is in totality and what may develop into greater fullness mark the essential dynamic of growth” (Weick et al., 1989, p. 352), which characterizes the helping process from a strengths perspective.
The quality of the helping relationship is essential for the strengths perspective. This empathetic, empowering relationship, characterized by the collaboration and partnership between two human beings, transforms the realities of both participants in the process. One discovers, uses, and transforms her or his strengths in pursuit of her or his vision, dreams, and hopes, and, thus, becomes increasingly empowered to make his or her own choices, to lead his or her life, and to contribute. The other person is also transformed; her and his attitudes and expectations change regarding the person who is guiding the process, the person who facilitates the discovery of resources, the relationship between them, and the relationship with oneself. This process takes courage, commitment, and generosity. A strengths based practitioner is required to change his or her heart and mind. It is a “personal paradigm shift” (Saleebey, 1997, p. 13).

While the Strengths Perspective has reached most, if not all, areas of social work practice, an emphasis on deficit, disease, and dysfunction still persists in the field (Cowger, 1994; C.A. Rapp et al., 2005). However, As Blundo (2001) asserts, “what is most problematic with the inclusion of strengths talk in social work conversations is that the insertion of strengths and empowerment language into a traditional frame gives a false sense of understanding to those learning and engaging in practice.” (p. 301). Many social workers may not be ready to shift from a traditional social work practice to a strengths framework because it challenges our cultural and professional traditions; it questions our “truths” and hidden meanings (Blundo, 2006). In fact,

“to learn the strengths perspective one must seriously challenge the basic foundations of practice knowledge, the 80 years of variations on a basic theme of disease and expertise as it is taught and practised today. Anything less is a distortion of the meanings employed in a practice from a strengths/empowerment perspective” (Blundo, 2001, p. 301).

How can we expect to find the assets, the strengths, the protective factors among the damage if we only see the damage? We, as social workers, need to look beyond the client’s damage and wounds. Sometimes we feel more “competent” or “empowered” when seeing the damage since we were trained to find it. To see beyond the damage it is necessary to fight against ourselves, our biases, our training, and even our own culture. We need to have positive expectations for our clients and true belief in them.

A related question is: How can we find strengths in our clients if we cannot find strengths within ourselves? Affirming our inner strengths is challenging, because it requires personal exploration, which many social workers are not willing to do. Because many social workers have been trained in the damage model, this negative perspective is applied to themselves and is much too painful to bear. However, the main tool of a social worker is his or herself (verbal and non-verbal communication, intuition, capacity for relationship, attitudes, life experience, and self-concept, among
What are Strengths Based Practices all about?

Without self-exploration, the most important tool of the social worker (self) may be misused and is potentially destructive. Moreover, the belief in a client’s strengths and positive expectations cannot be faked. So, it is crucial to truly believe in a client and his or her potential. This can only be achieved by shifting our internal perspective and becoming aware of our own strengths and resilience. Any helper must develop a deep self-awareness to effectively promote this change.

How can we help someone discover hope in the future if we do not have hope in our own lives? The importance of hope in resilience promotion and recovery has been previously discussed. We need to discover our own hope and positive expectations for our own lives. Again, it is a challenging process of self-recovery, which involves a positive attitude towards one’s life in general. Considering that hope is also related to spirituality, it is necessary to reexamine our belief system, the meaning of our lives, and our sense as a whole person in connection to humankind. It is not a daunting task, but it is definitely rewarding.

How can we provide opportunities for creating turning point effects if we do not believe in change? There is no possibility for creating any opportunity without a fundamental belief in change, first. A human being always has the possibility of change. Despite damaging experiences, what we learned about resilience shows that human beings have the capacity to construct new narratives for their lives. Benard (2004) insists in the importance of changing the life trajectories of children from risk to resilience, beginning with changing the beliefs of the adults in their environment.

How can we expect ordinary magic to happen if we do not believe in it? We must believe in the magic of resilience and we have to believe that the capacity for resilience is ordinary and universal. With these beliefs in place, it becomes obvious that everybody has the ability to bounce back from adversity; we can truly have positive expectations. If we believe these things, in the helping encounter, magic is likely to happen. Social workers are like alchemists because they have the possibility of changing lead into gold, by discovering the clients’ strengths and resilience and encouraging this magical transformation by the power of the word and a deep relationship.

Social workers interested in the strengths perspective need to engage in a personal process of analysis and transformation, recognizing that this will be a continuous process, recognizing signs of the traditional framework in their practice, becoming aware of themselves and their attitudes, biases, and limitations, and defining a new position for themselves in the helping relationship, that is, removing their "expert" hats and acknowledging the client’s expertise, knowledge, and capabilities. When we have “emptied our cups”, we can have them ready to receive what the client brings, in an open, curious, encouraging, empathetic, and empowering way. As Blundo (2001) affirms:
“Challenging this cultural and linguistic tradition, as well as a process that has become synonymous with the social work profession, is a serious task that needs to be undertaken if social work is to embrace a belief in human resilience and strengths” (p. 304).

Strengths based practices challenge us, our professional traditions, our cultural influences, beliefs and biases. As the client gains power and growth, the social worker grows as well. This process takes us away from our comfort zone, our habits, and hidden meanings in a process of discovery of our own strengths, resources, capabilities; our own resilience; our own hopes and capacity for transformation. In other words, without the “expert” hats, we are only, and truly, human beings, who care and believe in the human being sitting across the room, and thus, a partnership, emerges more easily and empowers our partner in this endeavor.

This paper had referred to Gandhian approaches to self reliance and inner strengths development in the beginning. It is appropriate that I end this paper with another Gandhi’s quote “Happiness is when what you think, what you say, and what you do are in harmony.” This quote illustrates the kind of paradigm shift that strengths based practitioners are required. Without our own labels, we, the social workers, engage in the collaboration with another human being by using our own strengths, capabilities, skills, and internal and external resources; we tap into our own resilience with the ups and downs of work and life; we discover and gain our own power within the environments and transactions in which we participate; we come to work in pursuit of our own dreams, hopes, and aspirations; we use our own inspiration to keep moving forward, to set a vision... and when our thoughts, words, and practice are in harmony; we also inspire others. Strengths based practices assists us to build hope, in fact active hope in our society.

“Be the change you want to see in the world.”
—Gandhi

References
What are Strengths Based Practices all about?


http://en.wikipedia.org/wiki/Mother_Teresa


http://en.wikipedia.org/wiki/Mother_Teresa
Journey towards Recovery in Mental Health

Abraham Francis
James Cook University, Australia

The world that we have created is a product of our thinking; it cannot be changed without changing our thinking. If we want to change the world, we have to change our thinking.

—Albert Einstein (1879–1955)

ABSTRACT

Traditionally, mental health professionals have tended to focus on symptoms, illness and dysfunction. Strengths based practice uses clients’ skills and personal strengths as the platform to engage with them. Using this as a background, this paper explores the emerging strengths-based perspectives in mental health field. It examines how strengths based principles can be applied in specific fields of mental health practice and specially in designing strengths based approach to recovery as each person’s journey of recovery is unique. In this context, the paper also examines how practitioners can enhance client’s capacities and instil a sense of hope, and empower the families and careers through this journey. Questions to be addressed include: what are some of the tools that social workers can use to assess the skills, competencies, and characteristics of individuals and families? How can Strength-based practice framework provide social work practitioners a reliable and valid way to engage with individuals and also in supporting them in their individual journey towards recovery?

Introduction

Recovery in general terms means the act or process of recovering, especially from sickness, a shock, or a setback. This term has been used in mental health field also to reflect the process of recovering from mental health illness. The idea that people can recover from mental illness has only come about in recent decades. There has been much of discussion about recovery since 1980s especially from the field written by consumers and thus concept of recovery began to gain its legitimacy (Sullivan 1997). Before this time, the prevalent belief was that recovery for people living with mental illness was not possible. This resulted in people being institutionalised and closed-off from ordinary life in the community (Allott, Loganathan, and Fulford, 2003; Barnett and Lapsley, 2006). Negative perceptions and an expected poor prognosis of severe
mental illness underpinned the dominant beliefs about and impacted on the enduring stigma and discrimination towards people living with mental illness (Allott et al., 2003). However, now there is evidence that people with mental illness can recover (Andreson, Oades, and Caputi, 2003, p. 587; Carpenter, 2002; Davidson, O’Connell, Tondora, Styron, and Kangos, 2006, p. 642; Kelly and Gamble, 2006, p. 247; Mead and Copeland, 2000, p. 317 cited in NSW CAG, 2009, p. 12) and that this can occur through the provision of treatment and care in community-based settings.

Couched in this discourse I am attempting a social work perspective as being central to the concept of recovery and the engagement process with the clients on their way to recovery. My own experience of working with consumers from various backgrounds and also of the current research evidences that are emerging from the field and the increased focus on the aspects of recovery emphasises the importance and need of social work practice in the sector. Social work as a profession adheres to the principles of social justice and human rights and it is believed to be the fundamental and crucial for social workers to be actively involved in the field of mental health and recovery. Over the last 20 years this concept has become quite popular and it has offered us a new way of looking at mental illness and a new way of understanding the illness which not only challenges the service providers and organisations but compels us to look beyond the illness framework of symptoms, treatment and deficits. Recovery framework asks for a “personal well-being”, which is living well in the absence or presence of illness.

Recovery, What is it?

Recovery has become the guiding principle of the mental health system, resulting in advocacy for care and services that would facilitate ongoing changes in the lives of people.

Recent literature on recovery describes it as deeply personal and unique to each individual and that recovery unfolds within a social and interpersonal context (Topor et al., 2011). However, most of the literature describes recovery as “individuals taking control of their lives” (Beers, 1921/1981; Deegan, 1996; Leete, 1989 cited in Topor et al., 2011). There is no single uniform definition on recovery as the individual journey itself is unique and personal. But one of the definitions that the practitioners, researches and consumers most often refer to is the one offered by Anthony (1993) where he identifies recovery as,

“a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.” (p. 13).
Noiseux et al. (2009) in their recent work discusses recovery as

“Recovery does not mean a cure, but rather an experience of adaptation to symptoms, well-being and a redefinition of personal identity to someone who was diagnosed with schizophrenia, states that recovery is an attitude towards various possibilities, an active stand and a non-linear process during which a person must find ways to face daily challenges. A person may thus not only try and fail, but may also try again in order to attain personal and professional goals. A relapse is therefore in no way an impediment to the process that characterizes recovery, but represents a move on to another stage” (p. 4).

This definition emphasises the individual aspect of recovery and this has also been reflected in the various documents and policies of government and organisations, acknowledging the importance of “lived experience of the consumer” as a meeting point for both the practitioner and service users.

Gehart (2012) developed the *collaborative, appreciative approach* using the recovery model elements identified in Onken, Craig, Ridgway, Ralph, and Cook’s (2007) The collaborative approaches deal with the working relationship with the consumers. The collaborative approach of Anderson and Goolishian 1992; Anderson, 1997 (cited in Gehart 2012.) describes the quality of working relationship in which consumers’ voices are honoured and equally valued in the recovery process. The appreciative aspect of model is associated with recognizing and valuing the strengths and abilities of consumers, which generates the necessary momentum for recovery. Following are some of the practical elements in this approach. This is a new approach in the recovery literature.

- Recovery partnership (*i.e.*, therapeutic relationship).
- Mapping the landscape of recovery (*i.e.*, assessment and case conceptualization).
- Recovery planning (*i.e.*, treatment planning).
- Facilitating recovery (*i.e.*, interventions).
- Accessing resources (*i.e.*, case management).
- Recovery maintenance (*i.e.*, aftercare planning).
- Context and format (*i.e.*, treatment team and work contexts) (p. 444).

Thoughts such as above are equally found in the state documents which by itself are a thoroughly encouraging phenomenon that indicates the direction in which this movement is travelling in Australia.

In the paradigm of mental health, the concept of recovery is understood to refer to a unique personal experience, process or journey that is defined and led by each person in relation to their well-being. While recovery is owned and unique to each individual, mental health services have a role in creating an environment that supports and does not interfere with, people’s recovery efforts. (Victorian Department of Health 2011).
Similarly in New Zealand, O’Hagan’s definition from New Zealand’s Blueprint (Mental Health Commission 1998) is a simple one to follow. “Recovery is living well in the presence or absence of one’s mental illness” (p. 113).

Principles of Recovery

Before we proceed further, we will examine the principles of recovery. Recovery literature from around the world emphasise a number of key aspects associated with recovery which are very important in our discussion throughout this paper. They will be explored in brief in the following paragraphs. Following is a table consisting of 10 key principles of recovery which I have adopted from the literature survey conducted in UK by Shepard et al. in 2008.

<table>
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<th>Principle</th>
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<td>1. Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems.</td>
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<td>2. Recovery represents a movement away from pathology, illness and symptoms to health, strengths and wellness.</td>
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<td>3. Hope is central to recovery and can be enhanced by each person seeing how they can have more active control over their lives (‘agency’) and by seeing how others have found a way forward.</td>
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<td>4. Self-management is encouraged and facilitated. The processes of self-management are similar, but what works may be very different for each individual. No ‘one size fits all’.</td>
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<td>5. The helping relationship between clinicians and patients moves away from being expert/patient to being ‘coaches’ or ‘partners’ on a journey of discovery. Clinicians are there to be ‘on tap, not on top’.</td>
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<td>6. People do not recover in isolation. Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying social roles within local communities, rather than in segregated services.</td>
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<td>7. Recovery is about discovering—or re-discovering—a sense of personal identity, separate from illness or disability.</td>
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<td>8. The language used and the stories and meanings that are constructed have great significance as mediators of the recovery process. These shared meanings either support a sense of hope and possibility, or invite pessimism and chronicity.</td>
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<td>9. The development of recovery-based services emphasizes the personal qualities of staff as much as their formal qualifications. It seeks to cultivate their capacity for hope, creativity, care, compassion, realism and resilience.</td>
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<td>10. Family and other supporters are often crucial to recovery and they should be included as partners wherever possible. However, peer support is central for many people in their recovery.</td>
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(shepherd et al., 2008 cited in stickley and wright, 2011)
The principle of recovery has been adopted as a central principle of mental health policy in many countries including Australia, New Zealand and Britain. In Australia, the principles of recovery are expressed clearly in the National Practice Standards for the Mental Health Workforce (Australian Health Ministers Advisory Council’s National Mental Health Education and Training Advisory Working Party 2002). The National Standards for Mental Health Services (Australian Government 2010) clearly states the following:

“From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of one’s abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. It is important to remember that recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery—hope, healing, empowerment and connection—and external conditions that facilitate recovery—implementation of human rights, a positive culture of healing, and recovery-oriented services (Jacobson and Greenley, 2001 p. 482). The purpose of principles of recovery oriented mental health practice is to ensure that mental health services are being delivered in a way that supports the recovery of mental health consumers”.

Recovery as a ‘Personal’ Unique Experience

In the literature on recovery, a distinction has been made between personal recovery and clinical recovery. “Personal recovery focuses on the internal processes and personal efforts to overcome and actively create movement toward regaining self-authorship and self-mastery against the impacts of mental illness. Personal recovery cannot be created or manufactured by others; it is not defined by the presence or absence of symptoms but more precisely how a person manages symptoms and creating a self determination to see and experience life beyond mental illness. However, Clinical recovery focuses on the destination and successful attainment of health related outcomes whereas personal recovery recognises the process of overcoming the personal barriers and impacts of mental illness. Ideally a person would desire both; one without the other is incomplete” (TARI, 2012, p. 8).

Recovery is not magic, it cannot be purchased nor can it be imposed on to people. Recovery is a gradual process where one makes an attempt to come back to the normal ways of living, regaining a sense of control, knowledge and power. Persons who see themselves as recovering have expressed their views as follows which will give us a new perspective and value to our discussion. Deegan (1997) a person diagnosed with schizophrenia, living in the USA is of the view that, recovery does not mean cure, it is a hopeful attitude, seeing the person as more than the illness, recovery is a
unique (individual) journey, and recovery may not mean symptom free. Therefore, recovery is a very unique personal experience and hence it may/may not make sense to people who are associated with the person affected by such an illness. Having an understanding about this will be crucial in delivering services, a key point to remember and be aware of when interacting with them. If we do not understand this as an outsider, ask for permission to know what they are going through in their lives. This can be an engaging and rapport building exercise but should be done with a sense of respect, great care and compassion. However it must be noted that it is not just an individual journey but recovery unfolds within a social and interpersonal context (Topor, 2011).

Recovery as a Journey

Many people have written personal accounts of their own journeys through mental health problems and recovery (Deegan 1988, Coleman, 2000). Many authors and persons living with mental illness have described it as a journey. Recovery is a unique journey (Deegan, 1997) that needs a wide variety of therapeutic options to be available to the person (Chadwick, 1997). The journey of recovering is at least as important as the end point and everyone has potential for recovering (Glover, 2001). This paper itself is titled as journey towards recovery because as a practitioner I myself have personally witnessed the journey of people in their lives. In a conversation with some of my clients, they stated the following which supports the argument that, recovery is a unique personal journey.

“I know it is very hard for me to get up in the morning as I take a lot of medications. They make me sleepy….and do not want to do anything except to be on bed. But when I know I have to go to my support group, I get up… because that is something that I enjoy doing and that is a small step in my recovery journey”. (Personal communication with a client, 2009)

Accepting the situation is very confronting and challenging and yet an important aspect in recovery process. Every small step counts and every small step makes a huge difference in the lives of people.

“I have now taken ownership of my illness and I take responsibility for what I do and do not do. I don’t let it control me…It’s not the whole of my life, it’s just a part of my life now…I have now learned to live with it … it is part of my life.”(Personal communication with a client, 2009).

Hopefulness and optimism are central themes in recovery literature, where “hope that leads to recovery is, at its most basic level, the individual’s belief that recovery is possible” (Jacobson and Greenley, 2001, p. 482). Professionals can be ‘holders of hope’ (Glover 2001) for service users whose ability to hope and dream for themselves
has been eroded by their illness and by negative messages from others. In this context the practitioner can engage in a meaningful relationship with the client to foster that self-belief and hope, help them see dreams for themselves, encourage them to be the driver in their journey and accept to become a compassionate companion on their journey. If required clients could ask for clarifications and as a collaborative practitioner when in doubt take the opportunity to consult with them and be accessible to them. Because all that matters is how you care about them. In the midst of all that sufferings, pain and emotional instability, they recognize the warmth of love, compassion and genuineness that we demonstrate as a practitioner.

Recovery from Strengths Based Perspectives

Strengths-based practice is a term that has gained momentum in social work literature and teaching in the past decade (Cowger, 1994). Strengths-based practice is defined by the idea that social work is principally about enabling people to function autonomously within society, by collaborating with individuals (through social casework) to identify the resources they have available to them, to make the changes they would like to make (McMillan et al., 2004). The proponents of the strengths perspective say that this approach requires a shift in paradigms from a pathology orientation to a strengths and resilience focus. It is more than ‘add strengths and stir’ (Rapp, 1998, p. 47). Understanding recovery from a strengths perspective is useful in this discussion as it recognizes that recovery is not necessarily about cure but is about having opportunities for choices and living a meaningful, satisfying and purposeful life, and being a valued member of the community on the journey of recovery. Before, we explore in detail about the way in which this can occur let us look at the theoretical underpinnings of strengths based practice.

Several authors have documented reservations about the problem-based approach. Weick et al. (2001:351) and Smith (2006:13) have summarized their views about the focus on the problem and the process of defining it as follows:

- The problem is seen as lack or inability in the person affected.
- The nature of the problem is defined by the practitioners/professionals.
- Treatment is directed towards overcoming the deficiency at the heart of the problem.

However, Saleebey (2001:103) describes reservations about a focus on problems stating that focusing on problems usually creates more problems. The longer one stays with a problem-focused assessment, the more likely it is that the problem will dominate the scene. Sometimes the complicated diagnoses about human problems do not see the more potent areas of strength and the small victories the person experiences. It looks as though a problem orientation begins to look like an exercise to meet the needs of the professionals, rather than the needs of the people they are working with. Therefore, the practitioner needs to be aware of such perspectives before beginning to
work with clients. At the heart of the strengths-based approach are social justice principles of ‘power with’, respect and the ‘ownership’ by the client of their own process of change. The strength perspective is based on the belief that every person, family and community has capabilities that can be drawn on to overcome problems, and that trauma, illness and struggle present opportunities for challenge and growth. It is also based on the principle that in every environment, people, groups and institutions have something to offer. Here, the focus is on the person’s strengths, not pathology, symptoms, weaknesses, problems or deficits. Saleebey (2009) states, “The principles that follow are the guiding assumptions and regulating understandings of the strength perspective. They are tentative, still evolving and subject to revision” (pp. 15–18). These are:

1. Every individual, group, family and community has strengths.
2. Trauma and abuse, illness and struggle may be injurious but they may also be sources of challenge and opportunity.
3. Assume that you do not know the upper limits of the capacity to grow and change, and take individual, group and community aspirations seriously.
4. We best serve clients by collaborating with them.
5. Every environment is full of resources.
6. Caring, caretaking and context.

In a similar way Kisthardt (1997; 2002) highlights the principles of strengths based helping as the initial focus in the helping relationship is upon the person’s strengths, desires, interests, aspirations, abilities, knowledge, resiliency, ascribed meaning, not on their deficits, weaknesses, problems or needs as seen by others. The participant is the director of the helping efforts and is responsible for their own recovery. The healing process takes place on many levels with professionals serving as caring community living consultants. All human beings have the inherent capacity to learn, grow and change. The human spirit is incredibly resilient despite hardship and trauma and people have the right to try and the right to fail. The relationship with the person is the essential component of the support process and is characterized by mutuality, collaboration and partnership. A person-centred, strengths-based approach promotes activities that are home and community based; the entire family and community are viewed as a pool of potential resource and naturally occurring resources are considered before segregated or formally constituted resources are used.

Although there are many models of recovery that we can locate in the literature, here we will limit our discussion to the concept of the strengths model of recovery. The six principles of the Strengths Model are:

1. Focus on the person’s strengths, not their weaknesses, problems or deficits.
2. Perceive the community as an oasis of resources, not an obstacle to working with a consumer.
3. Interventions are self-determined by the consumer. Nothing is done without the consumer’s approval.
4. The case manager to client relationship is primary and essential.
5. Assertive outreach is the preferred mode of intervention, *i.e.* seeing the client in their home, park or café rather than a practitioner’s office.
6. People with serious mental illness can continue to grow, to learn and to change. (Campbell, 2006, p. 43).

**What Makes this Journey Possible?**

As a practitioner, I have been able to learn more about recovery from my own practice and by working with my clients with whom I interacted regularly during my career as a mental health social worker. The lessons that I have learned from them are discussed in the light of the literature discussed in this paper, with a social work practice framework in the context of multidisciplinary team work approach in the mental health field. As mentioned by Coleman (2000) the importance of practitioners being interested in the recovery of people is key. Recovery requires self-confidence, self-esteem, self-awareness, self-acceptance, it is a liberalising process, a social process and one in which practitioners need to believe in. Some of the lessons that I have learned as a practitioner, which I believe are the most important principles for practice. These are also drawn from both literatures as well as from the experience of other practitioners in the field. Therefore, it will be appropriate for the practitioner to consider before commencing any work with his/her clients:

1. Have a strong belief in the power of people that they can recover and demonstrate a commitment to service.
2. Establish a therapeutic partnership with the client, family and other networks.
3. Develop an open communication, and patient listening with the clients and families.
4. Have an understanding that recovery is unique for each person and people may be at various stages of recovery. There is no “one size fit for all” approach in recovery.
5. Recovery is based on the foundation of hope and it is also about nurturing relationships.
6. Encourage and celebrating the achievements of your “clients” even if it is a small step towards recovery.

**Towards Recovery: Social Work Response**

Social Work is identified as one of the five mental health disciples on a multidisciplinary workforce in the National Mental Health Strategy (Australian Health Ministers, 2003). The purpose of social work is to support people’s self-determination and to “assist others to achieve more equitable relationships and greater power and control over
their lives” (O’Connor, Wilson, Setterlund and Hughes, 2008, p. 53). The Australian Association of Social Workers identifies social justice as a key value integral to ethical practice. Social justice considers issues of stigma, disadvantage, discrimination and marginality, and values the lived experience of mental illness and the importance of partnerships, mutuality, participation and choice (AASW, 2010). The Australian Association of Social Workers (2010, p. 17) states that social workers “obtain a working knowledge and understanding of client’s racial and cultural affiliations, identities, values, beliefs, and customs, including consultation with cultural consultants, where appropriate” and this statement guides ethical practice with regard to working with Aboriginal and Torres Strait Islander people.

In defining the aims of social work in mental health, the AASW (2008) states that “the purpose of practice is to promote recovery, restore individual, family, and community well-being, to enhance development of each individual’s power and control over their lives, and to advance principles of social justice” (p. 8). The AASW (2008) further highlights that “the domain of social work in mental health is that of the social context and social consequences of mental illness” (p. 8). At the level of ‘social context’, this means that social workers must seek to understand “the way each individual’s social environment shapes their experience of mental illness and mental health problems” (AASW, 2008, p. 8). A concern with the ‘social consequences’ of mental illness requires social workers to consider “the impact of mental illness and mental health problems on the individual, the family and personal relationships, and the broader community...” (AASW, 2009, p. 8). Finally, advancing the principles of social justice requires social workers to be attendant to, and concerned with “with issues of stigma and discrimination, of political freedoms and civil rights, of promoting access to necessary treatment and support services, and of promoting consumer and carer rights to participation and choice in mental health services” (AASW, 2008, p. 8–9).

However, as Bland et al. (2009) clarify, if the above-mentioned aims of social work practice are to be realised, social workers must argue for a broader agenda in mental health. That is, an agenda that looks beyond the dominance of narrow, clinical concepts of illness and treatment, to interventions more inclusive of a variety of practice methods, such as individual counselling, community work, group work, social action, social planning and social policy. Furthermore, realising the aims of social work practice in the mental health sector, requires that social workers draw upon the breadth of the professions’ knowledge base (for example, various theories of interventions), as well as the variety of social work skills and values (for example, respectful and empathic working relationships) (AASW, 2008). Combined, these features of practice emphasise the centrality of a social justice and human rights approach to mental health.
How can I Identify Strengths in My Client? The Role of the Social Worker

This is a question very often asked by the practitioners in the field. The demand here is to identify the protective factors and aim to see a future in the midst of all the problems. It is in this context that the skills, knowledge and values of the social worker play a major role in working with the client. The following are some tips that may be useful for social work practice with clients:

- Actively listening to client’s concerns and problems. “Listen to the client’s story, instead of zipping through an assessment protocol. Stories and narratives often contain within their plots and characterizations evidence of strengths, interests, hopes and visions” (Saleebey, 2002 p. 88).

- Solution focused interviewing which aims at facilitating hope, belief and agency. Begin with a ‘miracle’ question to talk to the client “…attention away from difficulties and focus on imagining a future when the problem is solved…” (De Jong and Miller, 1995, p. 731). The following question could be used: “Suppose a miracle happens tonight while you are sleeping. The miracle means that when you awake in the morning the problem is solved. What differences would you notice to tell you that a miracle has occurred?” Describing these differences should help the client to focus on identifying solutions rather than problems and “…develop both an expectation of change and a growing sense of the goals toward which to direct effort” (De Jong and Miller, 1995, p. 731). This is the first step in assisting a client to “…change his identity from one who is overwhelmed or disempowered by problems, to one who is capable of facing and solving the problems…” (Saleebey, 2009, p. 113). Another way of identifying the client’s strengths is to ask a series of ‘exception-finding’ questions to explore the past and present successes in relation to where there have been exceptions to problems (De Jong and Miller, 1995). For example: “When things were going well in life, what was different?” (Saleebey, 2009, p. 87).

Further options include (Saleebey, 2009; De Jong and Miller, 1995):

- **Coping questions**: “What makes you get up each day?”
- **Support questions**: “Who are the people that you can rely on if needed?”
- **Esteem questions**: “What achievements are you most proud of?”
- **Possibility questions**: “What are your dreams and future plans?”
- **Survival questions**: “How have you managed things in the past?”
- **Change questions**: “What do you think is necessary for things to change?”

These are processes that are not unknown to social work profession. It is the sequencing and consequencing that we have to regain control of and needs to find a place in our tool kit for practice.
“These thoughts, actions and feelings constitute the client’s strengths...” and formulate the path to “...client-devised solutions” (De Jong and Miller, 1995, p. 734). By harnessing identified capacities, including those developed from adversity, focus is placed on hope and future possibilities. Particular to the strengths approach, is asking the miracle question. This question is asked in many ways, but typically a therapist might ask ‘if tonight while you were asleep a miracle happened and it resolved all the problems that bring you here what would you be noticing different tomorrow’ (Iveson, 2002, p150). Iveson (2002) suggests that the practice of miracle questioning allows the person to draw on their creative thinking in order to create a solution.

Recovery does not just happen in a vacuum. It needs an environment of support, corporation, and partnership that can foster hope.” Because hope is the foundation of recovery “(Gehart, 2012 p. 444)” . The road to recovery starts only when we acknowledge and accept our mental illness and the toll it has taken in our life. After such an acknowledgment we can start taking steps to improve our life and work towards the sort of future we want or imagine “(Middlemiss, 2012). This realisation is a difficult thing in the beginning as people with mental illness may be socially isolated and may not have the luxury of human connections. It is at this juncture, we need people with a sense of head, heart and minds to walk in to the lives of people who demonstrate a sense of commitment and compassion. This acknowledgement is nourished again in an environment of positive thinking, collaboration, compassion and by recognising the strengths of the individual. This emphasis on strengths is used as a foundation for the recovery partnership (between a service provider and a service recipient) and is also central in mapping the recovery and facilitating the recovery process (Gehart, 2012). By engaging with clients with a sense of hope and a belief that people can change make a difference, social workers can work with the client to identify a sense of purpose for their life, create a sense of belonging and develop a sense of hope. Working from strengths based approach will ensure that client is supported to move towards recovery.

**Conclusion**

The concept of recovery offers social workers and other health professionals a new way of looking at their practice and it is in fact a challenge for social work profession to reclaim profession’s traditional ways of strengths based concepts in working with individuals and communities thereby championing an alternative approach to practice. This paper has argued that recovery is consistent with a strengths based perspective, with a focus on social work practice. The primacy of lived experience as a starting point for assessment and engagement is as challenging as it is exciting. The way that mental health services apply recovery principles and the tensions between
recovery and other practice imperatives like evidence-based practice and risk management remains to be resolved (Bland and Tulgreen, 2012).

In working with the clients from a recovery framework, the practitioner needs to believe that change is possible and acknowledge the small steps initiated by the clients. This will initiate the journey towards recovery. As the saying goes “Encourage the heart and celebrate the achievement”.

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Non-Violent Engagement with Weakness: For Stronger Mental Health

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ABSTRACT
This paper proposes that a realistic acceptance of both strength and weakness is foundational for ego stability. A non-violent, collaborative, and sensitive investigation into the history and context of a person’s interpersonal dynamics can provide a rich pathway for therapeutic work. It will be shown that, used with scruples, this conceptualisation process (known in psychoanalytic circles as the ‘case formulation’) goes beyond ‘diagnosis’, and provides opportunities for social workers in mental health to participate in clients achieving satisfying and sustainable levels of strength. By assertively engaging in the co-construction of therapeutic understandings from an informed psychodynamic base, social workers may offer an alternative sensibility to the reductionist pressures and anti-therapeutic notions that threaten humane mental health care.

Introduction
In the domain of mental health delivery, “Tensions about power and purview create a complex, often troubled landscape for contemporary social work practice.” (Probst, 2012, p. 379). Whilst biological/descriptive and psychoanalytic psychiatry have been focal participants in these tensions, some aspects of biological and analytic conceptualisations can offer a powerful antidote to the cultural and relational effects of what Mel Gray describes as ‘the calculative individualism’ of neo-liberal societies (Gray, 2011, p. 10). As Richard Bentall notes in his book, Madness Explained, there is no inseparable gulf between the psychological and the biological (Bentall, 2003, p. 143). Social work researchers have noted the disempowering and pejorative aspects of diagnostic processes, and urged social workers in mental health to offer an alternative, enabling and socially-oriented sensibility (Frazer, Westhuis, Daley, and Phillips, 2009; Kutchins and Kirk, 1988; Specht and Courtney, 2003; Turner, 2002). The strengths based approaches have, in that context, usefully emphasised the restorative power of authentic respect (particularly for people consistently demoralised by poverty and other social determinants of poor mental health), towards an increased sense of competency (Dekovic, Asscher, Hermanns, Reitz, and van den Akker, 2010). It is necessary,
however, that ego strength be developed beyond recognition and encouragement of abilities, and the use of social and community resources, to a level where failings and errors of character and behaviour can be acknowledged. Defensive processes, similarly, need to be recognised, understood, and sometimes accepted as unalterable.

**Realistic Ego-strength**

In an age where window-dressing is tolerated in society and in relational encounters, the candour required for realistic self-esteem, and for an effective therapeutic relationship, is an increasingly challenging matter. Both Freud and Jung noted the human propensity for avoiding the painful awareness of things we don’t like about life and about ourselves. They indicated that to become whole, each of us need to integrate both our acceptable and admired, as well as our disliked and limited parts, into a cohesive whole (Freud, 1901; Jung, 1981). In individualistic and consumerist-oriented cultures an appreciation of the personal and cultural benefits of this kind of integration, once introduced by the psychoanalytic project, has dwindled. Validation, empathy, safety, containment, strengths and “the adaptive rather than the pathological” have progressively become of more interest to therapeutic work, than defects (Danzer, 2011; Herman, 1993; Kisthardt, 2002; White, 1995). Who, indeed, would argue for emphasizing defects, or against the idea that people have a store of adaptive capacities that are influenced by the surrounding environment (Goldstein, 1984; Mitchell and Black, 1995; Saleeby, 2009)?

However, in a climate where economic and social disadvantage, and even human fallibility, are construed as individual failure; and advertising and social media propagate the impression that one can attain all that one desires, it is critical to resurrect the strength that can be found in facing uncertainty, ruthless realities, and accidents of personal history, with realistic appraisal. What is critical is not so much the therapist’s choice of theoretical position or clinical technique but a willingness to promote and elaborate a relationship that involves both safety and challenge (Norcross, 1993; Sullivan, Skovolt, and Jennings, 2005). The psychoanalytic project highly values scrupulous honesty about the world, and self-honesty in particular. This kind of honesty does not permit sentimentalising, redefining unpalatable truths, or fantasies of omnipotence or perfection, whether in relation to the self or the human condition.

Without the ability to tolerate the vicissitudes and uncertainties of living, which include weaknesses on individual, communal, and political levels, the human animal will be in denial. It is important that social workers genuinely recognise that there are very real problems occurring in their clients’ lives, many of which continue to have negative impact upon the client and others in the client’s relational world. This courage also entails the naming and discussion of the social worker’s (in most cases) comparative good fortune with regards to most clients’ life circumstances, and their membership
(in most cases) of privileged and mainstream societal groups. Social workers must not flinch in the face of the prevailing urge toward denial of the problematic, the damaging, the cosmic insecurity in the world: that is, denial of the many unchangeable ‘givens’ of the human condition (Estes, 1996; McWilliams, 2004; Spinelli, 1994; Van Duerzen, 2009; Yalom, 1980). Much of the insight arising from therapeutic work is intrinsically injurious to self-esteem and existential security; much of living well involves achieving a forbearing attitude to imperfection. Realistic appraisals of imperfection in the self and in society, a capacity to register the impact of one’s weaknesses and those of others without defensive denial or illusion, are standpoints of maturity and mental strength.

The strengths-based and recovery models in mental health are very valuable for their “humanizing potential” (Gray, 2011, p. 6). Gray further observes, though, that, “more than a focus on individual and community capacity is needed to deliver the transformative agenda it promises.” (p. 10). In similar vein, according to Browning, “many modern psychotherapists are aware that respect for persons gets to the heart of psychological cure.” He states, beyond this, that respect can only become restorative if it is shown concretely, with reference to that person’s specific story and not just to the abstract person (Browning, 2008, p. 381).

Social work commentators on mental health have long highlighted oppressive results of the power relations inherent in this field of practice, which contribute to fundamental “value collisions” for social workers in mental health work (Taylor and Bently, 2005, p. 470). The discrepancy between social work values for example, client self-determination, and some social work tasks, such as shielding others from harm, in mental health practice are keenly felt. The pressures of carrying out work that, in essence, often involves being the executive arm of psychiatrists creates moral strain for social workers. Psychiatry has typically been slower to be influenced by post-modern challenges to power and hegemony, and the descriptive and labelling gaze of psychiatry continues to be used against people on many levels and in various ways. However, a dynamic use of psychoanalytic formulations in mental health has significant conceptual and therapeutic power when employed from social work’s person-in-environment perspective, which recognizes client concerns as “contextual, transactional, cultural, and relational in nature” (Probst, 2012). Social work practice can benefit from these perspectives as much as it currently does from the findings of the biological and neurosciences around brain plasticity.

“Kandel, the eminent psychiatrist and recipient of the Nobel Prize in 2000 for his neuro-scientific research, writes that psychoanalysis has revolutionized our understanding of mental life. It has provided remarkable insights about the functioning of the psyche and ‘still represents the most coherent and intellectually satisfying view of the mind’ (3, 4). He also writes that psychoanalysis
has unfortunately not evolved scientifically and has not integrated and incorporated into its view of the mind “the rich harvest of knowledge about the biology of the brain and its control over behavior that has emerged in the last 50 years” (4). Kandel pleads, following Freud, for a psychiatry in which biology is integrated with the rich insights that have come from psychoanalysis, in which mind and brain are each given their appropriate place.” (Bohmer, 2011, p. 273)

One of the ways to add value to strengths and recovery model work is to make use of the psychodynamic case formulation. This kind of case formulation is directed towards a non-violent, sensitive recognition of the unique, personal aspects of the concerns and the life of the client. “Clinical formulation is not concerned with what category the problem fits into, but what situational, psychological and social processes are maintaining this particular client’s mental distress and how these could be addressed.” (Crowe, Carlyl, and Farmar, 2008, p. 801). Such an exploration should be a co-production, holding as its central principle the integrity of an individual’s personal history, and it should help “develop direct and respectful ways … to interact with mentally ill patients” (Kandel, 1998, p. 459). Wallace writes that dynamic psychiatry incorporates interpersonal theories, object relations theory, biological data, social and behavioural data, and systems approaches; which sounds remarkably like the bio psychosocial assessment familiar to social work (Wallace, 1983, p. 2). Unfortunately, as noted by several authors, the psychodynamic formulation informed by these perspectives is seldom incorporated in the psychiatric presentation of patients in medical settings (Bohmer, 2011; Crowe, et al., 2008; Perry, Cooper, and Michels, 1987; Sim, Gwee, and Bateman, 2005). Regrettably, the use of data around unconscious and intra-psychic structures in their work is largely unfamiliar to most social workers in Australia who work in mental health.

A psychodynamic formulation, beyond assisting the social worker to comprehensively register the unique, personal aspects of the experience and the life of the client, anticipates the possibilities of how this unique person may interact with others, and how defences and underlying conflicts may manifest themselves in the therapeutic relationship. Mace and Binyon, (2005) write that this understanding of the client’s habitual ways of coping with events and other people is critical.

“Formulation requires additional kinds of information, such as a sense of how the patient feels and responds in a variety of situations. It is concerned with why events have followed one another and the meaning of these for the patient. Apart from detailed questioning, the interviewer may use the experience of being with the patient to gather information…which can help him or her to infer characteristic ways in which the patient responds to painful experiences and relates to others.” (Mace and Binyon, 2005, p. 417).
The Process of Case Formulation

In providing the description, below, of what is entailed in the process of case formulation, much has been left out in order to avoid overwhelming the reader with too much detail. However, this neglects most of the aspects of finesse and appreciation of nuance that are interesting, and key, to the integrity of the exercise. In doing so, the steps involved risk appearing more simplistic than is the reality. Conversely, in Perry, Cooper and Michels’ (1987) seminal paper on the subject, the writers note that authorial attempts to be inclusive in description and complexity have contributed to the misunderstanding that the construction of such a formulation must, inescapably, be time consuming (Perry, et al., 1987, p. 544). Crucial to the whole enterprise is the core assumption that human living is continually influenced by inner, unconscious, mental activity that is relevant to an appreciation of a person’s outer life. The significance of developmental phases is also critical; that is, how accidents of nature and nurture interact with exposure of the person to the various opportunities and challenges associated with these phases, and shape their personal history. It is important to understand that the case formulation is a flexible process of organizing one’s thinking and material for the purpose of guiding the work of the therapeutic relationship, and does not operate as a diagnosis. “I want to know who they are, not what categories their symptoms match” (McWilliams, 2004, p. 41).

A good dynamic formulation tentatively enunciates an impression of the person’s individual temperament, relationship style, and self-esteem issues; their current problems and stressors in context; a preliminary understanding of their developmental history; the ‘givens’ and unalterable realities which impose upon them; a provisional definition of their defences and identifications; and a picture of their core beliefs and convictions. It encompasses cultural sensitivity (Lo and Fung, 2003), and attempts to hypothesise the meaning and use that the person may make of the therapeutic relationship. The various concepts and frameworks that inform psychodynamic understandings will also suggest the contours of the transference (and counter-transference) possibilities: that is, how this person tends to arrange their connection with another person. This will be manifested in some way in the early interviews; contemporary analysts stress the ‘co-construction’ of the reactions and relational forms that occur in this relationship (Orange, 2004).

Finally, the therapist’s working assumptions about the nature of their client’s difficulties is communicated to the client with due tact and timing. These provisional inferences then become the framework of the therapeutic alliance and the hypotheses contained in the formulation are subject to modification in the light of experience and new information. The sharing of the formulation offers to the client some ideas about how the therapy, on the basis of these cautious suppositions, will attempt to explore and tackle the problems. The requirements and expectations of the working relationship are negotiated with normal care and courtesy.
Anti-therapeutic Notions Rule in Current Mental Health Care

Findings from a recent study report clinical social workers’ concern at not being treated like autonomous professionals. They report experiences of being ‘devalued, denied autonomy, and compelled to obey decisions of “outsiders” whom it feels may be “less knowledgeable” (Probst, 2012, p. 381). Probst observes that clinical social workers find themselves “torn between endorsement of the medical model in order to be paid and reluctance to pathologise problems in living”.

“I feel like social workers are not as skilled as psychiatrists in diagnosing. I do feel unskilled at times when it comes to being really able to catch certain things that I think somebody else who’s more skilled with diagnosing would catch.....When I’m presented with something like that, my tendency is to immediately refer to a psychiatrist. And then get the feedback, rather than me going through the books and trying to figure out exactly what I’m looking at or whether I asked all the right questions. I don’t want to take full responsibility for it.” (Social worker interviewee, in (Probst, 2012, p. 376).

Crowe, Carlyle and Farmar, (2008), in discussing case formulation in mental health nursing practice in the U.S., similarly observe that “mental health nurses often seem to be reluctant to develop clinical formulations as a basis of their care. They seem more comfortable to go along with the descriptive approach of the DSM–IVTR (American Psychiatric Association 1994) rather than employing the interpretive approach necessary for clinical formulation.” (Crowe, et al., 2008, p. 801).

These comments indicate that social workers and mental health nurses may be morally “splitting hairs” in mental health settings, “not wanting to carry full responsibility for endorsing a psychiatric paradigm” (Probst, 2012, p. 372) and defensively rationalizing by over-emphasising social work values such as anti-discriminatory and anti-oppressive practices “as a substitute for a sound practice and knowledge base” (Jones, 1996, p. 190).

Is it possible for social workers in mental health to de-couple their response to ‘naming’ as necessarily blaming? Is it possible to “resist the dichotomizing rhetoric” (McMillen, Morris, and Sherraden, 2004, p. 324) and strengthen social work practice by acknowledging that social work can engage with the problems presented by clients without pathologising them? Truths are often painful but what is true can often be what is therapeutic.

A way forward may be found in the call some social work commentators have recently published for a reinvestment in relationship-based practice and emotional work (Howe, 2008; P. Trevithick, 2003; P. Trevithick, 2011). Due to their training in critical analysis of the social and economic determinants of mental illness, social workers are well placed to aspire to and attain sophisticated abilities in using psychoanalytic knowledge
This paper suggests that abdicating responsibility, perhaps due to the pressures of demoralisation and enduringly lesser professional status, is ultimately debilitating for the profession. Becoming educated about the aetiology and psychodynamic operations of the problems affecting a person’s mental health can expand and support social work expertise. In addition to anti-oppressive perspectives, informed and empathic engagement with the explanatory assistance of psychodynamic understandings can bring greater purpose to the complexities of everyday social work practice in mental health.

Summary

The importance of a stout awareness of both strength and weakness in clinical work with mental health issues has been emphasised in this paper. A certain level of rigorous honesty is involved in this kind of ‘take’ on human living. It is suggested that an additional basis for psychological and ego strength is potentially available to the client through the therapeutic work when complex understandings are sensitively sought, and organised through the development of a psychodynamic case formulation. Psychoanalytic ideas about mental life, it is proposed, are valuable when adopted from a scrupulously anti-oppressive standpoint. Some elements of the basic structure of a good psychodynamic formulation are outlined, and their potential for adding supplementary depth to social work’s holistic approach to clinical practice is claimed. The pejorative implications for clients that are associated with psychiatric diagnoses and nomenclature are acknowledged, as are the demoralising power deficits and professional status insults for social workers in mental health settings. It is reasoned that the frustrations of being professionally demeaned in psychiatric power hierarchies are significant, but it is unhelpful if this leads to avoiding responsibility for theoretical knowledge, clarity and courage.

References

Non-Violent Engagement with Weakness: For Stronger Mental Health


How to Reach Your Inner Self—
A Tantric Yoga Perspective

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ABSTRACT
Through the centuries, the subcontinent of Asia has gone through invasions, immigrations, climate changes, economic fluctuations, slavery and leadership; breakdowns and breakthroughs and it has endured, unlike many cultures, like the Roman, Egyptian and Greek civilizations.

This capacity to tolerate came about because of specific psychological and therefore social advantages. In the East, especially in the Indian subcontinent, the Concept of Dharma was part of the Collective Consciousness. Whether one could live by its tenets or not, it was respected, and people who upheld it in their personal lives were revered and hailed as leaders of the tribe that needed strength to sustain its more vulnerable members and at the same time, continue a way of life that remained unchanged at its core, of providing justice to all.

Dharma could be flexible. The word comes from “DHR” which means to hold together. It was flexible to adapt to different situations but did not compromise on its essence. There was Swadharma—that which held the individual’s physical, psychological dimensions in health and harmony; Kula dharma—the ingredients that went into keeping the integrity of the tribal group; Rashtra dharma, the nation’s integrity, and finally, Sanatana Dharma, the sustenance of all Existence.

This is helped by the Yamas or personal Yogic Value systems. Yogic techniques helped in giving up Adharmic Values, understanding the sources of one’s disharmonious thoughts and actions and dissolving them at source.

This presentation will discuss the weakening of these values; understand their breakdown at source and their healing, in restoring Dharma from a Yogic Perspective.

Keywords: Yoga, Tantra, Dharma.

Introduction
Yoga and Tantra deal with the science of the body and mind and Spirit. Both are sister disciplines and include a philosophical framework for understanding the working
of the mind as well as practical techniques to help each one of us experience and transform the deeper dimensions of our psyche. Yoga and Tantra aim at the wholeness of a person. They give us methods to integrate all human possibilities—of body, mind and spirit—in a meaningful and joyful way.

The Caregiver/Caretaker
Whenever we are working to help others, especially those who are emotionally unwell and who need tremendous support then even professionals can become tired or drained. Social workers, doctors, psychiatrists, nurses, teachers and voluntary health workers need a means of drawing from their own deeper sources of energy and replenishing themselves. Working with the psychiatrically ill is also to see within ourselves our own inner difficulties with relation to our personal lives as well as in the professional set up. Helplessness, frustration, inadequacy in the face of chronicity of symptoms, manipulative behaviour or apathy of the patients' needs to be dealt with the caregiver/caretaker has to have great personal honesty, a clear sense of values, integrity and compassion all of which arise by facing and working with the negative and positive nature of our own deeper psyche.

Yoga and Tantra
Yoga comes from the word “Yuj” which means “to Yoke”. It refers to the yoking of the finite individual mind with its essence, the limitless Super Conscious Self.

Tantra comes from two words “Tanoti” meaning “to expand” the mind and “Traayati” which refers to ‘liberation’ of consciousness from its finite state.

Both Yoga and Tantra refer to the same state of consciousness in this context.

Yoga describes six dimensions (shareeram—from “sheeryathe”—which means, ‘that which is prone to decay, or transient’—refers to a body, a dimension, a field: e.g.; a body of water) of being in an individual.

1. The physical and physiological dimension—Sthoola Shariram (concrete, material, gross)
2. The emotional dimension—Bhaava Shariram or Sookshma Shariram (subconscious mind—that holds feeling, emotion, sentiment)
3. Intelligence dimension (not intellectual)—Kaarana Shariram (unconscious mind—the causal body—the repository of cultural beliefs which are the reason we act in ways that we do not understand by reflection. It contains old conditioning because of which certain behaviour patterns happen
4. Intuitive dimension—Deva Shariram—[The word Deva means illumination and refers to the illuminated mind]
The perfected mind Which is in tune with the collective?

5. Pure Awareness not limited by body and mind. This dimension is the witness of all that happens in the above four Dimensions

6. Cosmic Consciousness—Brahma Shariram [from Brhad meaning expanding, large]

7. Super Consciousness—Para—beyond the known 6 dimensions

*India’s cultural heritage has a unique quality. All Sciences were interlinked and all worked for a holistic purpose—that of health and happiness for the individual, peace and prosperity in Society and well being for all sentient beings. Long before Sperry and modern research established the differences between the left and right brain functions, the ancient texts spoke of the Manas [internal organ of perception and cognition], the Buddhi [discrimination, judgement, intelligence], the Chitta from cittam—to be visible as being the repository of all memory, and the Ahamkar [sense of self or ego]. These are in today’s language put together and given a single name “Mind” Before we go into the meaning of inner strength and its ramifications it is worthwhile exploring the source of ethics. Scientific India has spoken of these 6 dimensions of Consciousness.

Dharma

From the word “DHR” means that which holds these dimensions, both individually and together in a harmonious Whole. That which is transient, ephemeral and prone to decay is called a Shareera or a dimension or field. There are 7 Shareeras and they are manifestations of energy in various vibrations of different intensities, permutations and combinations. Just as electricity can create light in a bulb, cooling in air conditioners, heating in geysers and wind in the rotation of fans, the energy that fuels, and sustains instincts, thoughts, emotions, intuitions, both in the individual’s inner world and in the world around him is one and the same and is called Praana. When Prana changes its vibration, and stops manifesting in the material Shareeram or physical body we say the individual is no more just as when a bulb fuses or a generator blows up we say there is a power cut. However electricity can be regenerated, because it has not really disappeared. It has just stopped being in that manifestation. In the same way, Prana is not lost when an individual’s body or Stula Shariram stops “being alive”.

This then, the Sthoola shareeram, is the first dimension or the grossest vibratory mode of Prana expressing itself as the physical body and all its functions of breathing, cellular exchanges, circulation, autonomic, hormonal, muscular, procreation, destruction, defence mechanisms, etc. Dharma begins here.
The next dimension is the Sooksha Shareeram or the field of the subconscious, thoughts and emotions. Since all dimensions are expressions of the same Prana but of different vibratory intensities, they influence each other constantly. The Sukshma Shareeram can be accessed in that we are aware of our superficial feelings and emotions which have an impact on our states of health, illness, immunity strengths and weaknesses and naturally our idea of what is right and what is wrong on a very superficial plane.

The third dimension is the Kaarana shareeram, the cultural and genetic component of the individual’s life. Here is where the deepest value systems are embedded. This area is responsible for psychologically linked chronic illnesses, psychotic breakdowns, allergic disorders, many forms of cancer and turmoil both within the individual and in society as a whole. The conditioning of the cultural past is responsible for our biases, prejudices, and preconceived notions that turn our world upside down without us being aware of its power. Dharma here becomes subtle. This dimension can be accessed only through meditation under guidance.

Then there is a dimension called the Deva shareeram or the Collective consciousness where our thoughts and feelings of the present influence all of us. Thus we see nations get empowered around the same time, being prosperous around the same time, families breaking down, civic society in unrest, individuals breaking down all around the same periods in history even when we did not have the technological means of communication with each other. The Dharma of different societies or cultures may change but the basic sense of stability, security, permanence, fears and reassurances remains the same. When challenged we go deep down and depending on the balance between our fragility and flexibility, we either breakdown as a society or make a breakthrough. When it is a breakdown, the culture collapses and when it is a breakthrough the culture forges ahead influencing other societies and nations. The contents of these four Shareeras are what constitute the storehouse of information that an individual reacts to and is called the individual Consciousness or the Chitta.

The rational, verbal, linear, sequential, analytical and mathematical left brain functions are referred to as Manas and are by and large the function of the second and to some extent the third dimension.

The intuitive, image oriented behaviour, synthesising in nature and discriminatory in action, the right brain functions are called as “Buddhi”.

The higher dimensions of the Super Conscious realms are three and will not be dealt within this lecture for want of time.

Dharma is a word which has no English equivalent and comes from the root as mentioned “DHR” which means “to hold”. In our dealing both with ourselves and with our fellowmen, whatever that relationship be, personal, or professional, dharma will
determine if that relationship will remain intact, be empowered or crumble. Dharma is interlinked with another term “Satyam” Like the word Truth which is often interpreted as a Fact, Satya does not mean factual information. Satyam and Truth refer to that which is Permanent and does not decay in time and space unlike a Shareera. It is Prana in its highest manifestation as the Whole—Poorna—that which endures. It refers to that Consciousness that Mystics have experienced where they are in harmony within and without, and therefore were in health and at peace. Any thought, act or word that raises one’s Consciousness and therefore the other, is in tune with Satyam.

Dharma which is wedded to Satyam sustains all creation, from its subatomic levels to the Super Conscious ones because India believes, as do all Mystics whatever their faith or religious belief, that all creation is one with myriad faces. If one part of this totality is hurt the whole is hurt. When we do not see this wholeness we see the unfamiliar as the enemy and are afraid. Our fear makes us defensive and this leads to confusion, both at the individual and group level, whatever that group may be. Confusion makes us behave in ways that are influenced by the Sookshma, Kaarana and Deva dimensions of consciousness which are by their very nature, limited, rigid and suffering oriented. If the Physician can be tuned to the Dharma of the whole, through fine tuning his own Buddhi, one becomes spontaneously ethical, knowing the needs of the other and placing one’s own interest to the side, a situation that is defined by the word “Integrity” or Asteyam. The Healer is loved and respected, therefore sought after, becomes an asset to society becomes efficient, effective, sensitive and being integrated within himself, becomes a seamless continuum of the patient, his family and the society in which he lives and is able to give the other what he needs, not necessarily what he desires. This becomes therapeutic. Doctors were revered, as the quality of the divine or whole working through their hands helps in treating the whole individual and his family and not just his liver, kidney or heart. In understanding his own weaknesses, acknowledging and accepting himself, the doctor learns to be non-judgemental, compassionate [Anukampana = vibrating with] with regard to the weaknesses of his patient, be it physical or mental. In learning that it is possible to go beyond one’s limitations the doctor learns how to empower himself and in the process empowers his patients into being healthy and the individual in turn helps a society become healthy, physically and mentally.

Such doctors in India were called Vaidyas, those whom knew [“VID to know”] and in knowing, were wise and caring. They were said to have, in local parlance “Kaiguna or Kairasi”, Healing Hands or Blessed hands. We are all of us like radios that are at different tunes tuned to different stations. While awake we are tuned to the 1st dimension although we are in contact with all other states of consciousness. While in the Dream State we are tuned to the 2nd and in deep sleep with the 3rd. With meditative techniques, we reach into the 4th dimension of consciousness. When meditation happens, the one is tuned to all these states, simultaneously. We are aware of all dimensions within ourselves and within others, because then we are part of the collective unconscious.
Tantra, on the other hand talks of the same states, but much more picturesquely.

All consciousness is enlivened by the Prana or vital life force. Prana flows or streams through all matter. These streams of vital life forces are called Nadis[from Nad which means to flow]. Wherever two or more Nadis cross each other there is a whirlpool of energy and this whirlpool is called Chakra[circle]. There are therefore millions and millions of Chakras in the universes. Those that pertain to the dimensions of consciousness in the human being—the important ones that confirm to the Shareeraras of Yoga are are called as mooladhar, swadhishtha, manipura, anahata, vishudhhi, ajna and sahasrar from below upwards and they are represented in images that are called “Yantras” and are quite self-explanatory. These pictures with their associated qualities of consciousness will be discussed in the conference.

Prana or the life force vibrates with different intensities in different chakras and manifests as 3 qualities or Gunas [qualities]. Tamas is Inertia. Rajas is activity and Sattwa is balance. These exist in all planes of Consciousness in creation as permutations and combinations, constantly changing, constantly moving and impacting one another as all things are, in essence, an unfragmented whole.

The gunas give an individuality to all beings. Thus a stagnant pond, an economy in recession, a failed, violent or perverse relationship, an ignorant stubborn or rigid person, a lazy or unmotivated person low in self-esteem are all classed as predominantly Tamasic. An ambitious dynamic person, a flooding river, a forest fire, a cyclothymic personality, a country going through a vibrant economy is all predominantly Rajasic. A wise selfless person, a stable economy which provides for all individuals contained within its scope, a river that flows tranquilly enriching lands along the way are predominantly Sattvic. A person can be Tamasic, Rajasic or Sattvic at different times. These changes create loss of concentration, a lack of focus on that which is truly meaningful and cause restlessness and suffering as a consequence.

Karma and Dimensions of Consciousness

They are a result of “Karma” the certain consequence of acts done earlier, in other words ‘momentum’. All desires create actions which decide destiny as a consequence of that desire. The momentum of a past conditioning [Baggage in lay terms] creates an expectation, followed by a desire, anger, frustration when one is denied gratification and this impacts the various dimensions of Consciousness. The therapists as well as the patient both have the body, emotions, intelligence, intuition, psychic qualities and the capacity to witness the totality. The therapist therefore to be really effective has to be able to go into all these various dimensions. In confronting his turmoil and channelling them positively he would be working at 2 levels—his own individual liberation from limitation and that of contributing to the well-being of the collective unconsciousness.
Every emotional disturbance is mirrored in the physical body. When a therapist feels hostility, rejection, anger, and frustration with a patient, not only is it reflected as body language but it also has an impact on the nervous system, hormones and immune system of the therapist and in the community at large through the collective unconsciousness. In the long run, if not handled healthily, it can lead to a ‘burn out’ situation. Yogic techniques help the therapist transform negativity into positive energy, both in himself in his patients and in community at large.

**Aasana [a particular mode or posture of sitting]**

These are body postures and movement that work deep in the body, regulating the endocrine and autonomic nervous system thereby allowing the therapist to deal with his turbulence in the comfort of a relaxed internal environment. One learns to understand and respect the tremendous resources of the physical body in helping the mind grow through its negativity. Strong or threatening emotions like fear and hopelessness, and anger can be “grounded” through the practice of Asanas. Emotional energy is redirected into the body where it can be recognised and discharged safely. Dynamic Asanas are simple movements repeated rhythmically many times. They set in motion stagnant energy, physical and psychic.

**Pranaayaama—[Prana—Life Force Aayama—Lengthen]**

Prana is vital energy. The various techniques of renewing, recharging and rechanneling prana are called Pranayama. The body and mind share the same vital energy or Prana. Prana expresses itself in 3 ways. Inertia, Movement Harmony respectively called Tamas, Rajas and Sattwa. When Prana is low or stagnant *i.e.* Tamasic, the individual is low in motivation, exhausted, lazy, dull depressed. When Prana expresses itself as movement, Rajas, the individual is active, dynamic, swayed by emotions. When the quality of Sattwa predominates, the individual is clear, tranquil and at peace with himself, therefore more effective. Various techniques to help tamas move into rajas and further into a sattvic state are available. When the practice of dynamic asana, which aids rajas, is linked with breathing practices like “Brahmari [the bumble bee]” and “Nadi shodana pranayama” [cleansing the nadis]”, the quality of activity becomes action. Through the practice of simple breathing techniques, turbulent emotions can be soothed, the mood lifted. A sense of optimism and well being helps in dealing with low morale. It defuses an upset before it becomes a crisis. These practices should be made a part of a therapist’s day to day repertoire of handling personal emotions. The breath then becomes a powerful tool of focusing the mind and temporarily breaking negative cycles of thinking. Conscious rhythmic breathing here is used to enhance energies, and provide greater mental clarity. The individual now becomes not just active but a man of action because the activity proceeds from centeredness.
Meditation

Although the practices of meditation are not used for deeply disturbed or unstable personalities, a therapist can use them for his/her own greater inner clarity. It then helps and becomes an essential part of his or her repertoire to remove deep seated attitudes and complexes that are not amenable to other techniques and which are responsible for negative patterns of reaction. Meditative practices therefore should not be experimented upon from books but learnt from a mature teacher, this can help the individual handle the anguish of watching his/her own inner storms before energy is transformed.

Emphasis

Yoga and Tantra techniques are for raising the consciousness of leaders of society so that they may in turn inspire and influence the Dharma of the whole. Awareness is Yoga. A mindless performance of body movements and breathing techniques however well executed is not yoga. One does not fight with the mind when it wanders. One brings it back to the practice of the moment again and again. This being in the moment is the beginning of serenity as all suffering arises because of dwelling in the past or future—in wallowing in past regret or greed for the future perceived pleasures.

Practising Together

It is worthwhile for the therapist to practice asanas and pranayama along with the patients, for family members to practice together and members of society to practice together. This allows the vulnerable, a chance to develop a greater social confidence and thereby helps in bringing up one’s inner and dormant strengths. In turn the stronger one feels empathy with the patient and indirectly removes his own sense of emotional isolation from the person he is trying to help.

Everyone Faces Difficulties

It is not realistic to expect that therapists or leader have no problems, no negative emotions and will never need to face a crisis. What is important is to have a technique and a philosophy that will help weather a storm when it arises. Yoga fulfils this necessity. It helps us see disrupting patterns and work out healthy ways of coming to terms with limitations and aspirations. It helps us to make contact with the goal of the inner spirit—which of being authentically human rather than deceive ourselves with false images of being supermen and superwomen. Eventually the role of the Individual is one filled with the struggle of inner exploration, which is rewarded by the discovery of the fulfilled whole person—body, mind and spirit. This is the promise of Yoga and Tantra.
References


The Mind Body Connection: Indian Philosophy and Culture for Holistic Interventions in the 21st Century

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ABSTRACT
This paper examines the Indian philosophy and cultural thoughts based on the Bhagavad Gita and their relevance for strength-based interventions in the 21st century. During much of the 20th century, mental health practice has been dichotomized: either following the Freudian psychoanalytical school of thought or developing alternative modes of interventions. Freud mainly focused on the repressed unconscious thoughts. He promoted detached approaches of mental health therapy to ensure objectivity. Since Freud, numerous theoretical models emerged in response to his deficit-model. However, long before neo Freudian intervention frameworks and other contemporary models were developed, in India there was an existing body of knowledge that was centuries old which centered on understanding the strength-based or positive dimensions of human behavior.

Introduction
From ancient times the Indian scholars have stressed the importance of the mind-body connections. To be a happy and content individual one has to achieve peace at both levels. The Bhagavad Gita is India’s famous sacred text of religion and philosophy. It contains the teaching of the major forms of Yoga; each of which contribute to the benefits of physical, mental, and spiritual health of a person. The Gita is a literal dialogue between the Lord and his disciple. Figuratively, this dialogue explores how individuals gain insight on the consequences of their behaviors and recognize what is right and wrong. Raja Yoga, one of the four methods of Yoga, assists individuals to discover how their mind and body are inter-connected through introspection. This method postulates that the mind is the instrument itself to observe the internal world of human beings. The Bhagavad Gita and Raja Yoga promote the positive aspects of human behavior and interactions with their environment. They emphasize a direct interaction and identification of each individual’s strength under the guidance of a teacher/guru/therapist. Thus, in the context of mental health interventions, the
The therapist must play an active role in supporting the individual as he/she copes in his/her environment. The interplay between individuals and their environment is central to the holistic approach of change. In this paper I will explore

- The major tenets of the *Bhagavad Gita*
- Their relevance for strength-based mental health interventions within a given society for its constituent members representing diverse cultures; and
- The importance of this approach for the 21st century.

This approach does not dichotomize the mind and body; it emphasizes the holistic configuration of individuals and the environment. I need to clarify that by no means have I claimed to be a scholar of Hindu religion or Indian philosophy, but as explained below, in recent years I have been actively involved in understanding these areas through not only from readings but also through long visits to India on a regular basis involving volunteer work and spiritual activities.

**Personal Struggle and Journey**

Before I discuss my paper I want to request you to bear with me while I briefly sketch out my life history and how over the years it has shaped my personal convictions and beliefs in developing my personal and professional self and identity. As we all know developing self-awareness and insight is an uphill battle. Most of us choose our profession not simply for altruistic reasons but also a way to understand ourselves better and try to resolve or at least understand our inner conflicts and find a way to take care of our own “Unfinished Business.” I left India fifty two years ago as a way to escape my life struggle of that time and also to prove that I was not a failure. Prove to whom? For a long time I thought it was my late father who was the source of all my problems. But over the years after many and different modes of therapy I have without a doubt learned to assume my own responsibility and accept that I was and I am my own captain of my destiny.

**Fast Forward**

The only option for me to escape from my internal turmoil was to go as far away from home as I could and I landed in Boston at the age of twenty two. I entered the Boston University School of Social Work in their clinical concentration. With my *Karma* and unexpected good fortune I met Dr. Eric Lindemann, the Chairman and Professor of Psychiatry at the Harvard University Medical School who offered me a Research Assistantship funded through a grant he had received from the World Health Organization. The expectations for this position was that I had to do my second year social work internship in the Department of Psychiatry at the Massachusetts General Hospital, plus I had to staff a working committee on cross-cultural understanding for setting up a child guidance clinic in India. This committee was composed of many
renowned scholars in mental health of that time. The committee, which met twice a month, provided me with a golden opportunity to work with these giants in the field. With this experience coupled with my internship I was beginning to be rooted in the psychoanalytic school of thought. During this period, as was expected of all beginning clinicians, I entered therapy. My therapist was non-directive and was oblivious of my cultural background. After struggling with free association and ventilation for months I took the bold step to end my therapy. Of course, my therapist was very unhappy and was quick to point out my resistance was mainly due to issues of transference.

After quitting psychoanalytic mode of therapy my internal turmoil was heating up. During that period I was introduced to Gestalt Therapy. I extensively read Gestalt Therapy literature, participated in numerous workshops and experiential seminars and received personal counseling. After six years of active involvement in Gestalt Therapy both on personal and professional levels my own work began to incorporate the philosophy, principles and techniques underlying this modality. But, even after participating in numerous intensive Gestalt Therapy and other experiential modes, I felt something was missing and so I spent many summers at different institutes and Ashrams in India to learn and understand the human behavior as discussed in the Hindu texts including the Bhagavad Gita. I became convinced how much of the contemporary schools of counseling and Psychotherapy is similar to the teaching of the Gita. For example, we will see how the individual who is depressed and anxiety ridden is assisted in his present context to mobilize his inner strength to restore his equilibrium so that he could decide to take the correct course of action.

Major Tenets of Bhagavad Gita

I must confess that any attempt to summarize or offer the basics of this ancient Hindu scripture, the Bhagavad Gita is not only an arduous but a presumptive undertaking. Nonetheless, scores of scholars from all over the world have presented and discussed their own views and thoughts about this great work. Hinduism is more of a way of life or philosophy of life and is not dogmatic and prescriptive. The teachings of the Bhagavad Gita are open to be discussed and dialogued without objections from any source. This ongoing intellectual and academic discourse continues to add depth in understanding the old as well as the new interpretation of this classic work for understanding human behavior. According to Ranganathananda (1971) “There is an instant demand for a philosophy of life which requires no submission of the hard-earned critical faculty in man. To such minds, the Bhagavad Gita brings a message of hope and assurance. In fact, its message is fully significant precisely because it offers such a philosophy of life” (p. 80).

The Bhagavad Gita, comprising of eighteen chapters, is one of the sections of the Mahabharata. The Mahabharata is one of the major Sanskrit epics of India. It is a story
of the Battle of Kurukshetra where two sets of cousins—the Kauravas and the Pandavas wage war against one another. These chapters are based on the dialogue which takes place on the battlefield between Lord Krishna and the famous warrior-prince Arjuna, belonging to the House of Pandavas. As the two sets of cousins are about to wage war against one another, facing the Kauravas who were full of greed, anger and hatred, Arjuna becomes confused, agitated, depressed and develops inertia to fight his own kith and kin. Krishna, the divine within and who is Arjuna’s charioteer inspires him to mobilize his strength and prepares him to bravely fight the evil manifested in the Kauravas. Krishna’s discourse is delivered in simple language but the meaning is very deep and relevant for all mankind and as such it is a universal scripture. Arjuna’s hesitancy to engage in the fight is attributed to his attachment and relationships with his cousins, uncles and teachers. The eighteen chapters of the Bhagavad Gita fall into three sets of six chapters each. Each of these three groups emphasizes three types of yoga: Karma (Selfless Action); Bhakti (Devotion); and Jnana (Self Transcending Knowledge). The first six chapters deal with Karma Yoga which is the means to the final goal, the attainment of Jnana. The middle six chapters deal with Bhakti or devotion. The philosophy of Knowledge fulfills the intellect; the philosophy of the Action accomplishes the will; and the philosophy of the devotion satisfies emotion. Knowledge, Action and Devotion cannot be divided into specific single units (New World Encyclopedia, 2006). But, as the focus of this paper is on understanding the behavior and bringing behavioral change in the people with whom we work specific focus is given to the first six chapters of the Bhagavad Gita which deal with Karma Yoga.

The interpretation and my discussion of the Bhagavad Gita are based on the works of: Desai (1946); Chinmayananda (1976) and Sivananda (2003). The essence of the Bhagavad Gita is beautifully captured by Swami Sivananda (2003) who says that the major emphasis of Krishna’s discourse is that one should cultivate an attitude of non-attachment or detachment. Attachment is due to infatuation and is related to the quality of Rajas, which in the Samkhya school of Hindu Philosophy is action, passion, excitement and unlike in the quality of Sattva it does not have the same degree of calmness, purity, clarity and total touch with total reality. Swami Chinmayananda (1976) clarifies that Krishna’s saying to Arjuna in the Bhagavad Gita as “He who does actions, offering them to Brahma, abandoning attachment, is not tainted by sin, just as a lotus leaf remains unaffected by the water on it (Bhagavad Gita V:I0, p. 301). This process which is enacted at every moment all around the world is further simplified by Chinmayananda in the following statement: “A doctor’s attachment to his wife makes him incapacitated to perform an operation on her, although the same doctor, on the same day may perform the same operation upon another patient, towards whom he has no self-deluding attachment” (p. 303).

According to Mahadev Desai (1946) “The Samkhya philosopher Kapila who introduced the Samkhyan concepts making provision for both matter and mind, started with
two eternal principles, one conscious, unconditioned, and passive, the other unconscious, but active and manifesting the operation of not one law, but three: or if we may say so, a triple law evidencing not only the struggle for life, but the stage before that, namely inertia, then the struggle for life, and lastly the struggle for life of others or sacrifice” (p. 21). Desai goes on to postulate that evolution of the manifested universe out of this unmanifest prakriti or Nature arises as a result of the disturbance in the equilibrium of its three constituents. These constituents referred to as gunas or strands which compose the string of prakriti which includes satva, rajas, and tamas.

“...the sources respectively of existence, of motion, and inertia, their functions being light, activity and restraint. They are, however, not mutually contradictory, and they exit together, in fact are never separate; they slip into one another and intermingle with one another. As soon as their equilibrium is disturbed, prakriti begins to evolve and whatever evolves bears an impression of these constituents (Desai 1946, pp. 21–22). Prakriti or nature and through its intelligence the universe exists and functions. The Bhagavad Gita emphasizes prakriti as a fundamental constituent and without it there can be no activity or creation, and the three gunas namely satva or creation, rajas or preservation and tamas or destruction the universe cannot exist (Yogananda, 1973).

Desai (1946) compares Plato’s division of human behavior into three main sources—desire, emotion and knowledge, which seems to be recognition of three gunas in another name.

Dharma is frequently translated as a religious code, as righteousness, as a system of morality, as duty, as charity, etc. But according to Chinmayananda (1976) Dharma means “the law of being” meaning “that which makes a thing or being what it is.” For example the Dharmas of the fire to burn, of the sun to shine, etc. Chinmayananda goes on to clarify what Dharma means in the context of the Bhagavad Gita it is “not merely righteousness or goodness but it indicates the essential nature of anything, without which it cannot retain its independent existence. For example a cold dark sun is impossible, as heat and light are the Dharmas of the sun. Similarly, if we are to live as truly dynamic men in the world, we can only do so by being faithful to our true nature and the Geeta explains to me my nature” (p. 12). Dharma is a principle which maintains the stability of society. It stands for moral law and it is a socio-ethical principle (Ganapathy, 2004). The one hundred evil brothers the Kauravas represent the numerous negative tendencies within a human being and the Pandavas represent the divine and positive features in the same individual. The Mahabharata war manifests that the internal conflict is constantly occurring within all of us when the large number of negative tendencies within us which are mightier and larger in number want to take a wrong course of action which is shorter and easier than the smaller number of positive and divine features. The reason for Arjuna’s conflict and anguish is due to such struggle between these two inner tendencies.
Among the scholars on Hinduism a theory is accepted as a philosophy only when the scholar espousing the theory also prescribes a practical technique by which all seekers can come to discover and experience for themselves the GOAL proposed in that discourse. Thus, in all Hindu philosophies there are two distinct sections: one explains the theory and the other describing the techniques to practise. The portion that explains the technique of living that particular philosophy and coming to a close subjective experience is called *Yoga Sastra* (Chinmayananda, 1976).

According to most major scholars of the *Bhagavad Gita* the second chapter of this volume can be taken as an epitome of its entirety. The first ten verses explain the circumstances under which Arjuna totally surrenders to Lord Krishna’s guidance. From Verse 11 to 46 the underlying thought of the *Sankhyan* philosophy is presented and in the verses from 47 to 60 the “Yoga of Action” is adumbrated, and the remaining 12 verses focus on the Path of Love or the *Bhakti Yoga* (Chinmyananda, 1976, p. 45). Mahadev Desai’s (1946) articulation of the *Sankhyan philosophy* in the following lines gives us the insight of this monumental epic. “By reason of delusion, man takes wrong to be right. By reason of delusion was Arjuna led to make a difference between kinsmen and non-kinsmen. To demonstrate that this is a vain distinction, Lord Krishna distinguishes between body (not-Self) and *Atman* (Self) and shows that whilst bodies are impermanent and several, *Atman* is permanent and one. “Effort is within man’s control, and not the fruit thereof. All he has to do, therefore, is to decide his course of conduct or duty on each occasion and persevere in it, unconcerned about the result. Fulfillment of one’s duty in the spirit of detachment or selflessness leads to Freedom” (Desai, 1946, p. 145). The Lord says to Arjuna, “You have grieved for those that should not be grieved for; yet, you speak words of wisdom. The wise grieve neither for the living nor for the dead” (II:11 *The Bhagavad Gita*).

The *Vedantic* philosophy of India is taught as free discussion and dialogue between the *Guru* and *Chela* (student). In no other religion in the world do we find this much freedom given to the students to openly discuss and debate with their teachers. In the beginning Arjuna is determined not to fight his kinsmen. He is ready to renounce everything and become a *Sanyasi*. He is a victim of his own delusions, illusions and hallucinations and as modern psychiatry would define him as psychotic. He is constantly seeking confirmation from Lord Krishna that he is not a coward and on the other hand his noble decision to not fight needs to be applauded, appreciated and supported. But unfortunately, his friend philosopher and guide is nowhere close to providing such validation and so Arjuna continues to believe that to fight against his cousins, teachers and elders is a terrible course of action. Krishna clearly explains the two paths of self-development for the world—the “Path-of-Knowledge” to the Meditative, and the “Path-of-Action” to the Active. (Lord Krishna for the first time giving us a glimpse of divinity, and the careful prescription of the existence of the different two paths for two different types of men from the very beginning of creation, Chinmayananda,
“Never does man enjoy freedom from action by not undertaking action, nor does he attain that freedom by mere renunciation of action” (III: 4). The mere renunciation action or taking *Sanyasa* is not the way to attain perfection. The Lord realizes that an ordinary man like Arjuna would not know how to save himself from the natural instinct and therefore he prescribes the following verse: “But, whosoever controlling the senses of the mind, O Arjuna, engages his organs-of-action in *Karma Yoga*, without detachment, he excels” (III: 7).

*Karma* means action or deed. Any physical and mental action is *Karma*. It is the sum total of our acts, both in the present life and preceding births. It is also the result of an action. The consequence of an action is not a separate thing. It is part of the action and cannot be divided from it. As a man sows, so he shall reap. *Karma* expounds the riddle of life and riddle of the universe. It brings solace, satisfaction and comfort to one and all. Westerners are increasingly accepting of this dimension of the Hindu philosophy. The Doctrine of *Karma* only can explain the mysterious problem of good and evil in this world. It solves our difficulties and problems of life. It gives encouragement to the hopeless downtrodden. It pushes a man to right thinking, right speech, and right action (Sivananda, 2003).

*Karma Yoga* is selfless service unto humanity. Action of some kind or the other is unavoidable. You cannot keep quiet without doing anything. *Karma* is binding when it is done with selfish motive, but when action is done without any expectations it is liberating. The practice of *Karma Yoga* does not require any wealth except for you to serve with your mind and body and you need to be free from lust, greed, anger and egoism. You should have a large heart, and have an amiable loving social nature (Sivananda, 2003). Is this not we would expect from a competent therapist? Lord Krishna tells Arjuna “Renunciation and performance of action both lead to salvation; but of the two, *karma yoga* (performance) is better than *Sanyasa* (renunciation)” V: 2.

According to the teachings of Hindu philosophy spiritual process of self-evolution fall into three stages: (a) desire-prompted activity, (b) self-less dedicated activity and (c) quiet meditation. Here we must understand that the Lord is not decrying renunciation as inferior to vigorous activity. But the state in which Arjuna is the best treatment is performance of action (Chinmayananda, 1976, pp. 2902–91). Before adopting the path of renunciation one has to conquer the self and be in control of all his senses. “When a man is not attached either to the objects of sense or to actions and sheds all selfish purpose, then he is said to have scaled the heights of yoga” VI: 4.

*Raja Yoga*

*Raja Yoga* is the king of the Yogas. It concerns directly with the mind. In this Yoga there is no struggle with the physical body. It is the Great Sage Patanjali who
formulated this science into a definite system under the name of \textit{Ashtanga Yoga} or \textit{Raja Yoga}. This form of Yoga is an analysis of the mind gathering the facts of the super-sensuous world and so building up the spiritual world. It is the highest way form of Hindu way of life. It teaches people how to concentrate and to be in touch with their power. When you try to practise concentration, the mind seems to be concentrated but gets distracted often. But with prolonged and repeated practice of concentration again and again mind becomes one-pointed. Later on it is fully controlled (Sivananda, 2003).

Concentration of the mind is the source of all knowledge. \textit{Raja Yoga} teaches us to make matter our slave. As it ought to be! According to this form of Yoga the obstructions to perfection are fundamentally the agitations within the mind-stuff. Outer nature is then perceived to be only manifestation of inner nature. Perfection in \textit{Raja Yoga} is the cessation of the agitations which obstruct the attainment of complete control over nature, inner and outer, individual and cosmic. Perfection it means the attainment of that state of consciousness in which there is no bondage, no limitation, no imperfection of any kind (Vivekananda, 1973). This form of Yoga also is explicitly prescriptive in how to overcome obstacles to meditation such as doubt, laziness, illusion, carelessness, etc. It stresses the importance of austere and disciplined lifestyle. It emphasizes analyzing one’s thought and motives and foregoing some of the objects your mind likes. When the craving for these objects is vanished then you are in control of your mind you are its master. In this form of Yoga the sitting posture, restraining the breath, turning the mind inward and concentration on one subject are the other important features.

\textbf{Holistic Interventions}

Two contemporary models of interventions, \textit{Strengths Perspective} and \textit{Gestalt Therapy} are examined to see how they are similar to what has been advocated by the \textit{Bhagavad Gita} and \textit{Raja Yoga}.

\textit{Strengths Perspective}

Saleebey (1997) one of the early proponents of this model stresses the need for early interventions for helping the clients to discover and embellish, explore and exploit their strengths and resources in the service of assisting them to achieve their goals, realize their dreams, and shed the irons of their inhibitions and misgivings. This collaborative endeavor depends on clients and workers to be purposeful agents and not mere functionaries. It honors the innate wisdom of the human spirit. This perspective advocates the worker to mobilize client strengths which include talents, knowledge, capacities and resources, for achieving the goals and visions so that the clients will have a better quality of life on their terms.
Saleebey (2013), in the latest revised edition of his book, enumerates the major concepts underlying this perspective and they are:

- **Empowerment**: It indicates the intent to, and the processes of assisting clients to discover and expand the resources within and around them. It is assumed that the strengths of individuals and communities are renewable and expandable resources.

- **Membership**: Most people want to be responsible, recognized, and valued members of a community. Without membership is to be in a dangerous position. The condition of alienation is tragically quite common for many individuals and groups and due to this they are marginalized and oppressed on a daily basis. It is important to be aware of the fact all of us are entitled to the dignity, respect and responsibility that comes with such membership.

- **Resilience**: It is a fact that people do rebound from major dilemmas, that individuals and communities do surmount and overcome serious and troubling adversity. It has been documented that particularly demanding and stressful experiences do not always lead to inevitability and vulnerability.

- **Healing and Wholeness**: Healing implies both wholeness and innate resource of the body and mind to regenerate and resist when faced with disorder either physical or emotional. Of course, for proper healing to occur there is a need for beneficent relationship between individuals and their larger social and physical environment.

- **Dialogue and Collaboration**: Dialogue implies empathy, identification with, and inclusion of other people. A caring community with love, humility and faith promotes open dialogue and in turn empowers its members. Collaboration requires being open with our clients and where both parties listen to each other and a mutuality of goals and means to achieve them are arrived at.

- **Suspension of Disbelief**: The worker needs to be open and listen to the clients without bias and avoids making value judgment. Clients’ belief systems based on their cultural norms and customs needs to be respected (Saleebey, 2013, pp. 11–17).

**Gestalt Therapy**

Developed by Fritz Perls (1947) and refined by subsequent generations of theoreticians/therapists after him, Gestalt Therapy is existential, present-centered and attentive to those processes which inhibit contact with other human beings and awareness about self and surroundings. The gestalt view of the world is organismic. The aim of Gestalt Therapy is for the client to discover alienated fragments of self, to restore a sense of wholeness, and to experience as fully as possible awareness of self and everything in the environment. It was through Perl’s genius that the wide range of diverse concepts was amalgamated into a therapeutic mode called Gestalt Therapy. The term itself *gestalten* is a German word which means whole entities, beings, and configurations. Dichotomies between mind and body, conscious and unconscious are neither drawn
nor desired. The aim of Gestalt Therapy is for the client to discover alienated fragments of self, to restore sense of wholeness, and to experience as fully as possible awareness of self and everything in the environment. Gestalt Therapy, according to Kempler (1973), is a model of psychotherapy that sees disturbed behavior as a signal of painful polarization between two elements in a psychological process. Interventions are aimed at assisting the individuals to re-own the disowned parts into one’s personality through awareness. Perls incorporated concepts from various orientations and developed Gestalt Therapy. It is a mechanism to facilitate the optimal integration of an individual with his/her internal/external environment. This process of integration is not a magical process, instead it requires willingness and commitment to be in control of one’s destiny rather than become a victim (Clifton and Balgopal, 1984).

To understand how Gestalt Therapy works as an integrative force within an individual’s life struggle, the following concepts are briefly presented.

- **Awareness**: Within this framework awareness is defined as the spontaneous sensing of that which arises in a person (Pearls, et al., 1951). It is the ability to describe all those experiences and continuing sensations and perceptions which flow into the organism, from the environment and from memories, thoughts and past experiences stored within. Awareness is not to be confused with introspection which turns inward to evaluate, correct or control.

- **Figure-Ground Configuration**: Figure-ground is closely associated with awareness. The figure is that feeling, memory or event which emerges from all possible life experiences and upon which the person focuses attention. The ground provides the context for figure and is also fertile with potential figures. This configuration is dynamic, with potential figures emerging from the ground. The background consists of three elements: prior living unfinished business and the flow of the present (Polster and Polster, 1973).

- **Present Centeredness**: Gestalt Therapy requires those trained in traditional modes of professional education to learn new ways of looking at, understanding and self-experiencing the world. In this method the assumption is made that a meaningful answer to “why” question cannot be found, for the answers lie in an irretrievable past. In other words, the evidence needed to respond to “Why?” is not available. Pursuing past events and searching for causes is not productive. To say that Gestalt Therapy is present oriented is not to say that past experiences of the client are ignored. Rather than “talking about” the past the therapist and the client can identify and consider themes which emerge from their engagement, and experiment with making the past, present (Lloyd, 1978).

- **Process**: As Gestalt Therapy is existential in nature the practitioners are careful to focus on the process. Content are not ignored, but process which evolve and keep evolving are of higher interest (Lloyd, 1978).
Experiments: The therapist may suggest an “experiment” to help the client experience a past sensation in a new way, thus draw fragments of the past into present figure. Experiments are the theatre of this mode in which the clients are encouraged to try out new roles, or play the old ones with new variations. In the context of Gestalt Therapy the therapist often introduces new experiments such as the “hot seat”, and becoming aware of one’s pattern and rhythm of breathing.

Polarities and the Impasse: The therapist also recognizes that clients reach critical points in day-to-day living and in therapy, where they feel unable to move which is referred to as “become stuck”. Rather than labeling this dynamics as client’s resistance the therapist brings to the client’s awareness the emotional polarities such as love-hate, joy-sorrow, and active-passive as a way to break the impasse (Lloyd, 1978).

Conclusion

In conclusion I would like to briefly discuss the relevance of the teachings from the Bhagavad Gita to the strength based mental health interventions. In the first chapter of the Bhagavad Gita, Arjuna is experiencing sorrow, anxiety, fear and guilt leading to a state of inaction literally becomes frozen on seeing his kith and kin, Gurus, and other elders lined up in the enemy camp and refuses to fight. He is distraught with guilt, and acute sadness and depression. As time is elapsing Arjuna is becoming acutely anxious and is manifesting all the classical symptoms such as weakness of limbs, dryness of mouth, shivering of the body, etc. Arjuna drops his weapons and seeks guidance from the Lord. He assumes the role of a patient and Lord Krishna assumes the role of the therapist, (Reddy, 2012). At this juncture Lord Krishna teaches his disciple the principle of correct action or Karma Yoga. This beautiful verse in the Bhagavad Gita in Sanskrit goes like this:

Karmanye Vaadhika-raste, Maa Phaleshu Kadachana
Maa Karma-phala-hetur-bhooma, MaTe sangostwakarmini (2:47)

The meaning of the above verse is explained by Yogananda as: The human right is for activity only, never the resultant fruit of actions. Do not consider thyself the creator of the fruits of the activities; neither allow thyself attachment to inactivity. (Yogananda, 1973).

According to Jeste and Vahia (2008), wisdom is one of the important concepts in the Bhagavad Gita but has not received much attention in modern literature. Gita as narrative is a lesson in wisdom taught by the Lord to his disciple. Arjuna was markedly ambivalent about fighting with his cousins even though he knew they had evil motives. Lord Krishna helped to solve this moral dilemma by emphasizing duty
over feelings. We as helping professionals frequently come across our clients encountering similar dilemma and we have to assume the active role of a teacher and help them to assume the appropriate roles demanded by time and context. The concepts of Empowerment and Collaboration in the Strength Perspective emphasize the worker to assume an active role in the change process which is similar to Lord Krishna’s role in empowering his disciple.

 Historically the mental health professionals were trained to keep distance from their clients and this was promoted so that objectivity could be maintained, however modalities such as Strengths Perspective and Gestalt Therapy are not so rigid that the human element is lost during the helping process. This is clearly the case during the dialogue between Lord Krishna and Arjuna where flexible and different roles were adopted by both. Such flexibility of roles is essential for the relationship to be genuine and authentic.

 The Bhagavad Gita clearly enumerates how Lord Krishna’s interaction with Arjuna was both individualistic and holistic which helped in interventions directed on enhancing personal well-being rather than just psychiatric symptoms. Two main themes were promoted during this transaction spirituality and work. Too often professionals confuse between spirituality and religion and are hesitant to focus on either dimension (Jeste and Vahia, 2008). It is unfortunate that spirituality an important dimension of the strengths perspective is not tapped by helping professionals as a vital resource for improving the clients’ life struggles. In the Eighteenth which is the last chapter after listening to the Lord’s advice Arjuna says “Destroyed is my delusion, as I have now gained my knowledge through your grace, O Achyuta. I am firm my doubts are gone. I will do according to your word” (Gita XVIII: 73). This is a good lesson to learn from Arjuna that revival and rediscovery of our personality are possible provided we truly understand the true significance of Indian philosophy as espoused in the Bhagavad Gita (Chinmayananda, 1976, p. 1114).

 Raja Yoga the king of Yogas practised regularly and with discipline is the best mechanism for developing and maintaining sound mental health. The positive gains from the practice of Yoga and meditation has been extensively reported. Benefits of Raja Yoga for present day human beings are endless. Contemporary man in his ignorance has become his worst enemy. He creates problems and in his anxiety to solve them creates more problems. Man is constantly encountering one conflict after another. He has lost ability to relax. His mind is always racing. He is not satisfied with himself or with his significant others for long periods. Due to this constant running to find peace and comfort he loses self-confidence and his self-esteem and self-image are tarnished. End result he is an emotional wreck. Patanjali’s Raja Yoga is very effective in helping the unhappy man to be tranquil and happy. Through regular and disciplined practice he can learn to control the mind. Control of mind helps with self-realization
and through that he achieves self-confidence and able to prioritize his needs and how best to direct his energy and harmonizing the tensions.

Present centeredness is emphasized both in the *Bhagavad Gita* and Raja Yoga. According to these works worrying about the past is a futile exercise and similarly what will happen in the future is not within one’s control. One of the major concepts of Gestalt Therapy is focusing on the here-and-now happenings, and similarly the strength perspective of interventions also is aimed at bringing change in the clients’ current situations.

The teachings of the *Bhagavad Gita, Raja Yoga* and Gestalt Therapy are valuable tools for knowing the reality of the world we live in. Help us to develop self-awareness of who we are and what are our strengths and potentials for achieving our goals. Develop a stability of our mind and adhere to our *Dharma* and abide by our *Karma* and in the end improve our quality of life.

**Resolving Personal Struggle (End of Tape)**

After arriving in the U.S.A. fifty two years ago my personal journey has been incredibly exciting. Since 1976 every year I spent many months in India. In 1984, my family and I spent the whole year on my sabbatical leave, in addition to my professional activities, I devoted significant time in reading books on Indian culture and religion. I also began to learn to chant in Sanskrit. When the HIV/AIDS epidemic struck India I got involved in working with a number of projects with NGOs in different parts of India. Since my early retirement from academia in 2000 I have been active on many other volunteer activities ranging from helping the Tsunami victims in coastal India to teaching in Nagaland, the tribal area in the North Eastern part of the country.

One might ask the question what all this has to do with the topic of my lecture. It is a legitimate question and my answer is that I left my motherland when I was tormented with severe internal turmoil and wanted to go as far away as possible. Getting actively engaged in spiritual and cultural activities and involvement in Gestalt Therapy and practice of Raja Yoga has helped me to resolve my personal and professional conflicts. I am able to say with confidence that I am responsible for my problems and do not want to fit the blame on anybody. I do not have many unfinished business. My frequent visits to India and active engagement in volunteer activities have been a rewarding experience as I fulfill my *Dharma* obligations/duty. As pointed out by Reddy (2012) the very first word in the *Bhagavad Gita* is *Dharma* and the last word is *Mama Dharma*—my duties. *Om Shanti Shanti Shanti.*
References


Troubling Times? Strategies for Countering Contemporary Challenges in Social Work and Human Service Practice

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ABSTRACT

Within the backdrop of the last twenty five years of turbulent periods in human services in the west amidst the interplay of neoliberalist ideologies and practices this paper seeks to explore some of the key challenges facing practitioners in contemporary human service contexts. These include the audit culture and its concomitant concerns with risk management, measurement and managerialism as well as the more recent wave of austerity measures and funding cutbacks. The second part of the paper begins to explore how we can respond to such challenges especially through strengths based practice. The endeavour is to raise the question of how to keep hope and move beyond mere survival to proactive positive change. My humble aim here is to offer practical, hope-generating strategies for the busy practitioner be they front line workers, team leaders or managers.

Introduction

For decades, indeed some would argue, centuries, human services have worked with change—the nature of change, the pace of change, positive change, difficult change, political change and change just for change’s sake. From the Settlement Movement and Jane Addams in the 19th century working to improve communities for the poor and disadvantaged to today’s community development worker working alongside women to create microenterprises in remote villages, change is at the heart of all social work and human service practice.

Perhaps one of the most turbulent periods in human services in the west has been the last 25 years as neoliberalist ideologies and practices have played out with profound results on the welfare state. This has been well documented elsewhere and it is not my intention to replicate that debate here. Rather, this paper seeks to explore the question: How can the ordinary practitioner respond to such demands and challenges? How do we keep hope and move beyond mere survival to proactive positive change?
This paper will first explore some of the key challenges that the practitioners face in contemporary human service contexts. These include the impact of the audit culture and its concomitant concerns with risk management, measurement and managerialism as well as the more recent wave of austerity measures and funding cutbacks. The second part of the paper begins to explore how we can respond to such challenges especially as strengths based practitioners. My humble aim here is to offer practical, hope-generating strategies for the busy practitioner be they front line workers, team leaders or managers.

Drivers of Change and Challenge

Several key forces have driven these changes in human service delivery and practices. Under the broader rubric of neoliberalism, policies and practices such as New Public Management, audit, risk management and welfare reform were to reshape human services throughout most western democracies. These are now briefly outlined.

New Public Management

From the mid 1980s, New Public Management (NPM) gained momentum in government policy and programs. NPM advocated for the devolution of services from governments to private or community sectors, increased competition and applying market philosophies to the human services in a bid to increase efficiency and effectiveness and get better value for the taxpayers’ dollar (Sawyer, Green, Moran and Brett, J., 2009). The key slogan of NPM was the notion that governments should “steer not row” (Osborne and Gaebler, 1992). Along with NPM came new layers of accountability and the need for auditing across a range of dimensions.

Cultures of Audit

The potent combination of economic imperatives of neoliberalism combined with New Public Management triggered profound change on our workplaces, our organisations and for some of us our state of minds. Practices of benchmarking, performance management, KPIs, and Quality Assurance have increasingly driven more measurement, more data demands and more reform in public and not-for-profit sectors with the aim of increasing productivity and accountability. This has been termed the “audit culture” (e.g. Shore, 2008) that “derives its legitimacy from claims to enhance transparency and accountability” (Shore, 2008: 278). For those in the human services, this has now reached such levels that those meeting audit demands refer to the burdensome compliance of funding requirements dominating their day-to-day work to such an extent that they have less time to do the real work.

I do not purport that anti-accountability is desirable. Indeed the idea of being accountable, transparent and delivering what is needed and what we know works,
must be a central plank to human service work. We have centuries of human service that was based on charity, or pity or punishment with no real accountability. Rather I am arguing that we have lost sight of what we should be accountable for and to whom that accountability lies. And somewhere over the past two decades we have become complicit in, and somehow unable to challenge the current audit processes. I suggest that we need to rethink what we should be monitoring and how we should go about it.

The notion of audit came from bookkeepers and accountants—the world of financial regulation. Its proliferation into other worlds where audits never previously existed has been pervasive and rapid over the past two decades. Almost every aspect of professional and social life is now measured and audited. We have environmental audits, waste management audits, clinical audits, land use audits, triple bottom line audits, ethics audits, democratic audits, compliance audits and audits of auditing processes. The audit has thus acquired an uncontested legitimacy as a tool of governance operated by bureaucrats (Shore, 2008). It has eroded professional autonomy and creativity by reducing professional practices to crude, quantifiable templates and checklists which actually hinder efficiency and are thus counterproductive to the original intentions. Rather than improving performance, the audit has fostered a climate of distrust between auditors and those being audited.

We all recall the disbelief and shock around the events that unfolded in the Global Financial Crisis. Somehow whole sectors of the hitherto seemingly unassailable and unfailing financial world crashed, revealing failed auditing processes, checks and balances gone awry. This was beyond mere unproductive performance or inefficiency; it was severe and irretrievable failure. And the regulators of this system had not noticed or chose to ignore, a series of events that would have disastrous consequences. The trickle down became a flood of evictions, foreclosures and prolonged unemployment. The U.S. Senate’s Levin–Coburn Report asserted that the crisis was the result of “high risk, complex financial products; undisclosed conflicts of interest; the failure of regulators, the credit rating agencies, and the market itself to rein in the excesses of Wall Street.” The audits had let us down.

In human services, the audit regime has heralded a plethora of practices that occupy much of our time, often displacing our attention and resources from the real tasks of serving our clients. And audit brings with it a culture of risk management.

Risk

Workers have always dealt with risk in undertaking human service work. However, the nature of risk changed under NPM and the increased regulatory environment. Some writers argue that the notion of risk has actually superseded that of welfare (Parton, 1996; Stalker, 2003). As changes in society increased uncertainty, fears and
insecurity, the need for managing risk also increased to the point where Parton (1996) suggested that risk became a way of thinking rather than a set of realities. The management of risk has become fundamental to human service work as agencies have been compelled to develop mechanisms and procedures for managing risk in a highly regulatory environment.

Managing risk as devolved to agencies has also brought increased monitoring of service workers, a decline in professional autonomy and more focus on the management aspects of service delivery rather than the helping, therapeutic interventions. Yet there are examples of resistance to risk regimes. An interesting study conducted in Australia of 24 community health practitioners, revealed that they maintained a strong sense of agency and were focussed primarily on the needs of their clients rather than bureaucratic procedures (Sawyer et al., 2009, p. 361).

**Austerity and Welfare Reform**

The current economic crises in Europe and decline in the U.S. Japan and other countries have seen a move by governments to cut back on spending usually in the welfare sector. This is an old and recurring theme in the human services and one of the most predictable responses in times of economic downturn. The period of globalised welfare reform over the past 15 to 20 years heralded in a reinvigorated discourse of deserving and undeserving poor. In the US this became known as “workfare” and largely targeted single mothers while in Australia the unemployed, single parents and people with disability became drawn into the workforce participation agenda. Currently in Australia governments at state and federal levels are cutting budgets, reducing welfare eligibility and cutting funding to the NGO sector.

**Responding to Challenges**

The impacts of such policy implementation upon practitioners are varied. While the vast majority of studies report the decline of social workers’ autonomy, deprofessionalisation, and a lowering of professional status (Green, 2007) such that the profession is completely transformed (Lymbery and Postle, 2010), there are glimpses of resistance and resilience. Ambramovitz (2005), for example, in her study of social workers in welfare reform in the US found that while the negative effects were well represented, there was also evidence of the resilience of practitioners who reported that they felt they could still make a difference in people’s lives and that the regimes actually renewed their motivation and skills in advocacy. McDonald and Chenoweth (2009b) in their study of social workers in Australia also found cause for concern by practitioners in implementing welfare reform. However, they also reported that social work had reshaped its roles and activities in the organisation and found new spaces of practice where their contributions were valued.
Working in troubling times calls for getting clear about the key principles and strategies that will guide us. It is here that strengths based approaches offer practitioners a platform to engage with each other around the skills, competencies, knowledge and strengths rather than surrendering to perceived deficits, inertia and oppression.

Key Principles and Strategies
I am proposing that there is an urgent need to revisit what really matters. Monitoring and improving performance has always been at the heart of practice, but what we measure is the crucial question. What really matters in human service practice? Here I argue for a return to what we know is important in human helping from the relationship between worker and client to how whole systems work.

Relationships Matter
In the human services most of what we do is relational. The relationships between worker and client, worker and worker, worker and manager are central to human service and social work practice. There is much evidence supporting the notion that the client/practitioner relationship matters more than many other aspects of the helping process such as clients and service users, this matters more than program design, intervention model, and other features of the helping process (see Michael Clark’s work at www.strengthsbasedpractice.com.au) In recent years the term “relational” refers to approaches that are more participatory, collaborative and emphasise the importance of understanding the nature of the relationship of the client and the helper (Hall, Boddy, Chenoweth and Davie, 2012). This refers to mutual engagement at the client-helper level, networks and complex cross agency work.

Clients Matter
Related to the points above, it is clear that we need to address ways in which our primary accountability is to those served. This means involving people who use services at all levels in service planning, determining goals, and checking back with them about what is working and what needs to change. Measuring outcomes should be against the person’s own goals as a priority as well as those of the organisation. The discourses of collaboration, participation and inclusion all contain elements of putting the person at the centre of those processes that affect them. However, the translation of these into practice within systems is difficult. Social work, as characterised by complexity, uncertainty and risk, can resist any narrowing of practice and continue to build relationships with service users even when the wider socio-political context is not conducive (Wilson et al., 2008).
Practitioners Matter

Alongside these numerous critiques and analyses of social work in troubling times, is a growing concern about burnout and stress of practitioners (Lloyd, King and Chenoweth, 2002, Schwartz, Tiamiyu and Dwyer, 2007). Loss of experienced practitioners from service delivery, high rates of staff turnover are all indicators of frustration and emotional exhaustion on the part of practitioners. How can these problems be addressed? A study by Schwartz et al. (2007) of social workers in the U.S. revealed some interesting findings about burnout and hope. Social workers in private practice had fewer symptoms of burnout and were more hopeful than their agency counterparts. However, the number of years in social work appeared to operate as a moderating factor. Burnout declined with increasing years in private practice but surprisingly, not in public practice. Moreover, the age-hope relation revealed an increase in public practice and a decrease in private practice, thus that as they age the hope scores of social workers in the two settings converge. This raises interesting questions about how practitioners can be better supported.

Other research reveals that there is a crucial need for investment in the front line, in offering relevant and sustained professional development and opportunities for critical reflection on practice especially in those fields with high levels of difficulty and stress such as child protection (Munro, 2011).

Place Matters

A final component of what matters in our practice is place. This is especially important in Australia where service delivery needs to spread beyond cities to regional centres, rural towns, small communities and remote inaccessible settlements. Accountability for what we do also matters to the communities in which we work. Service delivery is very different in a western mining town, or an aboriginal community in central Australia, an arctic settlement in Nunavut or an inner city slum.

In summary, the elements outlined above illustrate a need for us to revisit the heart of social work. Social work is a human service so those who provide that service need to be supported in their capacity for human connection whilst still remaining professional. How we can begin to address these needs is the focus of the following and final section.

Strategies for Troubling Times

Managing in contemporary contexts that are increasingly ambiguous and paradoxical, precariously balancing a range of competing demands—day-to-day work as well as additional pressures created from unstable organisational and policy environments requires high levels of resilience (Edwards, Cooke and Reid, 1996).
Building Leadership

A key ingredient for bringing in change is leadership. Here I am referring to practice leadership rather than management or administration. Leadership has created a degree of ambivalence for social work. While many other professions have embraced addressing the crisis of professional leadership with strategic vigour, social work has recoiled from this idea harbouring an historic view that leadership is somehow contradictory to its underlying values (McDonald and Chenoweth, 2009a). In a previous paper, several strategies for practice leadership developed from Fligstein, were offered which may be useful (McDonald and Chenoweth, 2009a):

1. Taking what the system gives—strategic social work leaders understand the ambiguities and uncertainties of the social welfare field and work off them. They have a good sense of what is possible and what is not. They know where they stand. They will grasp unexpected opportunities, even when uncertain of the outcome. They know the system and take what it will give at any moment.

2. Asking for more, settling for less—strategic social work leaders commonly press for more than they are willing to accept, either from other social workers or from those higher up the ladder.

3. Maintaining ambiguity—strategic social workers often keep their strategic preferences to themselves. This makes it difficult for other institutional actors to orient what they do in response, which in turn, makes then either act first, or not act at all.

4. Trying five things to get one—strategic social work leaders have multiple courses of action plotted simultaneously or in sequence. They expect that most will fail but a few will succeed, and these successes are what are remembered by other actors.

5. Networking with other challenger groups who have no other coalitions—strategic social work leaders set themselves (and social work) up as the node in a network of these other groups who also challenge the status quo.

Building Hope

Building an understanding of hope and how we can develop hopefulness in our practice would seem to be a useful approach for our clients, our colleagues and ourselves. Snyder’s hope theory is a helpful framework on which to base this process. Snyder (2000) considers hope to be a goal directed cognitive attribute that enables people to focus on success. By focussing on success we increase our capacity to attain it. Snyder’s focus rests on three interrelated constructs: goals, will power and way power.

Goals are mental targets that include both those about preventing negative outcomes and those that are about sustaining or increasing positive outcomes. These need to be attainable but also require effort.
Will power is the perceived capacity to persevere to achieve goals even when the going gets tough. This is the motivational component of hope that promotes goal-directed effort.

Wise power is the problem solving part of hope. It is how we perceive that we can generate effective pathways to get over or around obstacles.

Research shows that hope is a predictor of academic and athletic achievement, helps in the recovery from illness and helps us cope with adversity (Schwartz et al., 2007). Hope is an essential part of our work with clients (and is very familiar to the strengths based practitioner). In meeting the challenges of troubling times, I am suggesting that we need to work on engendering hopefulness for ourselves as well. High hope social workers will be better paced to foster hope in their clients, thus it is a logical development for managers, leaders and to develop ways to build hope in their practitioners.

An outcome of the study by Schwartz et al. (2007) is a recommendation consisting of two approaches: first, developing a supportive and hopeful organisational culture and second, conducting a hope-guided stakeholder audit. They suggest conducting Hope Training in the organisation whereby workers can learn how to apply hope theory to their work. This would need to be largely experiential involving role plays, personal reflection and interaction. The notion of the hope audit brings a fresh perspective to the “audit culture”.

Conclusion

Whether we are working at the front line or in management roles, in private practice or public agencies, in remote communities or inner-urban neighbourhoods, the challenges of our work is always with us. This paper has explored some of the challenges we face in troubling times and offered some strategies to move beyond survival to building hope. It suggests a revisiting what really matters in human services and developing practical approaches around leadership and hope.

References


Unpaid Labour in Slovenian Society: A Case for Mental Health Social Work Approach

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ABSTRACT

Paid employment was for a long time seen as a way of preventing poverty. In the past three decades this notion has changed rapidly, in that precarious, atypical forms of employment and work, resulting in the trend of so-called ‘working poor’ have been surfacing. This trend was first noticed in the United States in the seventies and now becoming a pervasive phenomenon throughout Europe. Thus full-time and decently paid employment is becoming a privilege, especially in Slovenia faced by the challenging market forces and simultaneous welfare reform. Paid labour is becoming a valued commodity deserved and held only by the ‘deserving’. An army of otherwise ‘deserving’, but nevertheless working poor, consisting also of people with university degrees, is additionally straining the traditionally ‘undeserving’ plainly poor and marginalised groups such as people with long-term mental health issues. Both the categories—the ‘deserving’ and the ‘undeserving’ are falling into a vicious circle: one lot are poorly paid and receives flexible forms of employment and the other lot is stigmatised as lazy and lacking in strong will and as such forced to work in ‘workfare programmes’ in exchange for social benefits.

How does social work as a profession view this emerging trend and respond? Does the profession see any moral issues? The purpose of this paper is to bring awareness and a critical comment about the issues within the context of current neoliberal reforms welfare ethos that appears to promote the notion of ‘deserving’ and ‘undeserving’ service users and welfare recipients.

The paper suggests a strengths appraisal to Slovenian society to improve gainful entry of the currently marginalised and vulnerable sections of the populations that are unable to claim beyond subsistence incomes which in turn clearly exacerbates their mental health issues and resigns them with long term poverty and long term welfare interventions.

Keywords: Slovenia, European Union, Work, Poverty, In-work Poverty, Welfare to Workfare, Mental Health, Social Work.

1This paper is part of the proposed study of Survival and Flourish of post-modern social work practice: Australian and Slovenian comparative study.
Neoliberal Quest for Poverty and Social Exclusion

Poverty in Europe is a phenomena traditionally associated with marginalised groups and unemployment. Especially after the 2nd World War when European social model emerged, full employment was seen as a remedy not only for preventing poverty, but also for ensuring the functioning of the European welfare states. In the past three decades the traditional notion of poverty and welfare has changed and is changing almost every day. At first it appeared as a consequence of Margaret Thatcher’s conservative neoliberal politics in United Kingdom during the late 70s, promoting holy triplet of neoliberalism—privatisation, deregulation and flexibilisation. Most obvious strategy that was used to promote this ideology was creation of sense of urgency described by a political slogan often used by Mrs Thatcher—“There is no alternative.” Eventually all other European countries adopted similar neoliberal policies, mainly because of the pressure rising from the effects of globalisation. Competition at the global market became necessity for European economies, influencing the appearance of precarious and atypical forms of employment and work, making work and workers cheap, frightened and available. Two apparent results of these changes became evident trough time.

First was the presence of so-called ‘working poor’ among working population, appearing in USA in seventies, now becoming a pervasive phenomenon in Europe. The other was changing of welfare regimes and appearance of social policy based on workfare as a result of neoliberal reforms. Participation in labour market became a norm for everyone including the marginalised and the poor who were traditionally excluded from labour market. For a long period of time, the concept of workfare seemed, especially to neoliberal enthusiasts, as an answer to the crisis of welfare state and a way to create fully functional markets. In reality combination of global neoliberalism and workfare ideology brought market fundamentalism (Somers and Block 2005), characterized by low wage labour markets, backed by the state through legislation, leaving to the poor to directly respond to the vagaries of market forces (Peck 2001).

Equality, solidarity and social justice, true cornerstones of post-war welfare states in Europe is replaced by inequality, exposing differences between ‘us’ and ‘them’, between natives and foreigners, rich and poor, those on top and those at the bottom, between man and women, between heterosexuals and homosexuals’ (Leskošek 2005: 247). Differences became even more apparent and even more abused by politics when in 2008 economic crisis first shook US economy and then pervaded the European geography that created struggling social and economic consequences whose ramifications are far reaching and are likely to see even future generations left with a

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1 Phrase or a slogan, often cited from the side of British Conservative Party leader Margaret Tatcher, during her political career as a UK prime minister (1979–1990).
flack of indebtedness. Many companies and banks, faced with market failure, reacted
defensively, protecting owners of the capital at the cost of workers and citizens. In
Slovenia and elsewhere in the world financial indiscipline cruelly provides an answer
to the question of keeping capital and ownership at the hands of the 1\%\(^3\), creating a
vortex of poverty, exclusion and rising inequalities in social status, health and wealth.
In Slovenia stories of workers not getting wages for months, are part of media story
lines. People are constantly losing their jobs and those who hold some current jobs
the wages of which do not provide minimal living standard as a consequence of
which lines searching for help are on an increase. Most welfare that is state run is
slashed, tightened or abolished. Substantial social rights and benefits are no longer
available to people struggling with poverty, exacerbating their morbidity and ill
health. According to the OECD Better Life Index, 57% of Slovenians in bottom
20% of population is rating their health as bad. Mental health influenced by work or
lack of work opportunities; poor working conditions and poverty are becoming the
reality of new social order. People who find themselves unemployed because of the
redundancies or as a consequence of social or health issues and are eligible for social
benefits are facing double pressure—on one side the social policies based on the idea
of workfare is requiring them to “work off” their welfare benefits and on the other
side they reside in the same realms of the same social and public policy, regarded
being “welfare dependant” (Peck 2001: 9).

Such politics is also creating the phenomena of groupthink amongst decision makers,
who are now convinced that the only alternative is to bow down to the corporate
needs instead of its people. International Labour Organisation World of work report
2012 clearly stated that the politics of privatisation, fiscal consolidation and
deregulation of labour markets are not showing any positive results, especially in
Southern Europe where it is possible to observe negative effects of such austerity and
policy measures.

Appearance of workfare ideology and rising inequalities brought some dramatic
changes to labour markets and welfare states and changed the notion of paid labour,
however many social services soon adapted to these changes, introducing the concept
of managerialism and workfare ideology in their everyday practices, while social work
remains generally distanced from such orientations some within the ranks continue
to practice their communitarian orientations. Social work professionals amidst these
wide spread social changes have challenging task to meet the professional commitments
to social justice.

\(^3\)The Slovenians use the term 1% in the spirit of a political slogan “we are the 99%” used by ‘Occupy
Movement’. According to the Global Wealth Report 2011, less than 1% of world population owns 38, 5% of
world wealth (2011: 4). In Slovenia the top 20% of the population earn more than three times as much as the
bottom 20% (OECD 2011).
Our attempt here is to develop an understanding of the consequences of neoliberal reforms on the concept of paid labour and various forms of labour markets. Our focus is on new forms of labour markets emerging in social services sector, providing specific forms of work to marginalised groups, especially people with mental health issues.

Stop the World, I’m Getting Off!

For the purpose of this article, we will define work as activity which produces goods or services for one’s own use or in exchange for pay or support (Reskin and Padavic 1994: 1). Work can take place in formal or informal context and it is valued through unique cultural understanding of it.

Svetlik (1988: 21) divides work in two categories—formal and informal and once again these work categories could extend to be formal employment or self-employment, which can be in individual or cooperative form. Likewise informal work is also of various types: such as non-formal exchange of work in informal economy settings and altruistic work or reciprocal work. Other possibility of informal work is individual or mutual self-production. Svetlik (ibid.) states that division of work between formal and informal is established when society assigns a status of work to some of the working activities, but not to the others. Those that are assigned a status or acknowledged and therefore, protected and regulated under specific formal work agreements and others are left to their own natural course of development or restrictions. Informal work is consequently unregulated, non-institutionalised, unpaid often gendered work, mainly taking place in private sphere of life. To this division, we can add coerced work, which people are forced to do against their will and with little or no pay (Reskin and Padavic 1994: 1).

Society tends to put a higher value on work that is paid for. This is especially true for Slovenia, where according to the Results of European Social Survey on social values (2010), people value work and achievement (median 2, 76) more than average European does and tend to associate work with »morale«, since they firmly believe that work is “individuals responsibility towards society” (World Values Survey 1995). On the other hand Slovenia is, according to 5th European Working Conditions Survey (2012), a country with high work intensity, betting mainly on wholesale and industry sector. Percentage of workers who believe that their work affects their health negatively is one of the highest in Europe (45%) and only small proportion (26%), feel they would be able to do their job at 60. When compared with 70% of German

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4 Refrain text of famous song from the 1988, performed by then Yugoslavian, now Croatian pop rock band Prljavo Kazalište (Dirty Theatre).

5 According to Reskin and Padavic (ibid.) work can be divided in three forms: (1) paid work or market work, which generates an income; (2) unpaid or non-market work which is voluntarily performed by people for themselves and others and (3) coerced work.
workers who share this feeling, we can conclude that Slovenian labour market competes on global market with cheap and quite weary workforce, not betting on added value.

In such conditions further segmentation of workforce reveals sad pattern, especially when it comes to in-work poverty and workfare. Slovenia has in 2010 suffered highest rise of people living at-risk-of-poverty compared with previous year in EU27, forcing social transfers to be the only welfare tool for achieving sanity and mental health within the society. These transfers are getting harder to obtain, and easier to loose causing additional pressure to people living in poverty or at-risk-of-poverty, influencing their well-being and mental health. Sad but true that the 33% Slovenians in a recent survey believe that poverty is a result of ‘laziness and lack of strong will’. When it comes to negative judgments about poverty this phenomenon is also characteristic of many European nations, while EU27 stands at an average of 24% (Rus and Toš, 2005: 72) Slovenia is content with its second place. By the same token work is highly valued in Slovenia and therefore creating a nurturing impetus for enforcement of neoliberal reforms in most radical forms. Consequently results of such reforms that cash on social environment and national culture or pride, also emerge radically. At first workers do not receive enough wages and get exploited and eventually become part of vulnerable groups and at the end will join the ‘socially excluded’ as their well-being is thwarted and results in many a mental health problem.

At the ‘welfare level’ there is rising number of programmes and specific services, such as employment centres or social inclusion programmes of community day centres, where work is done in exchange for symbolic payments and sometimes even food. Work then is not even a commodity but requirement, since one of the parties involved has no power for negotiations or demands.

Is it Still ‘Work Hard, Play Hard’ or is it Just ‘Hard Work, No Play’?

ILO recommends that every nation should formulate and implement a policy on employment taking particular account in ensuring effective protection to vulnerable workers, such as women workers, young workers, workers with disabilities, migrant workers, older workers, etc. (ILO 2006, ibid.). If at least one of those indicators exists, than work can be considered as employment relationship. Slovenian formal definition of employment relationship somehow coincides with ILO’s fundamental principle that ‘Labour is not a commodity’ but in reality the employment relationship is constructed vaguely, when considering vulnerable groups. It appears that from a Slovenian perspective the In-work poverty and social exclusion is actually paving the way to labour exploitation as workers what they get. Data suggests that in

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6 Social exclusion is defined as failure in society core subsystems: a) economic (labour market), b) democratic and legal (legal system), c) social (capability of individuals to use social services provided by the state and d) intrapersonal (social networks) (Commins 1993: 12–13).
EU27 18% of employed single parents and 14% of workers working on temporary work contracts are at risk poverty (European Commission 2011: 7). Thus the common belief that paid work is a remedy to fight poverty is unsustainable. Throughout history work seems to be commoditized to such an extent that it is an item, cheap, competes and is globally available. By the same token labour cost is defined, especially by free market actors, as unnecessary burden, as an obstacle to economic growth. Simultaneously one notices the diminishing role of the state as a regulator and as guardian of its citizenry. An assumption that the state is on its way to play the role of an agent of the economic elites in the society is not an exaggerated statement. 23.4% or approximately 115.5 million of EU citizens were at risk of poverty or social exclusion in 2010 and exhibited the following AROPE indicators or conditions:

1. At risk of poverty or *i.e.* remaining below the poverty threshold.
2. Surviving in situations of severe material deprivation and
3. Living in a household with a very low work intensity.\(^7\)

(Antuofermo and Di Meglio 2012:1).

In contrast Slovenia reported 19.3% of the population, being at risk of poverty and social exclusion by the same indicators (Eurostat 2012). In 2010, around 16% of the European population was at risk of poverty, *i.e.*, below the poverty threshold. As showed in Figure 1, the risk of poverty (after social transfers\(^8\)) has been on increase in Slovenia in comparison to other EU member states (see Antuofermo and Di Meglio, *ibid*). Social transfers are important factor, reducing the number of people who would be at-risk-of-poverty if those would be taken away from them. In 2011 at-risk-of-poverty rate by poverty threshold in Slovenia rose to 13.6%\(^9\) in 2011.

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\(^7\) By Eurostat methodology a work intensity of working age member of household (18–59 years of age) equal or inferior to 0.20 is considered as very low (Antuofermo and Di Meglio 2012: 7).

\(^8\) In the article we will use term social transfers and social assistance interchangeably. In both cases we refer to various cash benefits available to unemployed or people living below poverty threshold.

\(^9\) Comparative EU will be available in December 2012 on Eurostat website, under the chapter People at risk of poverty or social exclusion by age and sex (see Eurostat *ibid*).
Unpaid Labour in Slovenian Society: A Case for Mental Health Social Work Approach

Working poor population or ‘in-work poverty’ in Europe rose from 8.2% in 2005 to 8.4% in 2009 (Slovenia 5.2%) (EC 2011: 4).

As a former socialist country, Slovenia was a laggard concerning labour market reforms, but since it became a member of European Union in 2004, pressure from international institutions is forcing the country to adjust and adopt them. Social costs of these measures can become high, affecting most vulnerable groups much more than others. If we understand work in broader sense as an activity exercised under legal conditions in which a worker receives fair payment for work delivered, than the result of such a relationship shouldn’t end up in poverty of a worker, irrespective of the working arrangement or setting in which work is done. This is at least a fair expectation in most European countries. It is logical then to view, in-work poverty and proliferation of low-wage sectors jobs as a result of deliberate exploitation from the side of the companies, and expect the tab of social costs of poverty to be picked up by the state institutions. These private enterprises are opposed to the concept of welfare state and institutions and benefits, considering them as unnecessary burden. Paradoxically, this situation ushers in transformation of ‘working population’ into ‘working poor population’. Although full employment is the right answer for eradicating poverty, the current strategies to achieve such employment are not alleviating people from poverty but on the contrary is letting them remain in social exclusion; contributing to their disabilities and cause social stress, which in turn are contributing to social stress related mental illnesses. We contend that further research would be required to focus on aspects of inherent strengths and the preparation required for undertaking the redefinitions of the values in the Slovenian social context.

Research shows that unemployment has direct negative effects on mental health and physical health, causing reduction in self-esteem, influences on higher levels of anxiety, and increases the possibility of substance abuse, depression, and other psychosomatic symptoms (Feather 1990; Kates, Greiff and Hagen 1990; Leana and Feldman 1992; Vosler 1994; Warr, Jackson and Banks 1988; in Akabas and Kurzman ibid., 24).

In 2011 Slovenia introduced much stricter rules for obtaining and keeping social benefits. If we compare the two trends—number of unemployed and number of people receiving social assistance, we can see that in 2005 the percentage of recipients of social assistance in relation to the number of unemployed was 60.6%, and later in 2011 the percentage fell down to 46.8%, which indicates a gradual tightening of conditions in promoting the social benefits (see Figure 2).

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10 Individual can be qualified as working poor, when the following conditions are met: (1) he or she is living in at-risk-of-poverty household, (2) he or she is employed or is actively searching for employment or (3) he or she was employed or was actively searching for employment in given period of one to six months of previous year or was accumulating adequate (equivalent of) number of working hours in that time (Leskošek et al. 2009: 22).
When a person becomes unemployed in Slovenia, he or she receives social assistance upon registration with the state agency and if state finds some work, the offer of which cannot be declined without consequences. One of the consequences is erasure from the unemployment records. Data on six months’ period from January to June 2012 shows that the number of erased from records in period between January and June has risen up to 19.3% in 2012, making them ineligible to receive social transfers. The reasons cited are:

- A person is not available for employment when the offer was made.
- Person refuses employment.
- Refuses to participate in the programme of active employment policy\(^{11}\) (AEP).
- Discontinues participation in the AEP, is inactive.
- Works illegally ‘grey economy’ (Labour Market Regulation Act, No. 80/2010).

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\(^{11}\)Active employment policy is Slovenian workfare policy.
As evident from Figure 3 there is an emerging trend of erasures from records, influencing possibilities excluding people erased to obtain their social rights in welfare system, thus reducing the overall cost of welfare state. Similar cuts were made in past year in other areas of welfare benefits, such as income supplement for elderly and disabled for 70%, child benefits for more than 30% and number of other welfare recipients (state scholarships, financial social assistance, etc.). When presenting these data the current minister of labour, family and social affairs gave a media statement, saying: “Our preliminary results show, that goals of new welfare legislation were achieved.” (Website 1, 22. 9. 2012). These trends will allow state to save and comply with the pressures of financial markets, but will on the long run have devastating effects of society as whole. ‘Undeserving’ are under austerity measures, welfare reforms and reforms of labour market, becoming growing group. Nunn and Biressi (2009) wrote, that ‘undeserving’ are more judged from the side of so-called ‘deserving’, who rather uncritically attribute negative characteristics to ‘undeserving’, such as intolerance, racism, sexism, excessive consumerism, inflexibility, idleness, selfishness and especially failure. ‘Deserving’ are, on the other hand, presented as socially cohesive, socially mobile and cultural integrated majority, not questioning their values. We can agree with stigmatisation of ‘undeserving’, but can also claim that ‘deserving’ are in case of Slovenia, no longer a majority.

Slovenian Social struggles to grapple with important macro-economic and political trends and has difficulty to appreciate the influence of these changes on everyday life of their service users. Staying committed to the idea of social justice is one thing and finding ways to co-create adequate conditions for the well-being of community and individuals, another. It is our contention that Social work in most transition countries in Europe including Slovenia itself is at risk of becoming part of re-emerging authoritarian regimes of coercion and control, as most indebted governments implement austerity measures, and especially enforce work conditions around restrictive welfare benefits. Social workers are often involved in task of exploitative workfare and similar programs, becoming part of a new authoritarianism associated with austerity politics (Jordan 2012: 9; Jordan and Drakeford, 2012).

**Working for Inclusion, Not Fair Wage**

In Slovenia it has been estimated that around 8% of population, that is between 160,000 and 170,000 people, suffer from some form of the disabilities (disabled workers, children and youth with special needs, disabilities acquired during military and war and moderate to serious mental illnesses) and 230,000 people who are facing long-term illness and are not categorised as above (Website 2, 15.9.2012). On the other hand, 30,400 persons with disabilities, or 3.8% of all persons in employment, were employed in 2010 (Si-stat 30.11.2011). Various social rights of people with disabilities are covered in legislation—indepenent living, accessibility, schooling, training,
employment\textsuperscript{12}, technical aids, rehabilitation and similar. Discrimination on the basis of disability is punishable by legislation and people with disabilities are expected to be provided with equal opportunities regarding employment, housing, human, social and economic rights. Statistical data demonstrates \textit{(ibid.)}, that in September 2011 the registered unemployment rate for persons with disabilities in Slovenia was around 35\%, 3 times higher than Slovenian average in that time.

**Unemployment and Mental Health**

Work with people with mental health issues is significantly less understood in market terms. Social services, offering special forms of employment or work occupation activities follow a bio-medical model of mental health, which has a focus on the deficits and is less focused on understanding the persons’ experiences or strengths (Pritchard 2006, Bentall 2003).

Within Europe and more so in Slovenia a focus on social justice may provide an important corrective to what has been seen as a growing over-emphasis on individual pathology. That mental health is produced socially therefore requires social, as well as individual solutions. Solutions ought to focus on both collective efficacy and personal efficacy. A recent report based on 53 Member nations within Europe suggests:

‘A preoccupation with individual symptoms may lead to a ‘disembodied psychology’ which separates what goes on inside people’s heads from social structure and context. The key therapeutic intervention then becomes to ‘change the way you think’ rather than to refer people to sources of help for key catalysts for psychological problems: debt, poor housing, violence, crime. There is a need to think more critically about the relative contribution to mental well-being of individual psychological skills and attributes (e.g. autonomy, positive affect and self efficacy) and the circumstances of people’s lives: housing, employment, income and status. This also involves recognizing that ‘happiness’, ‘positive thinking’ and ‘trust’ are not always adaptive responses.’

(Friedli, L., WHO 2009)

The emphasis within a social causation approach is upon tracing the relationship between social disadvantage and mental illness. Social class has not been the only variable investigated within this social causation perspective. Disadvantages of other sorts, related to race, gender and age have also been of interest. Clinical research

\textsuperscript{12}In order to protect rights of disabled, Slovenia introduced quota system, obligatory for all profit and non-profit employers, who employ more than 20 people. Every medium or bigger employer (by Slovenian standards that is) should employ a person who is disabled or pay penalties in the state fund for promotion of employment of people with disabilities.
about the ‘management of depression’ suggests that there is a major overlap in practice with a wide range of ‘unexplained symptoms’ and there is a recurring conflation of social difficulties and the individual experience of distress experienced by patients (Chew-Graham et al., 2008). The presently viewed Social causation model contextualises mental health issues as a result of social causation, social construction and societal response (Roger and Pilgrim, 2009, see Campbell and Davidson 2012: 48–49). Social causation model implies relationship between social disadvantage and mental health problems, for example that unemployed are twice likely to have depression as people in work. Model of social construction, relies on idea that social forces, processes and contexts contribute to our ideas about mental health and illness. Meanings accompanying mental health are constructed as discourses and norms, promoted through social, cultural and economic practices. Societal response model on the other hand analyses societal reactions and ways of labelling those who do not comply with societal norms (see ibid.). Social services providing specific labour arrangements to people with mental health issues should consider influences and consequences of both approaches—bio-medical and social. Within the context of Slovenia, one of the most institutionalised countries in the world. Data shows, that for one percent of the population is contained in a closed type institution and around 20,000 people confined in psychiatric hospitals, social care institutions, old age and nursing homes, institutions for mental illnesses and other residential institutions. Only a 50% chance exist for People with long-term distress due to illness, old age, mental distress, otherness physical or mental disability to live in a free community settings (see Walk-out manifesto; available at: Website 3, 14. 9. 2012). Those who are lucky enough to live in community setting are often involved in different programmes of governmental and non-governmental organisations (NGO’s).

Responsibilities of NGO community programmes are defined under the Mental Health Act (2008, article 4) and include counselling, self-help, education, day center activities, network of counselling offices, group homes and residential facilities, help and support to those who are studying, working with families, trainings for life and social skills, organisation of leisure time activities, ensuring services of employment centres with sheltered employment, training for work. The last two namely sheltered employment, training for work are both legally regulated by Vocational Rehabilitation and Employment of Disabled Persons Act (Official Gazette No. 63/2004), which does not have a any specifics on methodological variations required with employment of people with mental health issues, those with mental health conditions are disadvantaged.

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13 There are six regional psychiatric hospitals in Slovenia with around 1,500 patients and 7 social care institutions with little over 300 users (see Videmšek 2011).

14 According to the data of Social Protection Institute of the Republic of Slovenia, who monitors all social programmes financed by Ministry of Labour, Family and Social Affairs, there are 9 NGOs and 3 public services community programmes for people with mental health problems.
Whereas work for people with disabilities is mostly covered under the act, according to the act, and receive opportunities to work in integrated working environments *i.e.* employment in regular working environments or supported employment in regular working environments or in sheltered employment in employment centres, programmes of social inclusion. There are 146 special enterprises for people with disabilities and 30 employment centres in Slovenia. Special, segregated working environments were seen back in 1976 when first appeared, as an opportunity for employment of people with disabilities and ironically today their cost-effectiveness is questioned by the court of audit of the Republic of Slovenia, in 2012. Visible positive results include greater integration of people with disabilities in employment as a result of subsidies offered to regular work environments. While the percentage of people with disabilities employed from the beginning of economic crisis was practically the same and the drop was only 0, 1% from 2006 to 2009, the costs have certainly increased due to work environments receiving subsidies. For example the Average year cost for the state to employ one person with disability in segregated or special labour environments was 12,046 euros, compared to average cost of 4,084 euros per person working in regular working environment—that provided adapted work environment to facilitate the person with disability to be mutually gainfully employed (2012: 46). The cost escalation is purely on account of subsidies given to normal employment providers for set up costs, ensuring provisions that are conducive for employment and social inclusion related provisions and for ensuring that up to 40 percent of employment could be carried on with the help of employees with disabilities. Yet this was questioned by the court of audit primarily on the basis of expenditure, parallel to which were also 17 cases of abuse of the subsidies system, unlawfully dismissing of the employees with disabilities even after receiving subsidies from the state in the year 2010 (see: Website 4, 11. 9. 2012).

Considering the fact that wages are 25% lower compared to regular working environment and that people working continue to be segregated the question often asked is how appropriate are these measures to improve the mental health and well-being of people? Most persons with disabilities in 2011 were employed as follows: manufacturing (38%); elementary occupations (21%); craft and related trades workers (18%); and 8% of them were professionals which meant that 272 people who were employed in labour market under disability provisions were professionals (Si-stat, available at: Website 5, 11. 9. 2012). These statistics point to the emergence of secondary sector of employment where employer abuse is more systematised by state funding and legislation.

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15 In 2006 3,99% of all employed were disabled, dropping to 3,89% in 2009 (audit report of The court of audit of the Republic of Slovenia 2012: 47).
16 Equal value to 15,724.85 US dollars.
17 Equal value to 5,331.25 US dollars.
Estimations from Employment Service of Slovenia shows that only 15.9% of long-term unemployed people with disabilities will be employable in the future, meaning that majority of people will be involved in workfare programmes in order to keep their social benefits, or will be involved in community work programmes named “social inclusion programmes”. The later are also part of Vocational Rehabilitation and Employment of Disabled Persons Act, and are aimed at people with disabilities in order to support and maintain their working abilities (article 35), upon receipt of a ‘vocational and work ability’ estimated by disability commission to be 30% or less (Uršič, Drobnič 1995:70). There are 18 non-profit and for-profit organisations contracted by the state to implement such programmes. These programmes are financed by the state. The service cater also to mental health service users of who work up to approximately 4 hours daily, earning in 2009 on average 62 euros per month net, which represents 11% of official net minimum wage in Slovenia and or 10.3% of Slovenian monthly poverty threshold.

Person living in a single household can, according to Financial Social Assistance Act and Exercise of Rights to Public Funds Act, gain supplementary allowance, special social assistance aimed only to people who are long-term unemployable or elderly. Maximum amount of this assistance is 450 euros\(^{18}\), including “wage” they get in social inclusion programmes, but this is means tested by savings and assets that are in their possessions\(^{19}\). People who are living in their own property and are receiving social assistance for more than 12 months in period of 18 months are entitled to this social right only when they sign the statement, that the state will become one of their legal heirs for the property.\(^{20}\) In practice 82% of houses and apartments in Slovenia are owned by individuals the cost of the state will on the long run, minimised. This is especially the case in poorer rural areas, were bigger multi-generational houses were built in the seventies and eighties, now rapidly losing their market value because of their underdeveloped local economies.

Slovenia is passing through repressing circumstances where people are faced with unemployment, ill-mental health, poor working conditions, being unable to exercise their basic human and social rights because of austerity measures. Circumstances also reflect overall orientation of Slovenian labour market—high intensity industrial labour. Social services and social work professionals, who are expected to soothe such negative consequences are overwhelmed by the task in front of them. The choices seem to be either to comply with demands of neoliberal welfare policies and readopting

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\(^{18}\)That is 587, 43 USD.

\(^{19}\)Regular social assistance for person living in a single household, who is unemployed but could work is 260 euros or 339, 40 USD, representing 43% of Slovenian poverty threshold, meaning that people receiving social assistance are living way below poverty line.

\(^{20}\)This rule applies when apartment is bigger than 60 square meters for single person.
bio-medical model of mental health or to daringly forge ahead to comply with ethical and professional standards of social work profession, and stick to the social models of mental health that will allow for social justice to come into the fore (Erveless 1996).

**Social Work of Recognition vs. Social Work of Personalization**

We believe that the workfare programme strategies do not appear to achieve social inclusion for the following reasons:

1. Those who are brought into the programme are ‘labelled’ and referred to as as unemployable and so have little opportunity to gain meaningful employment on open market.
2. People included are working for at least 4 hour per day, allowing little time to develop social capital and networks, which may assist them to find fair employment and fair wages.
3. Symbolic payments discriminate and perpetuate deficit discourse through such practices (work is seen as ‘killing time’). According to Honneth’s (1995) people have a ‘need and struggle for recognition’ from other people in order to develop their individual identity. In this case, their primary effort stands overlooked and undervalued.
4. They work in segregated environments as low skilled workers which is paradox per se, since these programmes with ‘social inclusion’ are nondescripts.
5. Little or no opportunity to step out from vicious circle of poverty due to their social position and mental well-being. Community programmes are often not assisting them in overcoming outer obstacles, putting more focus on their inner ‘obstacles’ thus again re-coursing to discourse of deficit and bio-medical model of mental health.

In this context what ought to be the position of social work? There is a mixture of care and social welfare programmes supplemented by employment-based programmes for people with disabilities in most of European countries, but according to Barnes and Mercer (2005: 527–528) in United Kingdom the outcomes for people with disabilities have been disappointing, in that they reinforced their experience of segregation from the rest of society. People who were diagnosed with mental health problems similarly submitted to stigma, described by Goffman (1963: 3) as “deeply discrediting” and experienced on a personal level as being stereotyped, rejected, discriminated, having low status and lacked any power (Link and Phelan 2001). “The mentally ill” are believed to be unpredictable, irrational, dangerous, bizarre, incompetent, and unkempt […] (see Thoits 2011: 20). Work can for mental health service users, become a privilege, particularly when fairly paid. On the other hand work can become an obligation, part of workfare policies or some sort of rehabilitation
process allowing people to gain access to various social assistance funds only if and when complying with rules set by the state.

The role of social work can be, in this case, purely administrative and sometimes characterized by so-called ‘amoralistic paradigm’, the absence of value-based or normative concepts or orientations and is evident in a technical, managerial or procedural approach to social work (Reamer 2006: 19). Such approach ignores basic values of social work practice, uncritically following social and other policies prescribed by neoliberal politics, doing irreversible damage to theory and practice of professional social work.

Another kind of harm, perhaps social work is witnessing directly towards service users, is that their voices are muted, ignored or unheard. Their need and struggle for recognition (Honneth, ibid., Houston 2010: 846—848) as previously mentioned in on three legitimate counts:

1. Recognition in the form of love or care. Recognition in the form of ‘love’, Honneth argued, emanates from close relationships involving mutual dependence as human beings that lets us develop personal identity.

2. Recognition as a means of bestowing rights to the person that the person is accorded dignity and respect by one’s peers. Self-respect was consequently mediated through social interaction and institutionalized through laws of entitlement.

3. Recognition as a way of validating achievement by a community of interest. A kind of recognition concerned with the social validation of a person’s unique talents or capabilities in informal or formal social settings. Such validation would heighten the person’s self-esteem and reinforce belonging within the social group. It would make a person feel ‘valuable’ within a community and it is therefore based on the strength perspective.

Houston (ibid.) develops the idea of two more or less binary attitudes toward social work theory and practice, based on the Honneth’s theory. First he calls “social work of personalisation” is characterised with administrative approach and mental and ethical adaptation to existing social, cultural and political forces of elites.

We have described practices of these forces of elites were described throughout this paper to show that there is no end to austerity measures, especially when it comes to the most vulnerable and least organised groups of our society and therefore no pity and no compassion. There appears to be a clear goal to weaken their collective power of any labour, easier to do with people with disabilities and people with mental health issues and this is pursued through the individualisation and personalisation of problems and life circumstances of members of these groups. Even though people living on the margins of our society don’t have any political or economic influence, their power lies in the fact that as a group are getting bigger every day (hence the 99%).
Second he calls “social work of recognition”, which views each person as a social, rather than an individual, being; that sees self-realization in the context of group life; and that explains human action in terms of social context. It is contended that a social work of recognition poses a direct and necessary challenge to a social work of personalization.

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Labour Market Regulation Act, No. 80/2010


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Bayanihan: The Indigenous Filipino Strengths Perspective

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ABSTRACT
Social work as a profession in the Philippines emerged during the colonial era, as such it was heavily influenced by deficit and vulnerability perspectives. The early social work professionals who were educated in the United States became the first social educators and relied on western perspectives. Social workers were saddled with rehabilitation and reconstruction efforts right after World War 2, that they glossed over the need to rediscover indigenous concepts and perspectives for the indigenization of the social work profession. Although the Filipino people have exhibited strengths through the years of colonization and disasters, it is only recently that strengths perspective entered the Philippine social work parlance via western reference books. This paper is an attempt to rediscover strengths perspective in the indigenous Filipino culture and use this towards a more culturally sensitive social work practice.

Keywords: Strengths Perspective, Philippine Indigenous Concepts, Rediscovering, Constructive Social Work.

Strengths Perspective: The Discourse
Building on the initial works of Weick, Rapp, Sullivan and Kirhardt (Eimers, 2012) strengths perspective in social work was popularized by Dennis Saleebey in his edited book “The Strengths Perspective in Social Work Practice” (Saleebey, 2002) first published in 1992. The book compiled the writings of Weick, Rapp, Sullivan, Kirhardt and several others about the importance and relevance of strengths perspective in casework, group work, community practice and even in macro practice such as networking for advocacy. The proponents of strengths perspectives aimed to move away from past-oriented approaches characterized by psychodynamic theories (Beckett, 2006) to present oriented approaches like behaviorism and solution focused behavior therapy (Beckett, 2006) to future oriented approaches like empowerment and advocacy (Saleebey, 2002; Beckett, 2006).

Mel Gray however took issue with the strengths perspective noting that this is being used within the neoliberal frame (Gray, 2009). Gray traced back the use of the strengths perspective to the Aristotelian concept of “eudaimonia or human flourishing” and the Kantian notion of obligation and sense of duty for the actualization of human potential.
These concepts have been used in conjunction with the Rogerian client centered existential-humanist psychotherapy. Tracing the philosophical underpinnings of strengths perspective Gray recognized that it is based on sound foundations, however, cautioned practitioners that strengths perspective if used within the neoliberal framework might divert the attention of practitioners to the structural defects of society.

Jones and Bricker-Jenkins (2002) however illustrated how the strengths perspective can empower not only the poor but also the social workers to wage war against poverty. They proposed a “Liberatory Practice with People Living in Poverty.” This practice according to them has the potential of mobilizing social workers and poor people toward structural change. This paper uses the liberatory strengths perspective in its attempt to rediscover indigenous strengths perspective in Philippine indigenous culture.

Social Work in the Philippines: From “Adjustment” to Social Change

Social welfare institutions were established by religious institutions during the Spanish period in the 18th century (Jocano, 1980) but social work as a profession in the Philippines was primarily influenced by the Americans. Social work pioneers were sent to the United States for training before and after World War 2 (Mendoza, 2002). The Associated Charities founded in 1917 by civic minded Spaniards and Filipinos was the seedbed of the social work profession in the Philippines. This was the first agency to employ fulltime social workers who used casework as an intervention method (Mendoza, 2002). Social workers who were employed by Associated Charities were sent to the United States to undergo training in social welfare; some of them were able to get formal social work education. Since the social work profession in the Philippines emerged during times of war and colonization it focused on relief, rehabilitation and other residual welfare activities. After the war, it moved into community development and community organizing. The kind of community organizing that was employed however was the one which prevented people from questioning forms of inequality. They were employed to quell the growing social unrest brought about by the growing inequality which was the product of colonization. This is the kind of social work which Lutes (cited in Veneracion, 2003, pp. 73–79) described as the “adjustment approach.” Lutes took notes of the speech of the Social Welfare Secretary in 1969, describing social welfare as “the potential to help people adjust to social change...” and another social worker who said that “the role of social workers as agents of change is one of modifying the adjustment experiences from an abrupt and total subjugation tone to deliberate and intelligent subjugation.” Lutes also noted that one urban community townhouse program of the government social welfare agency has a goal of making tenants adjust to their new environment. According to Lutes, social workers should be concerned with “ameliorating social problems of national consequence” not just making people adjust to their environment. Lutes was writing in 1971, a year of turmoil, when
there was social unrest, a year before the military rule was established in the Philippines. Moreover, Lutes was describing social workers who worked for the government.

Yu (2007) affirmed the observation of Lutes when he discussed the ideological roots of Philippine social welfare. Yu explained that the colonial past which brought about serious societal problems and became the seedbed of Philippine social work profession has influenced social work practice and education. Yu, then, brought his analysis to the global level and reminded social workers that as the colonial legacy influence the practice and education of social work in the Philippines, neoliberal ideology in the global arena has an overpowering presence in social work practice and education worldwide. He posed a challenge not only to social workers in the Philippines but to social workers around the globe to rethink their practice as the neoliberal ideology rules the world.

Mainstream social work in the Philippines has been criticized by Yu (2006) for being an apologist of the state especially during the martial law period. He however, recognized that there were social workers who became social activists and joined non-government organizations and people’s organizations to organize peasants, fisher folks, urban poor communities, laborers, rural and urban poor women, indigenous people, migrant workers, child laborers, political prisoners and internally displaced individuals even during the martial law regime in the 1970s and early 1980s.

Believing in the tenet that in organizing there is strength some social workers embarked on community organizing. One of these was Judy Taguiwalo, a social worker and social activist who in the 1970s and 1980s lived with the masses, educated and organized the peasants. She taught them about their fundamental human rights when the human rights based approach then was not yet officially adopted by the United Nations. She was incarcerated for working to change the structural fundamentals of Philippine society. Evelyn Balais-Serrano, a social worker and an activist also became a community educator, educating the people about their rights in the 1970s and 1980s later becoming a staunch human rights advocate as she worked with political detainees. She has since been involved in the promotion of human rights at the international level as the regional coordinator for Asia and the Pacific of the International Coalition for the International Criminal Court. Mary Lou L. Alcid, also a social worker and social activist organized the people to fight the establishment of a sintering plant which could have polluted a rural community in the late 1970s. In the 1980s she became a pioneer in organizing migrant workers in Hong Kong long before the Convention on the Rights of Migrant Workers and their Families was enacted and ratified. She became one of the founders of a Center for Migrant Workers in the Philippines. She has been promoting the feminist perspective in social work education and practice. Mary Ann Villaba, another social worker and social activist also went to organize indigenous people and educate them of their rights in the 1970s. She also was one of the pioneers in organizing migrant workers and later on founded the organization to build the economic capacities of migrant workers. Social worker, Alejandro W. Apit, organized
peasants and later on child laborers and became an ardent child rights advocate. He is also a social activist. Rainier V. Almazan, social worker and social activist, organized and educated peasants, industrial workers and urban poor communities to fight for their fundamental human rights in the late 1970s until he joined the faculty of social work in the state university in 2004. He co-founded a micro-insurance organization during the time when peasants, fisher folks and self-employed individuals where out of the coverage of the state’s social insurance. Several social workers conducted human rights education in the townhouse program which Lutes described as an example of an “adjustment approach.” The resident of this townhouse now-a-days are the most progressive people in the city. They are in the forefront of confronting the government of its failure to fulfill its commitment to human rights conventions which it ratified. These social workers have been and still are involved in advocating for fundamental changes in the socio-political and economic structure of the Philippine society. The efforts for social change can be enhanced more if social workers will use strengths based indigenous concepts in education and practice.

### Strengths Perspective in Philippine Indigenous Concepts

Saleebey (2002, p. 169) argues that “(D)ominated people are often alienated people; they are separated from their inner resources, external supports, their own history and traditions.” Drawing from Saleebey’s arguments, rediscovering indigenous strengths based concepts therefore is an imperative if social work as a profession will continue to be relevant. A social worker in the Philippines therefore has to consciously rediscover strengths based indigenous concepts in working with clients and partner communities.

The Philippines is composed of more than seven thousand islands with hundreds of ethnic languages but regional island groups can communicate with a common language. Although Tagalog (a language of southern Luzon based provinces) has been made as foundation of national language there is a conscious effort to incorporate the different ethnic languages in the dictionary of national language. This effort is part of reconstructing the national language and is an empowering process in itself because ethnic languages which are becoming extinct are revived. This is the reason behind this writer’s effort to rediscover an endangered ethnic language and incorporate this in Philippine social work lexicon.

### The Concept “Bayanihan” as a Source of Strength

Veneracion (1996) categorized types of conceptualizing “tulong” or “help” in the Philippines. One is from its indigenous conception and another is from the perspective of social work as a discipline and profession. The different languages in the Philippines are replete with concepts which connote ‘helping”, “cooperation,” “solidarity,” “compassion” and others. During disasters whether natural or triggered by persons,
Filipinos spontaneously exhibit “bayanihan” or “damayan.” “Bayanihan” is a Filipino tradition where people just went out of their way to help those in need. Its root word is “bayan” which means nation. It therefore evokes a sense of solidarity and service. “Bayanihan” is related to “damayan” or the capacity to be compassionate to another. “Bayanihan” is done without expecting a reward although generally people who have been helped feel obliged to return the favor some other time in their lifetime. The favor does not have to be returned directly to the person who gave the favor; one can give it back to other people in need.

“Bayanihan” although spontaneous can be used in community organizing. In organizing peasants the community organizer can invoke the spirit of “bayanihan” during community meetings and community planning. Community folks can be easily mobilized if one uses the term “magbayanihan tayo upang malutas ang problema natin” or “let us work together to solve our problems.”

“Bayanihan” should not be left at the level of community self-help projects. It can also be a force to move people to challenge institutions like the government to fulfill its obligation to respect the fundamental human rights of people. “Bayanihan” is a tagalog based word but this has counterparts in other Philippine languages: luyo-luyo in Albay province; suyuan, tumuhan, sosyohan in Quezon province; tiklos, alayon in Samar province; (Rodriguez and Tungpalan cited in Veneracion, 1996) and dagyao in Kinaray-a a language in Western Visayan Province (Ealdama, 1952) and pagtambayayong in Central Visayan language. Eugenio Ealdama (1952) described dagyao as a cultural trait that “creates the spirit that calls forth the will to serve, not to exploit; it fosters mutual helpfulness, not selfishness. It is a key to friendship; it is a factor of progress” (Ealdama, 1952, p. 46). Through the years, bayanihan became a common language for the people of the Philippine Islands and used to mean, cooperative action.

The Conceptual Building Blocks of Bayanihan in Kinaray—A Language

This writer chose to study concepts from the language of her ancestors who lived in the hinterlands of southern Philippine Islands. These concepts were incorporated in Eugenio Ealdama’s book written in 1952. The writer as a social worker used these concepts when she worked with the local people in that western island in central Philippines.

- Kakugui—Kakugui is a concept which means to perform one’s work judiciously without harming the environment. This is a concept which can be used to promote sustainable development. Community people can be encouraged to exemplify “kakugui.”

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1 Kinaray-a is an indigenous language in Panay Island—one of the islands in the western part of central Philippines.
• **Karoro**—Karoro denotes sympathy, compassion, tenderness, openhandedness, kindness and love. This concept can be a source of strength if used within a group or community organization. Although this concept is basically used in the context of the family, this can also be employed in group work.

• **Patugsiling**—Patugsiling "means to view things through the window of one’s conscience, to put into subjective relations with others. It embraces the meaning of love, kindness, justice and considerateness" (Ealdama, 1952, p. 82). This concept is appropriate not only in working with families and groups but also in working with communities especially in forming organizations. People can be encouraged towards consensus building by invoking the word ‘patugsiling’ during meetings and discussions. Leaders should exhibit “patugsiling” in the execution of their duties.

• **Unong**—Unong is a concept which is more akin to “empathy.” This concept is the foundational block for dagyao.

• **Bahandi**—Bahandi is a concept which is equivalent to “treasure.” This is similar to “mutya” which is used in other ethnic Filipino languages. Bahandi is akin to bisa. Bisa according to Filipe Landa Jocano, an anthropologist, means inner strength, and “energy-generating force, a power stream emanating from within the body and flowing outward as feelings influencing the direction and outcome of everyday life.” (Jocano, 1977).

• **Tao**—“Belief in the worth and dignity of the human person” is one of the fundamental principles of social work. In indigenous Filipino culture and values the “tao” (Jocano, 2001) or the “human person” is in the center of important relational concept. From “tao” emerged “magpakatao” meaning to behave as a human person with worth and dignity; and “makikipagkapwa tao” or to relate to others as equals with respect. When Filipinos knock at one’s door they say, “tao po”. This means that one is knocking at one’s door as a person with dignity and this person greets the owner of the house as a person with dignity also. This concept “tao” is helpful in working with individuals, groups and communities. In working with distressed individuals one can make the person realize his/her own dignity and worth as a human being, because he/she is a ‘tao.” Making a distressed person recognize him/herself as a “tao” is the starting point for empowerment. Veneracion translated “pakikipagkapwa” as “shared inner self” (Veneracion, 1996, p. 9) but she made a short cut by omitting the word “tao” because the full word should be “pakikipagkapwa tao”. The concept “tao” is part and parcel of “pakikipagkapwa.” “Tao” therefore is a vital empowering concept, because “tao” has worth and dignity. “Tao” embodies the strength of the human person even if that human person has lost her/his self-esteem. Using the strengths perspective a social worker only need to make the person realize his/her “pagkatao” meaning his/her worth and dignity which will capacitate him/her to realize his/her full potential as human being. The concept “tao” can be a force to launch a human rights approach which will propel people to assess the performance
of the state as duty bearer in the fulfillment of human rights. The “tao” being imbued with worth and dignity is also entitled to enjoy his/her fundamental human rights. If these rights are amiss then the “tao” has the right to claim his/her rights; and to struggle for these rights is itself a fundamental human right. Tao being a gender neutral concept should be used to promote gender sensitivity and equality.

Operationalization of Indigenous Concepts

Promoting Gender Equality and Responsiveness

There is a prevailing notion among ordinary people in the Philippines that gender equality and feminism are western concepts. A closer look at the concept of tao, however, reveals that equality and gender neutrality is its essence. In conducting gender sensitivity seminar for rural and urban poor communities, this writer noticed that starting the discussion by expounding on the concept “tao” resonates to the sensibilities of the participants than starting with western concepts of sex and gender. Much more in the discussion on the prevention of violence against women, the trainer only has to make the participants reflect on the concept “tao.” Several male participants shared that they themselves have forgotten the essence of the concept “tao” since this has not been taught in basic education and not any more discussed in family gatherings. The discussion can proceed from belief in the innate dignity and worth of “tao” towards the improvement of “bayan” or nation through “bayanihan” or cooperative action.

From Assessment to Community Mobilization

The conventional focus of assessment after a disaster is to watch out for symptoms of trauma among adults and children. As a social worker, this writer has been on the lookout for indications of trauma during and after a disaster. In her social work practice since 1981, this writer observed that many children exhibited resiliency instead of trauma after a crisis, conflict or disaster. When this writer volunteered to be part of a psychosocial intervention program for children after disasters children were initially assessed about the effect of disasters on their psychosocial wellbeing, through the use of creative techniques like psycho drama and drawing/painting. The results showed that majority of them displayed a positive outlook despite the disasters. A few who have lost family members have exhibited sadness but even they fought not to succumb to depression. When asked what keep them resilient, the usual answer is “tungod kasalig kami nga unongan kami sang kasimanwa namon.” This means that they are confident that people in the community will empathize with them and subsequently help them move on. The statement connotes that people in times of disasters derive their strength from the community. This worldview however can either lead people to dependency or to community action (Lynch and de Guzman, 1970;
Jocano, 2001). When a social worker is imbued with a strengths perspective, he/she and is culturally sensitive then she/he can motivate people to action despite disasters.

Indigenous people though expect social workers and other human service providers to be imbued with these strengths based characteristics. This writer often times hears people from ethnic communities say that “hindi kami humihingi ng limos o awa” or “we do not seek alms or pity.” Often times, people will judge the human service provider/social worker according to how they exhibit “patugsiling” “unong” and “kakugui.” People also expect human service provider/social worker to treat them as “kapwa-tao” and not merely a client.

Indigenous strengths based concepts are not only useful, to mobilize people to organize self-help projects but they can also be used to propel people to make the government accountable to the people. People invoke “patugsiling” to demand action from their government officials.

**Conclusion**

Years of colonization have alienated the Filipino people from their indigenous roots (Jocano, 1977). Filipino people who have been living in more than 7,000 islands have been strengthened by the need to survive in the midst of precarious situations. The 400 years of subjugation by the Spaniards, generally 50 years by the Americans and four years by the Japanese have made the Filipino people resilient. The strength of indigenous people however, have been taken for granted by social scientists and human service practitioners in this case the social workers.

Although the social work profession in the Philippines emerged during the period of colonization and was founded on western ideology with ideological underpinnings (Yu, 2007), several social workers have sought relevance and struggled to make social work a catalyst for social change. Going beyond the western preoccupation with pathologies and deficits these social workers lived with the masses, learned from them as they educated them of their fundamental human rights and tapped indigenous strengths based concepts to mobilize people for action.

Since social work as a profession developed in the west, social work education tended to overlook the use of indigenous concepts in imparting knowledge to students. Through constructive social work, social work will be able to uncover and rediscover indigenous strengths based concepts and framework which will make social work practice relevant and culture sensitive. The challenge for social work is not just to translate western concepts to local words but to consciously revisit and rediscover indigenous strengths based concepts and incorporate these in education and practice. Veneracion (2003, p. 423) posits that “social work has been part of the Filipino culture even before the term social work was introduced to the Filipinos. Social work was, then,
in the form of acts of helping people outside of one’s own immediate family, and this has always been part of the egalitarian barangay\(^2\) structure.”

Strengths based indigenous concepts are not only found in the Philippines. The different languages in different parts of Asia are replete with strengths based concepts like resiliency. Resiliency is katangiang bumongon in Filipino, hoi-bok-eui-Gil\(^3\) in Korean, gaya lenting, gaya kenyal, gaya pegas, kegembiraan in Indonesian, daya tahan in Malay, and Khả năng phục hồi in Vietnamese (How to say org, 2012). Social workers from Asia are challenged to revisit their respective cultural concepts and languages and use these in their social work practice and education.

References

\(^2\)Barangay is a smallest unit of government in the Philippines.
Traditional Culture in Nepali Youth Empowerment Work

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ABSTRACT

This paper aims to identify the strengths based practices within five cases of Nepali youth work that utilise traditional Nepali culture as a means to empower young people in urban and rural Nepal. Cases exemplify service work in the field, to youth work through popular culture and approaches in social work education. Through analysing these cases within a strengths based framework and identifying the characteristics of strengths based practice, the author aims to highlight the effectiveness of utilising culturally specific methods within youth work.

Keywords: Traditional Culture, Youth Work, Youth Empowerment, Strengths Based Practice.

Introduction

This paper identifies strengths based practices within five diverse cases of Nepali youth work that utilise traditional Nepali culture as a means to empower young people in urban and rural Nepal. The Government of Nepal defines youth as aged between 16–40 years and estimates approximately one third of the youth population to be between 102–4 years and unemployed. For the purpose of this paper the author will refer to youth within the age bracket of 15–24 years as defined by the World Health Organisation (Government of Nepal Ministry of Youth and Sports, 2010).

Similar to many developing countries around the globe, Nepal is experiencing a ‘youth bulge’, wherein the youth population is increasing at an extremely fast rate. This phenomenon carries with it many implications such as an increased pressure on national resources, employment and education (FES Nepal, Social Transformation in Nepal, 2010; British Council and AYON, 2011; Bhardwaj, 2012).
Challenges facing the youth of Nepal today include lack of access to quality education, lack of access to information on sexual health, migration to urban areas so as to access employment and education, impacts from the previous armed conflict, unstable government, HIV/AIDS and sexually transmitted diseases, poverty, extensive lack of access to employment and economic opportunities, insufficient youth services, inadequate implementation of effective youth policies, inter-racial discrimination, gender based violence, violence, crime and risk taking behaviour which in Nepal often translates to reckless driving and substance and alcohol abuse (SPW/DFID-CSO Working Group, 2010, British Council and AYON, 2011; Bhardwaj, 2012; Pringle, Bajrachaya and Bajrachaya, 2004).

Nepal has further endured a turbulent social and political past, following the decade long armed conflict of the Maoist insurgency that commenced in 1996. The nation is still grappling with social unrest as many factions and youth groups are fighting to have their voices heard and their ethnicities represented by government (Youth Initiative and AYON, 2007).

A brief snapshot of the state of Nepal’s youth indicates a pressing need for effective and accessible social service provision (GTZ, 2008; Asia Foundation, 2010 cited in Youth Survey of Nepal, 2011) recently published a study that suggests youth who experience social exclusion and lack of access to resources such as employment and education combined with periods of political and social unrest have an increased risk of involvement in criminal and violent behaviour.

Patterns and behaviours that emerge at the adolescent stage have a significant effect on an individual’s adult life such as alcohol and drug use. Similarly, positive behaviours practised at this time can result in significant long term positive impacts on patterns of behaviour, self-perception, lifestyle habits and mental health. The World Development Report (2007) carried out direct consultations with Nepali youth from diverse ethnic backgrounds and local youth organisations. Recommendations specifically highlighted the need for positive role models and youth programs that promote Nepali culture (pp.8–9).

The following cases demonstrate the culturally appropriate and effective nature of using indigenous culture as a strengths-based approach and emphasises how youth participation in these programs is strengthening positive development in youth for their advocacy and participation in the development in Nepal.

Case Study (1) Search for Common Ground (SFCG)—INGO, Kathmandu Kailali District, Patharaya Village

Search for Common Ground (SFCG) is an international organisation that operates across 18 countries with local partners to promote culturally sensitive methods to
strengthen communities’ capacity to deal with conflict in a positive context through utilising indigenous cultural tools such as music, song, dance and folklore. SFCG aims to provide alternatives to violence through the promotion of positive activities. Through the period of armed conflict of Nepal from 1996 significant numbers of youth were involved as soldiers or victims or both. Many young people left their education and villages to join the Maoist army movement, however upon return experienced discrimination and alienation by their families, friends and local communities. A convincing method that has been utilised by SFCG and numerous other organisations to address youth issues refers to Lok Dohori that utilises singing as a medium of intervention. (should there be a footnote here explaining the definition?) As singing is an significant and integral part of Nepali culture Lok Dohori is a powerful and popular communication tool and is commonly used throughout many forms of youth work in Nepal. Originally a lover’s courting duet between a female and male singing group with accompanied dances, the duet creates a collaborative ‘call and answer’ dynamic that can emerge as an unstructured musical dialogue in rhyme between two groups. It is such an effective method is has been utilised previously by Maoist groups to spread their message and propaganda with much success (D’Errico, 2009, p. 12). On the basis of Dohori programs SFCG has set up an extensive youth network throughout rural areas of Nepal (SFCG, 2011).

Outcomes

SFCG continues to utilise this traditional process in rural areas of Nepal to facilitate positive interaction between younger and older generations in communities that have been fragmented by the armed civil conflict. Using simple language this musical conversation is an accessible and adaptable medium that requires few resources or professional training from the group mentors. Dohori promotes inclusiveness and provides a supported space for participants to creatively express themselves whilst reinforcing traditional culture and ritual harmony. Such songs refer to notions of love, marriage, harvesting and valued rituals of society. SFCG encourages youth to take leadership and facilitative roles throughout the program, simultaneously demonstrating to both youth and older generations their capabilities.

“I left [the Maoist army] when I realised that the involvement was not worth [it]. Returning back I expected some support from society, my family and friends, but it was very difficult in the beginning. Being involved in the youth network was encouraging. I became aware that I have to do something for others like me and for society. I gained self-confidence and I think I can and will do something for society in the future.” (Participant in Dohori Program, Former Child Combatant).
“Prior to the training I had the habit of drinking, fighting and staying away from home due to my circle of friends. This has hindered my education and my personal development. The opportunity to participate in the training was also an opportunity for me to be active in a positive way. I am [now] president of a youth club and through it we organised youth and built a waiting place.” (Secretary of Youth Network, Participant in Dohori Program).

The SFCG program encourages participants to collectively learn and discuss how to carry out songs and delegate roles and responsibilities. Engagement in the songs facilitate social skills and abilities in forming meaningful intergenerational relationships and promote the process of verbally exploring issues and differences between younger and older generations in a public and open environment. Intergenerational bonding and traditional healing and rituals further create long term strong foundations of social and psychosocial support. Youth participants are further supported to engage in leadership roles within the groups and through this develop their capacity in a supportive environment.

**Case Study (2) Children Working in Nepal: (CWIN), NGO, Kathmandu**

One of the pioneering NGOs for child rights in Nepal, Children Working in Nepal (CWIN) advocate against exploitation of children and youth within areas of child labour, trafficking, juvenile justice, child marriage and commercial sexual exploitation. This analysis focuses on programs offered in *Naikap Orphanage and Kavre Peace Home Youth Refuge*. Backgrounds of the residents of these two services range from children with physical and intellectual disabilities, mental health, abandonment and/or neglect by parents or guardians, youth with previous involvement in armed conflict, child workers and individuals with issues surrounding substance and alcohol use. These young individuals are often extremely mistrustful, have had little exposure to positive roles models, engage in risk taking behaviour and display a range of challenging behavioural issues.

**Music and Dance Program**

Programs within these two services involve employing dance and movement from a range of ethnic backgrounds with an emphasis placed on integrating the ‘low caste’ cultural practices, so as to break through existing negative cultural conventions and acknowledge and celebrate groups that experience discrimination within Nepali society. Songs and dances further involve *Dohori* where the question and answer format facilitates positive interaction within groups. *Gairi Ganul ki San* (The Village

\(^1\) Youth Centre.
Farmer) and Subaru celebrate Nepali food, dress, and festivals along with many other songs that are usually carried out on joyous occasions. National and patriotic songs such as Hami Nepal (Our Nepal) are learnt and sung together with participants also learning how to play traditional instruments such as the madal (drum) and bocal—a traditional style of singing. Other dances draw on Buddhist and Hindu practices and emphasis calm and gentle movements that are similar to meditation practices.

**Outcomes**

Program mentors have reported that although the participants display physical violence, outbursts of anger and an unwillingness to talk or work with youth workers, the programs entice even the most high needs participants to engage in the music related activities through providing an accessible and unique medium. Observations of positive outcomes include youths’ enhanced ability to become calm and focused on the tasks at hand which in turn supported them to deal with their previous experiences and trauma associated with the political conflict in Nepal (CWIN, 2012).

**Case Study (3) Kutumba—Popular Nepali Music Group, Kathmandu**

There are numerous examples of popular music groups in Nepal that strive to encourage acknowledgement and celebration of traditional Nepali culture and social issues through fusing indigenous with modern music. Popular music groups such as Kutumba, Nepathya² and 1974AD³ tap into the strengths of Nepali culture and encourage youth expression in a positive and relevant context through fusing classical Nepali folklore with modern culture.

Kutumba conducts frequent programs in urban and rural areas with youth in areas of mental health, poverty and intellectual and physical disability; encouraging participants to express themselves through traditional and modern music. The growing trend in Nepal to study and work abroad carries with it a very real impact on rural and urban areas, as huge numbers of young people migrate taking their skills with them to practice elsewhere. Furthermore it is not just employment and education that entices Nepali youth abroad, but the pull of a global culture which can often highlight the “haves and have-nots” of Nepali youth which therefore strengthens the common perception that there is not a fruitful future in Nepal for young people (British Council and AYON, 2011; Youth Initiative and AYON, 2007; Bhardwaj, 2012; Maharan, 2012).

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² Nepathya are a popular traditional and modern Nepali band that strive to promote social issues and ownership of Nepali culture.
³ 1974AD.
Pressures upon a young Nepali’s identity can emerge from numerous areas, such as the clash of modern and traditional lifestyles, cultural expectations or the stage of physical, cognitive and emotional development (Bucholtz, 2002). Kutumba aims to broaden youths’ perception to see the opportunities and strengths of Nepal through celebrating and enhancing young people’s knowledge of Nepali culture. Through promoting ‘low caste’ songs and youth programs the musical group encourages youth to develop respect and acknowledgment for the diverse ethnic groups that make up the fabric of Nepal. Youth are encouraged to step forward and claim the unique entity that is contemporary Nepali culture and face issues of racial conflict and discrimination through engaging with positive role models. Through this process Kutumba directly support youth in their development of personal, cultural and national identity (Maharjan, 2012; R. Bhandari, 2012; C. Pratham, 2012).

Case Study (4) Local Music Mentors, Program Location: Semi-Rural Nepal

Female Ego is a music group of young Dalit women from semi-rural Nepal formed out of a project facilitated by local female mentors. This project provides a platform for music groups of young women to express themselves through learning how to play and sing modern music. Women are often excluded from many of the local youth programs in this village and the local music scene is also predominantly male dominated. Additionally Nepali society exercises predominantly Hindu practices that perceive men and woman to inhabit particular roles. The participants further have limited access to urban area opportunities and resources.

Outcomes

Engagement in these musical groups provides a platform for the participants to express themselves and presents an opportunity for them to engage with positive female role models, a crucial process at their stage of development in a male dominated society. Asserting their perceptions and experiences of social and political issues that are occurring around them may further provide a positive process in which to carve out their identity in a highly influential stage of their development (Anderson and Mitchell, 1978). As one of the music mentors explains:

“We organize shows that try to be gender, class and caste sensitive—that talk about socio politics in a way other forms of music often don’t. On face value, of course it’s good to have more women playing and teaching music, and being role models for the future, but it doesn’t just stop there. The socio-political influences of anarco punk⁴, which is where I’m from, is as important as the

*Anarcho Punk is a genre of modern rock that promotes anarchism that emerged out of the UK in the late 1970’s.
actual music learning process itself. So, I’d have to say that anarco punk music helps young people to always question authority, patriarchy, and all forms of oppression and to express this in an uninhibited, simple, direct way without the necessity to become professional musicians. This can be helpful for young women and men anywhere in the world.” (Sareena Rai, Musical Mentor, September 12, 2012, Raikoris Nepali Music Band).

Case Study (5)
Kadambari Memorial College, Purvanchal University Affiliate, Bachelor of Social Work Student Practicum, Kathmandu, Koteswore Sworswoti Higher Secondary School. This format does not match the others with location and title of organisation etc.

Nepali culture is utilised as an educational tool and catalyst to broach social issues by social work practicum students. In this example four practicum students integrated a cultural program into a community education project (S.K. Rai, 2012). Although it may not be overtly taught throughout the university curriculum it is possible to identity strengths based practice within student practicum placements (S.K. Rai, 2012). In this case they devised a youth program which involved a range of activities aimed at gaining insight into the young participants’ knowledge of environmental sustainability and culture in Nepal.

Outcomes
The group leaders found this medium was ideal for interacting with youth and building rapport. Activities included traditional music, games and stories from festivals such as the Navadurga dance, which is used for religious celebration after communities overcome troubled times. A further aim of the program was to enhance the participants’ knowledge of cultural conflict in order to break down the barriers that exist between many ethnicities in Nepal. The social work students found participants to be highly responsive and observed a correlation between using traditional culture and carrying out successful and relevant community education programs with youth (S. K. Rai, September 10, 2012).

Discussion of Case Studies
All five cases demonstrate collaboration between participants and positive role models and foster social skills, confidence, self-esteem, decision making, judgement and contribute to developing a firm personal foundation and positive self-perception. We further observe that strengthening cultural ideas and values promotes a sense of belonging and membership to a group in a supportive environment (C. Pratham, September 5, 2012, CWIN R. Bhandari, September 9, 2012, CWIN; P. Maharjan,
September 4th, 2012, *Kutumba*). Bernard (in Rapp, Saleebey, 2005) states that research is increasingly illustrating young people’s ability to overcome previous experiences of hardship. Similarly McLaughline and Talbert (in Rapp, Saleebey *et al.*, 2005; NASW, 2002) point out that youths’ strengths and abilities are able to emerge through adverse circumstances if they are able to develop in a supportive environment with a positive role model.

Studies such as Anderson and Mitchell (1978) acknowledge the fusion of traditional Nepali music and culture with modern Indian and western forms from over two decades ago. Specific to these case studies our observations are that *Kutumba* embraces the cultural tension within Nepali youth culture and consciously aims to broaden youth’s perception and develop their hope in the possibilities of a future in Nepal, rather than looking abroad for opportunities (British Council and AYON, 2011; Pransky in Rapp *et al.*, 2005).

Similarly use of traditional songs and dances demonstrated in case study one, three and five are specific to particular ethnic groups or ‘castes’ and were contextual to particular identities and cultural practices. Furthermore the use of traditional instruments reinforces identity and important links to culture and provide an opportunity for collaboration and sustainable skill development. These programs illustrate participants’ abilities to develop in a positive environment to friends, family and the wider community. This in turn can transfer the development of a young individual to strengthening a whole community (R. Bhandari, September 9, 2012, CWIN; C. Pratham, September 5, 2012, CWIN).

Youth sector research around the globe increasingly advocates the need for youths’ voices to be heard in policy development (SPW/DFID-CSO Working Group report on Youth Participation in Nepal (2010, p. 7, pp. 31–36; pp. 67–68). Providing effective strengths based support for youth has the potential to develop their capacity to rise up and contribute to shaping the direction of a developing Nepal (British Council and AYON, 2010, p. 10; Youth Initiative and AYON, 2007, p. 10).

These case studies demonstrate specific characteristics of strengths frameworks developed by Rapp, Saleebey and Sullivan, 2005, pp. 79–83; Saleebey 1997, pp. 12–15 as cited in Woong, 2008, p. 35 and Woong 2008, p. 33 and corroborate with themes from other strengths based practice models include Delgado’s (2000 as cited in Woong, 2008, p. 36) where youth orientated frameworks are stated to directly increase self-esteem. Delgado further states the importance of perceiving youth to have the ability to contribute to their community; have realistic goals, providing them with decision making opportunities and assisting them to build intergenerational connections is an important indicator of best practice youth work. As strengths based group work emphasises verbal and non-verbal activities, the importance of providing groups with authority and supporting the development of relationships with relevant people in
the groups members’ lives gains importance (Malekoff, 2004 in Woong, 2008). Limitations within these examples include lack of clarity around methods and perhaps lack of structure and indications of formal theory and models. There is as yet limited accessibility and availability of documentation, local research, previous case studies, findings and general material on the utilisation of Nepali culture in youth work.

Conclusion
The nature in which the methodologies in these case studies have developed directly reflect the nature of Nepali culture overall. An organic development that requires little to no resources which by itself is a great tribute to the true enterprising nature of Nepali culture. Although it is possible to ease out some western theoretical notions within these practices there appears to be a strong cultural foundation for Nepal’s ability to exist and grow independently of western influence or western formal theory and analysis. It is quite within reason to construe that these programs have been effective within their specific contexts due to their informal nature. Given that there are youths with similar backgrounds and needs in the western world, the Nepal youth case studies compare quite well on their therapeutic value and due to their informal nature they can not be classed as clinical and systematic interventions. It is equally debatable if something that borders on clinical intervention is needed at all in young peoples’ programs in Nepal, when things seem to be working quite well within the growing organic culture. By building upon young people’s cultural knowledge, creativity and resilience, the programs offer opportunities for young people to speak out. These five cases offer a small sample of the resourceful strengths based practice that is occurring throughout urban and rural Nepal.

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‘Kwimenya’: The Cultural Foundation for Self-Discovery

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ABSTRACT

The Nobel laureate Prof. Wangari Maathai suggested that traditional African culture should be the foundation of self-discovery. Acknowledging that African culture is not perfect, she argued that it had deep and meaningful roots, while adopting a colonizer’s culture leads to self-loathing and disharmony. African culture is based on collectivity, harmony, interdependency and spirituality. These features are not unique to African culture but they are in contrast to dominant Western cultures which have heavy emphasis on individual autonomy. Kwimenya stands for deepening self-knowledge that goes beyond the colonial distortion and reaches to the pre-colonial cultural foundations. This African self, however, goes beyond the individual self and includes the collective self and the social and natural environment.

This paper evaluates how this approach could inform strength-based practice in social work with African people and people of African descent. The approach can also be extended to other people whose indigenous cultures have been marginalized through colonialism, slavery or occupation. Using culture as a basis of strength involves a critical appraisal of what aspects of culture are a source of strength and building on them while rejecting aspects that are incompatible with the present society. It is suggested that Kwimenya can be a foundation for engaging communities and facilitating their rediscovery of their strength which is based on their cultural heritage, self-esteem and care and protection of their social and natural environment.

Keywords: Kwimenya, Self-knowledge, Culture, Community, African.

Introduction

The legacy of the late Nobel Peace laureate Wangari Maathai in Kenya is multifold. She pioneered the Greenbelt Movement which involved ordinary women in tree planting of indigenous trees and the protection of the environment. She also pioneered community education aimed at kwimenya or self-knowledge. These may not sound like monumental achievements, but if the background is considered, the
significance becomes clear. The colonization of Kenya, like many other countries, involved massive land clearance to make way for plantations to supply European industries. The increasing indigenous populations also needed land to grow food and cash crops and they were also clearing the land of forest cover. The net effect was decimated forests and degraded agricultural land. The post colonial governments had not halted these processes, but instead had become dictatorial and regarded indigenous cultures as a hindrance to modernisation. The post colonial Africans were left with degraded and unproductive lands. They were silenced by corrupt and dictatorial post colonial governments. They had abandoned their traditional cultures to a large extent but had not been fully Westernised either.

The challenge that still faces African scholars, activists and other progressive thinkers is working out how Africans can rediscover the strength and creativity that had sustained them before colonialism and the neo-liberal market system stifled their creativity. Kwimenya suggests rediscovering the strength based on culture. Critical psychologists such as Mkhize (2004) agree that it is important to pay attention to culture. The Afrocentric paradigm theorists such as Asante (2007) also think that African culture and history have a lot to offer in the search for solutions to the problems faced by Africans in the continent and diaspora. The principles of human rights and human dignity espoused in Ubuntu also offer some ideas of how to address the problems posed by modernity without sacrificing human dignity.

Kwimenya

The word that Maathai has used is from the Kikuyu language and means to know yourself. In social sciences like philosophy and psychology it can be compared to the concept of self-knowledge. In philosophy the ideas of self-knowledge can be traced as far back as Des Cartes and focuses on individual thoughts and mental state but can also be extended to non-individualistic realms (Berge, 1988). In psychology, Neisser (1988) views self-knowledge as a complex web that involves both the self and the environment. In this framework the ecological self is related to perception of the physical environment. The interpersonal self is related to the emotional rapport and communication with others. The private self is based on understanding of experiences that are exclusively our own. The conceptual self or ‘self-concept’ is considered to be the socially constructed meanings and assumptions about human nature in general and about ourselves in particular. The extended self is based on memories and the anticipation of the future.

Culture is fundamental in the construction of the self. Kitayama, Duffy and Uchida (2007) suggest that culture plays a fundamental role in the construction of the self as a mode of being. As a social construct, the self is also amenable to change. Self Psychology therefore emphasizes the importance of context and the self is expressed differently in different contexts.
The problems that Maathai identified were that the colonized self for the Africans’ collective extended self is distorted by cultural domination and oppression. The African communities over the last five hundred years were ruptured first by slave trade, followed by colonialism, proxy wars during the cold war era and poor governance in the post colonial period. The effect of slavery on the African continent was to deprive it of its workforce. For the enslaved Africans, cultural legacy and practices of African people were suppressed in order to exercise more efficient control over the captives and render them acquiescent and passive (Akbar, 1996). The goal was to destroy the Africans’ humanity, by denigrating their culture, history and language by savagely brutalizing them (Schiele, 2000). Colonialism achieved similar goals with respect to those people left in the continent.

Like other people who experienced colonialism, foreign cultures were imposed on indigenous people. The result was the destruction of both cultural and spiritual heritage. Maathai (2009) considers that the distortion of self-knowledge that results from cultural destruction is the most devastating and long-lasting impact of colonialism:

Like other people who experienced not only physical colonization but also what might be called a colonization of the mind, Africans have been obscured from themselves. It is as if they looked at themselves through another person’s mirror—whether that of a colonial administrator, a missionary, a teacher, a collaborator or a political leader—and seen their cracked reflections or distorted images, if they have seen themselves at all (p. 34).

The long term effect of mental slavery and colonization can be seen through the problems of formerly enslaved or colonized people, even after they are no longer in bondage. Ngugi (1986) notes that a prominent circle of Kenyan intellectuals still ‘identifies with the imperialist heritage, colonial and neo-colonial, and sees in imperialism the motive force of Kenya’s development’ (p.102). This view assumes that indigenous cultures are an impediment to development and assimilating Western culture would lead to rapid modernization and development.

The cold war era (1945–1992) that divided the world between pro-United States of America and pro-Soviet Union camps was devastating for Africa. In one sense it caused confusion in the simplicity of capitalism and communism, as represented by these two super powers, as the only two alternatives there were in social and economic development. Africa was torn apart by wars in Angola, Mozambique, Ethiopia and elsewhere with devastating human, social and economic deleterious consequences that are still being felt (Akaki, 2008). In blindly following either of the two camps the Africans failed to develop political, economic or theoretical models based on and relevant to the African people and their cultural heritage.

African communities had their own systems of government that ensured their survival before the advent of colonialism. Maathai (2009) argues that the social and cultural
organization in the pre-colonial African communities was sound. The leaders were accountable to the people who were also able to feed, house and clothe themselves. The leadership was authentic and ‘people lived in harmony with the other species and the natural environment, and they protected that world’ (Maathai, 2009, p. 161). This is in complete contrast to post colonial Africa, where many leaders have been imposed on the communities and the destruction of other species and the natural environment for monetary gains is common place.

How to address the erosion of culture and rediscover the lost creative strengths that sustained the traditional African communities is the challenge that Kwimenya addresses. Maathai practiced Kwimenya in the approach advocated by Freire (1996). Freire’s work is based on critical theory that attributes social problems to social structures that privilege certain segments in society while oppressing others along lines like class, race/ethnicity, gender and sexuality (Mullaly, 2002). This approach of Freire is referred to as ‘conscientization’, which means developing critical awareness of one’s social reality through reflection and action. Freire, who developed this terminology with regard to adult education, argued that if people developed critical consciousness then they could become aware of the nature of their oppression and therefore do something about it. The Green Belt Movement headed by Maathai put this theory into practice and integrated cultural self-knowledge, environmental activism, political consciousness and human rights awareness. Freire referred to the concept of ‘praxis’, or learning and doing in adult education. Maathai practiced similarly in the adult women environment and civic education and identified the intersection of culture, environment and politics:

Through this analysis of the intersections of culture, the degradation of the environment and political corruption I realized it was important to enlarge the Green Belt Movement conception of conservation to include the recognition of cultural heritage and the consequences of its loss, why and how culture was important, and why its neglect manifested itself in the ways the public reacts to the environment, and even to life itself... This is how the Civic and Environmental Education seminars became part of the Green Belt Movement’s approach to development (Maathai, 2009, p. 167).

It was possible then to demonstrate that self-knowledge included taking care of the environment and that caring for the environment was caring for themselves. The participants were able to see that their problems were related to their loss of culture and that was also related to the degraded environment which in turn explained their poverty. They could see how they had a responsibility in the choice of how they were governed. Self-knowledge therefore extended beyond the individual to encompass the society and the environment.
Self-Knowledge in Theory

The ideas that Maathai (2009) discusses from an environmental activist perspective are in alignment with the theoretical framework of critical psychology espoused by Mkhize (2004). This framework argues that ‘the self in non-Western societies tends to be context-based, defined in terms of relationship with others, such as family, community and status of position within the group’ (Mkhize, 2004, p. 27). This is contrasted with the traditional or positivist Western psychology framework that assumes a discrete, separate individual self competing in hierarchical relationships.

The concept of a collective self is recognized by African and African American scholars as part of traditional African thought and philosophy. The African worldview recognises that no person exists in isolation but people are linked in an invisible web as described by Mbiti (1970):

Whatever happens to the individual happens to the whole group, and whatever happens to the whole group happens to the individual. The individual can only say: ‘I am, because we are; and since we are, therefore I am.’ (p. 141).

This is in sharp contrast to the prevailing neo-liberal economic and philosophical paradigm that presents people as atomized consumers whose sole purpose of existence is to maximize their consumption.

In the Afrocentric paradigm that was largely developed by African American scholars, the primacy of African culture and history is underlined for all African people. Key elements of this worldview include: harmony and interdependency, collectivity, and spirituality (Schiele, 2000; Graham, 2002; Asante, 2007). These elements are claimed to be fundamental but not exclusive to Africans and similarities can be found in other non-Western traditional cultures.

Instead of the adversarial approaches found in Western judicial systems, harmonious approaches such as consensus through dialogue is the preferred approach to resolving conflicts in traditional Africa. It is also assumed that human beings will live harmoniously with animals and nature (Mkhize, 2004). The present situation in the African continent is the complete opposite of this and conflicts have ravaged the continent over the last six decades after independence from colonial rule.

The reckless exploitation of the environment started under colonial rule has got worse since independence. This is in contrast to the African worldview which is holistic and regards everything to be interconnected and would therefore suggest protecting the environment. The African worldview is that all elements in the universe are considered to be dependent on one another, whether they are animate or inanimate (Mbiti, 1970; Belgrave et al., 1993). This high regard to the natural world was critical in the preserving nature but with Christianity replacing the traditional gods and spirits and
modernity replacing traditional beliefs with scientific rationality, nothing is sacred and only the market rules (Maathai, 2009).

Self-knowledge in the African worldview is not restricted to the individual but includes the collective. The assumption of collective identity also implies an emphasis on human similarities or commonalities rather than individual differences (Graham, 2002). The ‘family’ is also very important part of that identity but the family is more than the Western notion of a ‘nuclear family’. The ‘family’ therefore extends to include relatives, including both living and the deceased (Mkhize, 2004). It could also extend to non human elements such as animals and plants or even non-living objects through a totemic system common in many African and other indigenous traditions (Mbiti, 1970). This can be quite baffling at times for non Africans trying to understand African families.

In the African worldview the self is also connected to the spiritual world as all beings are imbued with spirituality. It is therefore argued in the Afrocentric paradigm that ‘ontologically, the nature of reality is believed at once to be spiritual and material’ (Myers, 1998, p. 5). The Afrocentric paradigm recognises the importance of spirituality in combating social ills such as family violence, alienation and drug abuse (Schiele, 1996). My own culture reflects this spirituality as demonstrated in the way names are regarded as perpetuating the existence of the souls of the relatives they are named after (Kenyatta 1938). Libation, where alcohol (or other offerings) is poured to the ground in honour of those we call ‘the living dead’ is another expression of spirituality and is practised in many traditional cultures. Armed with ideas of modernity and Christianity, the European colonizers were relentless in cleansing the Africans of spirituality with devastating consequences to social relations and environmental conservation as nothing was any longer sacred (Maathai, 2009). Ben Okri conveys the destruction of the African spirituality in his poetry:

They took the masks
The sacrificial faces
The crafted wood which stretches
To the fire of natural gods
The shrines where the axe
Of lightning
Releases invisible forces
Of silver.

(Okri, 1992)

While there are undeniable benefits in having scientific knowledge to assist in solving the problems experienced in daily lives, what is lamented is the loss of the connection
that people had with the natural world. Sacred trees and sacred forests as well as sacred relationships helped to maintain societies, and that is what has been lost.

Self-knowledge in the African worldview has attaining what is best for humanity at its core as conveyed by the concept of Ubuntu. Ubuntu has been traced back to the Zulu proverb umuntu ngumuntu ngabantu (‘a human being is a human being through other human beings’). The proverb conveys the importance of both the individual person and the collective. African worldview places a high value on each person and even ‘personal shortcomings cannot invalidate it’ (Bangura, 2005, p. 19). A practical example of the application of Ubuntu is the restorative justice movement and programs in South Africa (Anderson, 2003). The Truth and Reconciliation Commission, which investigated human rights crimes under apartheid, was underpinned by Ubuntu philosophical foundations (Gade, 2010). Ubuntu is also based on a person’s knowledge of themselves and their duties and responsibilities within a community of interdependent people (Mkhize, 2004).

**Application of Kwimenya in Strength Based Social Work**

*Community Development*

*Kwimenya* was conceived for work in the environmental conservation area and civic education in Kenya as discussed above. There is no reason why it cannot be applied to social work. The area of social work where it is most readily applicable is community development. Another area of application is cross-cultural work and this discussion will confine itself in these two areas.

The collective nature of African self-knowledge suggest that the traditional social work and psychology disciplines’ focus on the individual may be inadequate for working with African people. Not surprisingly, the concept of community development is traced to early development work in Africa. Defining exactly what community development is, however, remains problematic. Pawar (2010) defines community development as a people-centred process aimed at comprehensive development:

> A participatory people-centred process that involves bringing people together, mobilizing or organizing people, keeping them together and enabling them to work together to address their needs and issues and thus to facilitate their own, their communities’ and society’s comprehensive development (pp. 1–2).

Implicit in this definition is that community development utilises peoples’ knowledge of where they are and where they want to go, and the community development worker only acts as a catalyst for this process.

The idea of culture and cultural competence appears in community development texts with an emphasis on cultural competence for community development workers.
The objective of understanding different concepts of time, for example, is that it helps in understanding the ideas and manifestations of different constructions of time and space (and) assists us to understand our assumptions of how best to work with other people (Kenny, 2007, p. 284). Kwimenya takes the position that the destruction of Africans and other colonized people is the source of disempowerment, dislocation and disorientation. Maathai (2009) notes how rediscovering one’s culture brings about psychological and spiritual clarity but is also both overwhelming and exciting:

There is enormous relief, as well as anger and sadness, when people realize that without a culture (that is not distorted by domination) one not only is a slave, but also in effect collaborated with the slave trader, and that the consequences have been long-lasting and devastating, extending back through generations (p. 171).

Community development workers cannot ‘fix’ the cultural distortion for the people they work with but can facilitate for this to occur. Maathai (2009) speculates that a focus on culture could lead to creativity, productivity and confidence to spur the African and other post-colonial people back to self-knowledge after cultural domination over many generations.

**Cross-Cultural Social Work**

In cross-cultural social work the workers from non-indigenous background face the dilemma of when to make use of cultural knowledge and which cultural aspects are compatible with their professional ethics and human rights. The focus in cross-cultural competence should be based on ‘respecting the validity of other cultures and becoming a skilled intercultural communicator’ (Kenny, 2004, p. 282). In the teaching profession, teachers are encouraged to have self-knowledge of themselves as ethnic and encultured in order to understand their students and their cultures (Santoro, 2009). This is critical because Europeans and people of European backgrounds have tended to assume that their cultures are universal and only the ‘others’ have ethnicity-based cultures. This self-knowledge needs to go beyond ethnicity and culture to include gender and class and the privileges that are attached to them (Pease, 2010). For Africa the process of deculturalization, the failure to acknowledge the existence of pre-colonial culture, continued even after the end of colonial rule (Maathai, 2009). A similar pattern pertains to African Americans and Indigenous Australians.

**Challenges of Cultural Approaches**

Culture is shown to be a strength in the Green Belt Movement work but there are also many challenges as some cultural practices have been forgotten or may not be compatible with modern day existence. Indigenous knowledge that is uncontaminated
by modernity is hard to authenticate in Africa today (Bar-On, 1999). Despite this difficulty, it remains true that culture gives meaning to our lives and as such it is ‘a centrally important aspect of human existence; indeed, we are nothing without our cultural context’ (Ife, 2012, p. 95). It is important when working with people to start by understanding their cultural context. The problem is when some cultural practices are deemed harmful or oppressive. One of the ways of dealing with cultural practices that may be harmful is to focus on the significance of cultural rituals rather than the actual practice. Mkhize (2004a) argues that it is important that ‘the analysis of transformational rituals is limited to their social and spiritual significance, rather than the visible, outside criteria’ (p.74). Thus a cultural practise like female circumcision may be replaced by celebratory activities that mark the coming of age for the girls that do not involve ritual cutting. That is what happened in Kenya with a practise called Ntanira Na Mugambo or ‘circumcision through words’ and offers an alternative for girls to undergo a rite that consists of a week of seclusion where they are taught basic anatomy and physiology, sexual education and health, hygiene and other relevant subjects (Chelala, 1998).

A common dilemma in dealing with indigenous cultures is the issue of equality between different people. The African worldview, for example, the family and community is hierarchically organised and respect for parents and elders assumed:

The family is hierarchically organised, from the oldest member to the youngest child... The elder, usually the oldest member of the family, has the all important responsibility to ensure that the family remains a thriving, cohesive unit… Elders earn their status in the community by virtue of the richness of their knowledge and experiences... Failure to act responsibly diminishes the elder’s status (Mkhize, 2004, p. 49).

Western families are not exactly equal either but they have less power differential between various groups. Children, for example, are able to have discussions with parents and teachers without any fear of contradicting them (Kenny, 2004). Families that migrate from societies with hierarchical approaches to societies with greater equality in power, experience relationship problems within families as children and wives suddenly realize they have elevated powers (Mungai and Pease 2009). This is a matter of interest to workers dealing with settlement issues.

Gender and Culture

Gender issues are of interest when discussing culture. Some feminists in Western societies argue that organising around women’s agenda against patriarchy, or against a social order dominated by men, is a fundamental approach to social equality (Eisenstein, 1981). Freedman (2001) notes that some Black feminists have challenged the Eurocentric and essentialist nature of some trends in feminism and indeed the right or
even ability of white women to speak for black women. The Afrocentric paradigm approach to the gender issue rejects the conflict arguments at the heart of feminisms and instead theorises that men and women are different but complementary and ‘understanding this complementarity is at the root of any theory dealing with African women’ (Mazama, 2001, p. 401). This approach was developed by Hudson-Weems (1997) who called for what she has called ‘Africana womanism’. Africana womanhood is grounded in African culture, history and traditions and focuses on the unique experiences, struggles, needs and desires of African women. This approach does not claim that men are superior to women but that they have different but complementary responsibilities and roles within the family.

Culture and Human Rights

For an approach based on the strengths embedded in culture to be effective and acceptable it should also be consistent with human rights. Mkhize (2004) notes that critical social sciences reject oppressive cultural practises and they are indeed based on ending oppression. Despite cultural differences, there are commonalities based on common human rights and the dignity and worth of all human beings which can guide workers facing ethical dilemmas when addressing issues based on cultural diversity (Kenny, 2004). Another argument in favour of human rights is that while other moral or cultural values that may be superior to rights fail, then human rights need to be invoked to protect those who have their rights violated (Freeman, 2011). It can be argued, for example, that when parents love their children and care for them, rights have no role but if the parents are abusive, irrespective of any cultural arguments, human rights for the child have a role to play. While there is an argument that human rights have a Western cultural bias, all countries in the world subscribe to the Universal Declaration of Human Rights (UDHR), thus conferring a clear moral authority to the human rights framework (Skegg, 2005). While Western thoughts and philosophies are evident in the human rights discourse, it is also true that the concepts are also evident in many other philosophies and religious traditions (Ife, 2012). Human rights can therefore enrich traditional cultures and these cultures can also enrich human rights. Ife suggests that neither human rights nor culture are static and they can accommodate each other for mutual benefit:

The challenge for the human rights worker is to maintain a strong human rights perspective that regards universal human rights as important, but also to work towards culturally appropriate ways in which they can be realized in different cultural contexts, remembering that those cultural contexts themselves are subject to change and that cultural values tend to be pluralistic rather than monolithic (Ife, 2012, p. 113).
For formally colonised people the challenge is probably greater than acknowledge here by Ife as colonial domination included forced self-hatred. Respecting the existing culture and being culturally sensitive does not address this situation. Reclaiming the culture and rediscovering self-knowledge has to be done by the people who use the *Sankofa* concept of the Akan people of Ghana, represented by a bird flying forward but looking back for forgotten things to build the future. Culture and history in African worldview are not linear and *Sankofa* looks at history as a circular process, where the past is not viewed as events frozen in time, but rather as occurrences that are at one with the present and the future (Kanu, 2007). It is an exciting and challenging process.

**Conclusion**

*Kwimenya* or self-knowledge was shown to work effectively by the Green Belt Movement in Kenya. Freire developed the theory of conscientization based on critical theory and argued that when people developed an in-depth understanding of their condition they would take action. *Kwimenya* takes a similar approach but anchors this conscientization in people's deep understanding of their cultural roots as well as their current circumstances. The two are regarded as inseparably linked.

For social workers, the potential to work with culture to tap on people’s self-knowledge and strength is not given sufficient attention. What we have is a reference to cross-cultural competence and the importance of being sensitive to cultural and linguistic characteristics of the clients in both community development as well as counselling or therapeutic interventions (Healy, 2005; Kenny, 2004). *Kwimenya* places a much greater importance of self-knowledge based on culture that goes beyond mere sensitivity and respect and suggests an approach that is more akin to Freire’s concept of conscientization.

*Kwimenya* addresses the link between social issues and the natural environment. This is an area of growing interest in social work. It is easier to see the link between degraded land and loss of livelihood in rural areas but social workers based in the cities might not readily identify a direct link between the degrading of the environment and the deterioration of the wellbeing of the communities. There are, however, many examples of poor people being located in areas that are highly polluted and with many social problems. Assisting the communities to see that they have abilities and responsibilities to demand a better life is what Maathai and Freire suggest to social workers.

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Tagore’s Rural Reconstruction Experiment—
A Strength Based Social Development
Practice for Rural India

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ABSTRACT
Gurudeb Rabindranath Tagore was not only a poet and writer to be awarded with the Nobel in Literature, but also was multi faced creative genius as philosopher, artist, music composer, musician, dramatist and above all one of the great humanist. He was concerned about the decaying people and the planet. He observed the sufferings of the rural mass with extreme poverty, illiteracy and ill health, leading to poor quality of life. To him many of these obstacles could be dealt with its own mechanism inbuilt in the structure and norms of Indian rural society with the participation and cooperation of each other and by using its own resources. It has to find its own strength and weakness and plan strength based strategy to overcome those at their endeavor. Rural organization for rural reconstruction was basic principles he applied to cope with illiteracy, ill health and poverty. His dream of model village could have taken the country to a different social status than what we have in about six hundred thousand villages in India. His providence towards the people and the planet was far reaching e.g. the need for environmental education introduced by him in his 'Brahmacharyashram' during the first decade of the 20th century has ultimately been implemented by UGC as a compulsory course to be taught at the undergraduate level since last decade of the same century. His thoughts and philosophy of rural reconstruction in India on self-help basis is the current concerns in social development of the country.

Philosophy
Tagore emphasised and focussed on the self development through knowledge, skills and attitude as good citizen first. He believed that the capacities of our people is to be mobilized at the right direction for an awaken self. ‘Atma shakti’ potentialities inherent in individuals but not used by ‘Atmiya samaj’, the platform we all belong to; the society where we all are in relations to each other. Hence, need collaboration and cooperation as the traditional Indian society was bestowed upon. The mission was to bringing back those social and ethical values to live in peace with happiness. ‘Ananda’—the bliss is the ultimate aim to achieve by human being. He believed in
holistic education to make a complete human by nurturing them in nature following the natural law. As a humanist, he has not only described the pains of the poor and vulnerable people but tried to find out the way to sustainable system, inbuilt in Indian society and its culture through promotion of self-help, building civil society organisations, and cooperative societies in his experiments in rural reconstruction.

Moved by the poverty, illiteracy and ill health of rural people, and in his address to Sriniketan workers in 1939 “It seemed to me a shameful thing that I should spend my days as Zamindar, (Land lord) concerned only with money-making and engrossed in my own profit and loss account” (Sen Sudhir, 1943). A deep sense of solidarity for the vulnerable rural communities, and therefore, giving back to such people for whom he survived and prospered.

Emergence of Tagore’s thoughts in Rural Reconstruction

When Tagore was 22 years old in 1883, he wrote “We may get many things from the British by begging, but never self-reliance; what is obtained by begging can never last; what is achieved by our own efforts has permanence” (Sen Sudhir, 1943, p. 73). His vision on society and culture, the way it was moving leaving aside its own heritage and self-reliance moved him to work for the suffering humanity. The dependence was found to be damaging our potentialities to achieve self sufficiency as we had in the past. The seed of rural reconstruction was sown in by Gurudeva at the end of 19th century while he was entrusted with the responsibilities of administration of his ancestral estates at Silaidaha and Patisar, the then undivided Bengal but now in Bangladesh. While visiting the communities as a landlord he observed how the social and economic conditions of the people and society were decaying. To Tagore, service to suffering human being, to the downtrodden, should be the benchmark of selfless service to mankind. To quote from Gitanjali (song offerings) No. 10;

“Here is thy footstool and there rest thy feet where live the poorest, the lowliest,
and lost”

Serving the poorest of the poor and other vulnerable sections of the society was the philosophy of two other contemporary great sons of India, Mahatma Gandhi and swami Vivekananda who were socio-political and spiritual respectively. Here, the thoughts of Gurudeva are in consonance with them i.e. God lives among the people, especially, the poor and the backward classes. At the inaugural address of ‘Silpa-Bhandar’ (store for the products from the faculties and students of Handicrafts) at Sriniketan in 1345 BS he said, “Those who worship physical quantity often say that the field of our operation is very circumscribed and, therefore, as against the need of the entire country, the result will be insignificant. But we should remember that truth establishes itself on its own dignity and not on its quantitative measurements in terms
of length and breadth. In whatever part of the country we establish ourselves through
discovery of truth, we establish ourselves over the whole India” (Tagore, 1938).

Being moved by the sufferings of the farmers he was also trying to address the
problems of the rural mass on his own. e.g. he experimented with cultivation of new
varieties of crops at Silaidaha (presently in Bangladesh) adjacent to his Kuthibari
between 1899 and 1906 (Rabindranathe Gram Unnyan Prayas, 2010). During this
period he had sent his son Rathindranath and his friend’s son Sontosh Chandra
Majumdar to University of Illinois (Urbana-Champaign Campus), USA, to study
agriculture and animal husbandry. Later, he deputed his son in law Nagendranath
Gangopadhyaya to the same institute to learn agriculture in the larger interest of
farmers and the farming systems of India. The objective was to bring in change with
the pattern of cultivation for higher yield that benefits the farmers. His second drive
for rural reconstruction could be observed between 1908 and 1909 when made an
attempt at ‘Birahimpur’ to solve all sorts of social, cultural, and economic problems
the people faced with using their own efforts on a holistic approach. In Pabna conference
(1908) Kalimohan Ghosh was influenced by the philosophy and approaches to rural
reconstruction of Tagore and joined as worker of the team and continued to work all
along his life at Sriniketan.

The third phase of his work seems to be gaining maturity between 1915 and 1940
when he finally established the experimental project at Sriniketan with the following
objectives:

“to bring back life in its completeness into the villages, making the rural folk,
self-reliant and self respectful, acquainted with the cultural tradition of their
own country and competent to make an efficient use of the modern resources
for the improvement of their physical, intellectual and economic conditions”
(Tagore, Rabindranath, Sriniketan, Visva-Bharati, 1922). His basic philosophy
and approaches to reconstruction was based on self-help and mutual help,
upon which the communities lived with happiness during the older times in
India. He wanted to bring back and reconstruct those values and principles of
the society. This is why he did not use the word ‘development’ but
‘reconstruction’ in his experiment in rural India. He said, “do not insult the
villagers with your help .... it will harm more than your help. We shall not uplift
the villages as such but see that upliftment takes place naturally and internally
with the efforts of the people of the community. He motivated and organised
the villagers to establish health cooperatives, credit cooperatives, consumers
cooperative, weavers’ cooperative, farmers’ cooperatives, and cooperative banks
at the village level combining a cluster of communities on self-help basis. As
these organisations are made and maintained by the people it will be sustainable
to continue to benefit the poor farmers, weavers, carpenters and other vulnerable
populations. His interventions started with education at the communities, skill
upgradation of the rural artisans, and formation of nucleus organisations with youth and women of the villages. He was convinced that if life is equipped with necessary knowledge, skills, attitude and belief, their livelihood is made forever. In fact, Tagore wanted to channelize the inherent capacities of the people and the planet to legitimize a good quality of life within the existing social order of the rural inhabitants in India which is indigenous, hence sustainable. The system will eliminate all kinds of dependency of the people on the state and other charitable organisations. He wished to make one such model village for replication across the country and that will represent true India.

Sriniketan Experiment

Relying on his observations as landlord in three districts (now in Bangladesh) he planned for Sriniketan Experiments in Rural Reconstruction, which later became a pioneer project on models of community development of the government of India launched since 2 Oct 1952. He shared philosophy and approaches to rural reconstruction with Mahatma Gandhi during his visit to Santiniketan. They agreed on the development of eternal strength among the people though Gandhiji differed in being dependent on funding projects from outside. Tagore first met Leonard Knight Elmhirst, a British citizen in New York while he was studying agriculture at the Cornell University of USA. Knowing his interest in agriculture in India, Tagore invited him to come and work at Sriniketan. He joined as the first Director of Rural Reconstruction experiment from 1922.

During the initial days of L.K. Elmhirst at Sriniketan, he encountered a number of hurdles beginning from languages to health and suspicion from the adopted communities as they were not very clear about the programme objectives and its outcome. Being concerned about, naming the project, Elmhirst wrote quoting Tagore “A fuller description of how our programme for village rehabilitation grew and developed must be given later. It was later too that the Poet came to give ‘Sriniketan’ as the name for the whole project instead of more clumsy title ‘Institute for Rural Reconstruction” (Elmhirst, Leonard Knight; Poet and Plowman, Visva-Bharati, 1975).

He was very much affirmative about the potential contribution from Elmhirst once he conceptualize and plan for implementation. However, Elmhirst could not continue at Sriniketan owing to his ill health but he and his wife Dorothy Straight Elmhirst continued to support Sriniketan experiments even after the demise of Tagore in 1941. Elmhirst had to leave for his motherland by 1925 and established Dartington Hall at Devon as replica of Sriniketan experiment of Tagore. He was so deeply and emotionally involved with the philosophy and approaches of Tagore to rural reconstruction. Later he became the Chief Consultant to the Ministry of Agriculture of the government in the country.
In the late 1930s Sudhir Sen took over the charges of Sriniketan Economics as it had to face multiple problems and mainly on financial crisis to maintain the establishment and run the programme. On his arrival to Sriniketan he studied and went around the communities, speaking to the poverty stricken people. He then found two main obstacles:

“a. rural poverty could be reduced only if much more wealth were produced within the village; and
b. to produce more wealth one must rely overwhelmingly on agriculture, including wide range of agri-related activities and rural industries.” (Sen, Sudhir, Tagore, 1943).

Since then, the focus of Sriniketan activities was redesigned to explore the means to produce more wealth within the communities by applying the high yielding variety of crops and allied income generation programme like animal husbandry etc. On the other hand training in cottage industries was also intensified bringing in diversity in product design, inclusion of new crafts trades. Rathindranath Tagore and his wife Pratima Devi were instrumental in taking the crafts with new product like artistic leather crafts, Batik on clothes etc.

Tagore’s strength based interventions to uplift rural communities includes:

- To his understanding the people in general suffer due to illiteracy and technical/vocational education to deal with the problems they encounter in life. Therefore, development of literacy and knowledge keeping in mind the traditions of the country, using indigenous methods and updating it from time-to-time in tune with the emerging changes in society. Convergence of knowledge with current practice was another important factor for reconstruction with self reliance and attaining a good quality of life. As the people possessed capacity to resolve issues, there is need to intervene to use their potentialities for good reasons.

- Organising the communities and setting their attitude for a positive change in the larger interest of the people and the planet. He observed that rural habitants are not organised as they were in the past. There was time when each one was concerned about others—a sense of fellow feeling inculcated from belief in spirituality learned from generations. Industrial revolutions brought in a self centred lifestyle and individual differences on issues of citizenship and governance affecting the normal life as were in the past. It continued to damage our unity which furthered the sufferings of the masses as the days passed by. The salvation from poverty, illiteracy and ill health was lying with the affected people themselves believed Tagore. He also firmly believed that they possess all those strengths required to tackle the issues but not channelized appropriately. Therefore, tried with an experiment in Sriniketan planning a strategic intervention over the years to make model village.
• For the purpose of organising the communities he thought that formation of self supported rural organisations could be the vehicle for rural development alongside the cultural tradition of the country. He planned to form ‘Mahila Samities’ (Women’s Group/Cooperatives), Weavers’ Cooperatives, Health Cooperatives, Credit Cooperatives, Consumers’ Cooperatives, and Farmer Cooperatives etc. to promote mutual help and assistance. These organisations were planned by the people and implemented with their own strength of organising for a better living. He was convinced that these organisations will play a pivotal role in their life. Any systematic activity like building an organisation for achieving a goal to serve the essential needs of the targeted population for poverty alleviation needed a great amount of lessons, honesty, and integrity, felt Tagore, hence he stressed on the education and health first before intervening with other problems.

• Learning before serving. “There is nothing so dangerous as inexpert service, if we want to serve we must learn”. He was of the opinion that if one wants to serve the people and the communities he/she must learn to serve through training and develop the required skills in observing, analyzing, and mobilizing the people for a positive and desired change. The principles and participation and involvement of the people in programme planning, executing, and evaluating the impact are essential skills one has to apply in organising and uplifting the communities. Social work as a profession emerged in the third decade of the 20th century but Tagore planned and applied its principles and methods in the second decade of the same century without coining it as social work. He also observed that people in the villages did not understand the value of self respect and potentialities they possess. His interventions with the communities focussed on the inculcation of self respect and self confidence, which in turn helps people to achieve the desired goal in life. He coined the designations of workers of rural reconstruction as the ‘gram karmis’ (village workers) who are solely responsible for all types of activities carried on in the communities adopted for social, cultural, and intellectual improvement. Interestingly, he used all the indigenous resources and methods available in the social and economic systems available in the ancient and medieval India.

• Capacity building of the individuals, groups and communities at the grassroots level mobilizing the people and available resources. Since illiteracy and ill health coupled with poverty were identified as the vicious circle to all the rural problems, he stressed upon building the capacities of the villagers by bringing out the inherent potentialities as believed today by the social work professionals. Since the farmers and other inhabitants of the communities were busy during the day, he opened night schools for the farmers, women and youths to learn. Beginning with literacy to skill development in different trade and crafts were the objectives. Education on farming systems for the farmers was incorporated in the subjects of learning curricula, although there were no formal syllabi as we have today. While
describing the role of universities, he said, ‘the university should play the role of a brain in human body, which spreads its nerves for free flow of blood to keep us alive, similarly, the university should spread over its branches in the communities for education and dissemination of knowledge to the people to give life to the country.’ Establishing learning centres at each community was an essential part of the programme of interventions in rural reconstruction.

- Organizing village scouts with young boys and girls. Trusting on the power of the youth in any community, he advised his workers to organise the boys and girls scouts in each adopted community and teach them disciplined physical exercises, health and hygiene, and above all citizenship which will go a long way in building the rural communities to make model village. He wanted to channelize the power latent in youth to awaken the people in their communities—the finesse thought the great social thinker and modern philosopher had and we find its appropriateness even after a century. The government of India including the state governments have initiated a number of programmes for the development of the youth in the country. Of late, the Rural Extension Centre of the Institute of Rural Reconstruction continue to train the boys and girls scouts in about 50 villages around Sriniketan which is renamed as ‘brati balak’ organisation.

- Health cooperatives on self-help basis for disease prevention and cure were the second agenda after the studies were carried on in the pilot communities. There was no health service for the Indian villages during the British regime. He then organised a cluster of villages to come together to form a health cooperative and succeeded in doing it in 1932 which was followed in about 180 communities making a total of a dozen of health organisations. Each family had to subscribe a meagre amount annually to fund for a Doctor, a Pharmacist, and a Cleaner for the dispensary. Pharmacist normally used to keep the accounts of the health cooperative. Almost all such cooperatives became obsolete when the government introduced health services by 1980s but the second one located in Surul village still survives and provides services to the poor and needy with a minimum subscription per annum.

- Producers in agriculture, dairy keepers, weavers, carpenters, blacksmiths, and other rural artisans suffered from a number of setbacks, owing to low yield, intensive labour with low return, paucity of raw materials and overall the inadequate capital made them fall on the moneylenders lending on high and exorbitant rate of interest. He thought if they could be put together with funds contributed by members forming cooperatives for higher return and to stop exploitation of the moneylenders, they could be saved from further decay. Following the successful cooperative movement in Europe he indianized the policies of cooperatives in his writings on ‘Cooperative Principles’ suiting to the requirements of this country. Initially, this movement had received a very positive response and successfully implemented for the benefit of the communities.
His effort in building model village under Visva-Bharati University at the beginning of 20th century is finesse and proactive interventions in strength based practice. Unfortunately, we are talking and trying to implement the same in the form of university community partnership at the turn of the 21st century. Better late than never, time has come to produce evidence of successful implementation of the welfare and development programmes at the community to maintain good citizenship and governance with our knowledge and skills. Strength based practice facilitates the evidence based practice in social work. Tagore felt it a century ago and tried out with limited resources and got success at the time of interventions. Anything cannot remain static in a changing society with the advent of fast ever changes, we have to change with speed to catch up, using the methods to which Gurudev said, “if you try to swim against the flow, you will find yourself in grave”. Alongside changing society and its culture we have to adopt some keeping in view the traditions of the country. Use of information and technology is inevitable in our life and make a rationale use of these developments.

Strength based practice further intensified when Tagore introduced learning before serving.

There is no explicit mention of the term social work in the works of Tagore that is understood and defined professionally. A close approximation used by Tagore to explain social worker is ‘Viswakarma’ and social work is ‘Viswakarm’ (Banerjee, Gouri Rani, 1975). The other reference we come across the term social worker in Tagore’s work is the organisation and administration the rural extension services at Sriniketan. The workers who were posted at the village were called ‘Samaj Karmis’ or social workers and those at the senior level called ‘Kendra Karmis’ i.e. Centre Workers. The ‘Gram Karmis’ were responsible for implementation of the plan at the village level and the ‘Kendra Karmis’ were responsible for a cluster of communities. The social workers were placed at the lowest level of hierarchy of the organisation but they were given due importance as primary functionary at the community level and the success of each programme depended on the performance of social workers.

Tagore applied professional approaches to organise the communities and asked his workers to win the friendship of the villagers taking a real in their concern, their welfare and making lively effort and assist them in solving the most pressing problems.

Tagore also reflected on the professional and personal self of the social workers. He envisaged the true social worker having a balanced personality, instinctive humanity, definite amount of tact, patience and adequate insight into the human nature. In his essays of spiritual union he explained some qualities of a social worker (Joseph, Sherry and Ghosh, P.K. Sriniketan, 2002). To quote him “In order to be united with Him we have to divest to our work of selfishness and become ‘Viswakarma’, the ‘World Worker’, who works for all. I do not mean for a countless number of individual. All
work that is good, however small in extent, is universal in character. Such work makes for the realization of ‘Viswakarma’. The world-workers means the worker who works for all. In order to be one with Mahatma, ‘The Great Soul’, one must cultivate the greatness of Soul, which identifies itself with soul of all people and merely not with that of one’s own” (Tagore, Rabindranath, 2000). ‘Viswakarmas’ are now named International Social Work Practitioner if we relate to modern social work practice.

Conclusion

According to Tagore, social workers should do work that serves the interest of the community both at micro and macro level and these services should be altruistic in nature. He used to say that even if one village could carry out the programme he visualized, it would be like a lamp from which light could radiate in all directions (Kabir Humayun, 1961). The main thought of Tagore was strictly confined to holistic community welfare. He used to appreciate and recognize the voluntary workers who work without any expectations in return. But he never negated the concept of paid and professional workers as he maintained many such workers at Sriniketan.

The framework of values to Tagore was mainly intrinsic in nature of the people upon which the traditional Indian society followed from generations. He believed in Truth, Beauty, Goodness, Freedom and Bliss which plays pivotal role in shaping the life of people in India. These are also identified as the strength of the people and the community as a whole. The wholeness of a person’s life is more important and decline in it amounts to decline in the social order in which we live. Therefore, he tried to intervene to preserve and promote these values in his efforts in strength based practice in rural reconstruction.

The decaying social and physical environment pained him that extent he tried regenerating the social and cultural traditions of the country to make it sustainable on the basis of self help and self reliance. He began teaching about the environment at the turn of 20th century when we have taken it at the undergraduate level at the end of 20th century. His vision on rural community development is as relevant as it was a century ago. Considering the above discussions on Tagore’s rural reconstruction effort we can say that all his intervention were based on strength of the individual and the community emerging from the village level which has been done by government under 73rd Amendment Act almost eighty years later.

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Strengthening Village Communities: 
An Indian Case Study

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ABSTRACT
This paper explores the Community Organization (CO) as a basic method of social work to address the problems of villages in India. According to Census of India 2011 more than 65 per cent of India’s population reside in villages. The governments both at the centre and the states are faced with the predicament of providing basic amenities effectively and efficiently to its villages. The problems for the villagers become aggravated primarily because of lack of adequate information and awareness about the government rural development policies. Community organization is thus, seen as an effective method in creating awareness and disseminating information about the village problems and issues through participatory approach with an aim of finding solutions. The author has used the community organization method in ‘Chhota Shimulia’ a small village in (the land of the Nobel Laureate, Rabindranath Tagore) Santiniketan, West Bengal. In this study village a three stage approach for practice of community organisation (Christopher, 2010) was adopted. Firstly the project undertook the identification and prioritization of the community problems; followed by the planning and implementing activities related to the mitigation of problems and finally the third stage focused on evaluation in the context of problems identified and social work solutions.

Keywords: Community Organization, Participatory Approach, Social Work Intervention.

Introduction
According to Gandhi, India lives in its villages (GOI, Website). Factually the statement is valid even today because according to Census of India 2011 more than 65 per cent of India’s population resides in rural areas. India is a land of diversity in terms of geographical distribution, race, caste, language, religion, political ideologies, region, flora and fauna. Rural literacy rate according to Census of India 2011 is 68.91 which is 5.13 per cent less than national average and 16.07 per cent less than urban literacy rate (84.98). Governments both at the centre and the states are faced with the predicament of providing basic amenities effectively and efficiently to its villages
primarily because of high population, lack of adequate information, awareness about the government programmes and schemes and lack of community participation.

**Theoretical Framework**

Community Organization as a problem-solving model has various components such as problem identification and assessment, goal setting and implementation and evaluation. Gilbert and Terrell (1998) have added two additional components to this model that require specific community organization skills such as inform the community about the problem and build public rapport and legitimacy for action to be taken (Donna, 2002). This understanding is especially useful in the context of the rural settings in India as this process of sustained information release builds the trust of people and provides them opportunities to think about their own problems. Two of the primary perspectives associated with community practice are the empowerment and strengths perspectives (Donna, 2002). These approaches provide us with a generic description of how we should interact with constituents, recognizing their strengths and abilities and valuing their right to make decisions that affect their lives. The value assumptions associated with each of these approaches are easily incorporated into theoretical frameworks and practice of community work (Donna, 2002).

The strengths perspective assumes that residents of low-income and other marginalized group have skill, resources and knowledge that they can utilize to transform their lives (Lum, 1996; Saleebey, 1997). The purpose of the strength perspective is to counteract traditional approaches to social work practice that emphasize personal deficits and consequently result in the victimization of people in need. This perspective can be incorporated into community practice in several ways. Saleebey (1997) describe community practice from the strengths perspective as oriented toward developing the capacities of individuals to change their own lives as well as the quality of community life and one of the more important ways of doing this is by disseminating adequate information about resources as well as the rights of the marginalized people in the villages.

Most of the theories associated with community organization practice help us understand the role of the social change organization within the context of the larger society. Social Work uses system theory to examine small systems such as families or larger organizational system. However, system theory also pertains to the life of the community (Donna, 2002). One can examine communities in terms of subsystems comprised of individuals and group and its ecosystem to include a variety of components: residents, housing structure, population density, land use and social structure. The various groups in the community may compete for land, housing, jobs, and other resources. Those who can acquire these resources can dominate others (Donna, 2002).
In community practice, we rely on models to “provide a level of abstraction and simplification that assists in comparing interventions and selecting appropriate models of action for particular situations” (Weil, 1996, p. 6). Models of community practice vary in terms of strategies and tactics used to carry out intervention plans, their orientation toward the power structure, and the use of process versus task accomplishment. The three most widely known community practice models such as locality development, social planning, and social action are identified by Rothman in the early seventies (1976).

In ‘Chhota Shimulia’ it was important to consider the locality development model that allows us to focus on correcting problems in geographic communities and addressing locality development efforts is to address perceptions of alienation or the feeling of their exclusion from community life and or their resignation about their incapacity to resolve community problems. Thus this focus signifies that all efforts are on process, relationship building and problem solving.

The intellectual roots of social planning probably lie in Weber’s (1984) description of organizations as rational entities in which goals are accomplished. The process of planning is often described as having distinct components: problem identification, assessment, goal development, implementation and evaluation. Social work will recognize this as problem solving model. The paper will describe further the profile of Chhota Shimulia

**Chhota Shimulia**

Chhota Shimulia is situated 15 km away from main town Bolpur in Burdwan district of West Bengal in eastern part of India. The village is situated near a river. It is a community consisting of significantly Schedule Castes (SC) and Schedule Tribes (ST), who are considered to be minority communities in India. The main source of livelihood is agriculture and most of them work in the farm labour. Bolpur is the nearest semi urban centre for the people of this village. Basic facilities like transportation, telephone, shops including medical are not available in the village and consequently this impacts on their living condition. Almost all the houses in the village are made of mud Kucha (or non permanent) and thatched and few Pakka (permanent) houses. The village is divided into nine paras (sections), with the total population of 1,884 namely: Gosi Donga, Donga Para, Rakhadanga, Majhi Para Kamar Para, Doulhin Para, Majh Para, Bangal Para and Kana Para.

In all 520 people belong to scheduled caste community while 600 belong to the tribal community. People in village can read and write. The school dropout rates have been high. This is due to the fact that there is no middle or high school to pursue beyond grade five. The community’s natural resources include ponds, tress, land, greenery, environment, etc. and the physical resources include hand pump for drawing
underground water, public toilets, a privately owned grocery stores, domestic animals, etc. Basic means of commuting is motor-cycle, bicycle and bullock carts. The nearest public transport is a kilometer away. The village has the characteristic of homogeneity. Intimacy and bonding is observed among the villagers. Traditional rituals, practices, culture, etc. are some of the key determining factors of the village. There is almost equal representation of schedule castes, schedule tribes and general caste population in this village. Chhota Shimulia has a patriarchal structure. Many members of extended families stay together but are able to portray a nuclear family structure is maintained by a separate kitchen. Girls get married at an early age at about the age of fifteen. Working women part of the farm labour belonging to the scheduled caste and scheduled tribe that earn wages daily appear to be better off in comparison to women from traditionally land holding families. Additionally these working women are also known to do embroidery work to support their family. Both girls and boys are given equal opportunities for education. In this village even three young people with disabilities are employed.

People in the village earn their livelihood through farming. Both male and female work on farms but some women also engage themselves in embroidery and tailoring. The non-farm occupations include a cycle repairing shop, motor bike repairing selling and a few persons running eatery and other food stores. Two main political parties exist in the village namely, Trinamool Congress (TMC) and the left front. The panchayti raj system exist in the village which include representatives such as Pradhan, Up Pradhan and ward members followed by government representatives like VDO\(^1\), ADO\(^2\) Panchayat, etc.

**Cultural Profile**

The village has diverse cultural profile. The demographic profile of this village is mixed and people belonging to this village represent different cultural background. There is tribal culture as well as typical Bengali culture that can be seen in their dressing, living style, food, habits, customs and traditions, ritual, mores, values and beliefs.

Creating awareness and disseminating information about the village problems through various techniques of community organization

Community organization began with the entry into the community by the social worker (author) along with a team of volunteers of the Visva-Bharti, Santiniketan. The volunteers facilitated the worker in communicating with villagers in local language namely, Bengali. The theoretical framework, practice models, values and ethics discussed above were practiced and followed. Strength perspective and models identified by

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\(^1\) Village Development Officer  
\(^2\) Additional Development Officer
Rothman formed the base of practice. Three dimensional approach was used for strength based practice (Ref. Figure 1).

**Problem Identification and Assessment**

Before problem identification and assessment, the social worker established excellent rapport with the community being facilitated by the volunteers. The emphasis was given on participatory approach. In this regard the worker had used the Participatory Rural Appraisal (PRA) technique for identification and prioritization of the village problems.

**Techniques Used**

Participatory Rural Appraisal (PRA) technique was used for problem identification and assessment in community organization practice. Qualitative and quantitative approaches were also used to engage with a broad range of individuals and groups to understand their problems, perspectives or culture by using qualitative methods to...
collect information in a structured, standardized way. Standardized PRA techniques include Venn diagram (chapatti diagram); transect walk, structured surveys, focused group discussion, observation, social indicator analysis and time series analysis. Various methods were used to examine physical and spatial attributes of the community like social and resource mapping. Participatory approach forms the basis of problem identification and assessment.

**Problem Identified and Assessed**

Problems were identified and assessed by applying various techniques through participatory approach. The worker conducted assessment to determine the services or interventions that the community needed.

**Venn Diagram** *(Chapati Diagram)*

It is a technique of participatory rural appraisal which involves the community to identify their own community problems and needs with the support of community organizer. In the whole process, community organizer plays a role of facilitator and all the problems and need are exclusively decided by community. They made big circles for major problems and small for minor problems. There are two important aspects in this tool—one is size, and second is distance. By applying this tool the worker could identify community problems with the support of community members. The problems which were identified by this tool include health and hygiene, poverty, education, and unemployment (Ref. Figure 2). The first and most alarming problem was health and hygiene followed by poverty, unemployment and education respectively.

![Venn Diagram](image)

**Fig. 2**: Problem Identified by the Venn Diagram

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1 Venn diagrams were conceived around 1880 by John Venn.
Transect Walk

Transect walk is another form of technique where organizer dissects the entire village and walk straight at the end of the village and interacts with the family members. In this process worker tries to identify the social as well as economic status and the problems and concerns related to the family members in a form of community problems. Sanitation and unemployment were identified as major problems (Ref. Table 1).

Table 1: Problem Identified by the Transect Walk

<table>
<thead>
<tr>
<th>Social Category (Hhs)</th>
<th>SC–13 hhs</th>
<th>ST–12 hhs</th>
<th>General–10 hhs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic category</td>
<td>Poor and low income level</td>
<td>Middle class with irregular income</td>
<td>Regular income from agriculture and laboring.</td>
</tr>
<tr>
<td>Economic affordability for education</td>
<td>The status of economic affordability for education is very low</td>
<td>The status of economic affordability for education is very low</td>
<td>They can afford but sometimes payment may be delayed.</td>
</tr>
<tr>
<td>First major problem</td>
<td>Sanitation</td>
<td>Sanitation</td>
<td>Sanitation</td>
</tr>
<tr>
<td>Second major problem</td>
<td>Unemployment</td>
<td>Unemployment</td>
<td>Unemployment</td>
</tr>
<tr>
<td>Migration—spilt clientele</td>
<td>People migrate seasonally but not all</td>
<td>People migrate seasonally</td>
<td>People migrate seasonally</td>
</tr>
<tr>
<td>Others—problems</td>
<td>Not getting full government services</td>
<td>Not getting full government services</td>
<td>Not getting full government services</td>
</tr>
</tbody>
</table>

Focused Group Discussion (FGD)

Focus group was an additional technique that the worker used to identify common perspectives about a community concern. It had taken place within the context of a community forum, in lieu of structured dialogue or nominal group technique. Worker had chosen eight participants representing the interests of various community groups for focus group discussion. The worker interviewed the people with eight open ended questions. Responses were recorded. Various problems were identified such as poverty, unemployment, education and health issues. During focused group discussion various questions were asked (Ref. Table 2).
Table 2: Question Asked During Problem Identification

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What social problems do individuals and groups in the community experience? Can you arrange the problems on the top priority basis?</td>
<td>Poverty, unemployment, education and health problems</td>
</tr>
<tr>
<td>2. How should these problems be addressed?</td>
<td>Government should provide all the services</td>
</tr>
<tr>
<td>3. What actions you take to address these problems?</td>
<td>Nothing</td>
</tr>
<tr>
<td>4. What action government agencies take to address these problems?</td>
<td>Nothing due to corruption</td>
</tr>
<tr>
<td>5. What action Panchayati Raj Institution (PRI) or local bodies take to address these problems?</td>
<td>PRI is not giving even full employment under National Rural Employment Guarantee Scheme (NREGS)</td>
</tr>
<tr>
<td>6. Are any services offered by government and local bodies to address these problems?</td>
<td>NREGS, but not effectively</td>
</tr>
<tr>
<td>7. Do you feel that you need services to address the problems identified?</td>
<td>Yes</td>
</tr>
<tr>
<td>8. Are you ready to solve these problems by your own means?</td>
<td>Yes, but do not know how to do.</td>
</tr>
</tbody>
</table>

Observation

Observation is very effective tool for data collection. Worker had used this tool for keen observation about the village and members dynamics. He felt that community members are also responsible to some extent for their day to day problems such as and hygiene and sanitation problem, internal dispute and lack of cohesiveness.

Nominal Group Technique

Nominal group technique is another method of fostering a shared understanding of problems affecting the community. In this method worker asked the individuals to write down a list of problems affecting the community. Each individual read his/her list out loud. The worker facilitated writing down the identified problems on a flip board. The list of problems was constructed and group participants were given time for discussion. The discussion period depended on participants understanding of the issues identified. In the concluding session members were asked to rank their problems in order of seriousness namely, 1 to 5. The worker read each issue from the list, then called on each participant to give the ranking. The rank that each individual assigned the issues was posted on the board. Very often, this process clearly identified the issues of greatest importance to group members. In the event of ties among issues, the author as a facilitator calculated ranking by taking the average scores for each issue (Ref. Table 3).
Table 3: Ranking Using Nominal Group Technique

<table>
<thead>
<tr>
<th>Issues</th>
<th>Ranking, Person1</th>
<th>Ranking, Person2</th>
<th>Ranking, Person3</th>
<th>Ranking, Person4</th>
<th>Ranking, Person5</th>
<th>Ranking, Person6</th>
<th>Ranking, Person7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Education</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Sanitation</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Health and Hygiene</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Poverty</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>3</td>
</tr>
</tbody>
</table>

Problem Prioritized

After identification and assessment, problems were prioritized for making social work intervention. Data collected from various used techniques while problem identification by using a number of different data sources assessed and prioritized by using the tool triangulation analysis. All the information were collated and checked on the basis of frequency, serial order and then priority were given. As per the exercise unemployment was the first problem followed by sanitation, poverty, health and hygiene, and education on a time of priority (Ref. Table 4).

Table 4: Prioritization of the Problem

<table>
<thead>
<tr>
<th>Sl.</th>
<th>Used Tools and Identified Problems</th>
<th>Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Venn Diagram</td>
<td>Transect Walk</td>
</tr>
<tr>
<td>1.</td>
<td>Health and Hygiene</td>
<td>Sanitation</td>
</tr>
<tr>
<td>2.</td>
<td>Poverty</td>
<td>Unemployment</td>
</tr>
<tr>
<td>3.</td>
<td>Unemployment</td>
<td>–</td>
</tr>
<tr>
<td>4.</td>
<td>Education</td>
<td>–</td>
</tr>
<tr>
<td>5.</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

Social Work Intervention through Community Organization

Five major problems were prioritized by using triangulation tool. First problem was unemployment followed by sanitation, poverty, health and hygiene and education. As the worker had less time, he could focus on only the first two problems as a field of social work intervention.
Unemployment

Unemployment occurs when people are without job and they have actively sought work within the past four weeks. The unemployment rate is a measure of prevalence of unemployment and it is calculated as percentage by dividing the number of unemployed individuals by all individuals currently in labour force. In rural areas the literacy rate is very low and the opportunities are very less for employment. All type of livelihood and employment is directly or indirectly related to agriculture. Worker assessed his role to intervene in this problem. He had put certain objectives to reduce the unemployment status in the particular community. The objectives were: a) To provide basic knowledge of local employment opportunities, and b) To make them aware about the benefit of indigenous employment. On the basis of these objectives worker planned some activities. (Ref. Table 5)

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Objectives</th>
<th>Planned Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>To provide the basic knowledge of local employment opportunities</td>
<td>Awareness creation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Capacity building</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rally</td>
</tr>
<tr>
<td>2.</td>
<td>To make them aware about the benefit of indigenous employment</td>
<td>Awareness creation on indigenous employment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Group meetings</td>
</tr>
</tbody>
</table>

With the support of community members worker could implement all planned activities to reduce the unemployment status of the villages. He emphasized on government provision and also on indigenous livelihood opportunities. Worker could convey the essence of the particular activities.

Sanitation

Sanitation is the hygienic means of promoting health through prevention of human contact with the hazards of wastes. Hazards can be physical, microbiological, biological or chemical agents of diseases. Wastes that can cause health problems are human and animal feces, solid wastes, domestic wastewater (sewage, sullage, and grey water), industrial wastes and agricultural wastes. Hygienic means of prevention can be by using engineering solutions, simple technologies, or even by personal hygiene practices.

Sanitation is the one of the major problems of the rural areas. Since people are less educated and careless to maintain the hygienic condition in the villages. Everybody wants to throw their garbage in front of other’s house. This type of tendency carries the poor sanitation condition in the villages. It is not a personal problem but is a
community problem which can be solved only through community participation. To solve this problem worker formed some objectives: a) To provide the basic awareness about sanitation, b) To make available few very indigenous preventive measures for sanitation. On the basis of these objectives worker planned some activities (Ref. Table 6).

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Objectives</th>
<th>Planned Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>To provide the basic awareness about the sanitation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Awareness creation through rally</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Group meetings</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>To make available a few very indigenous preventive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Awareness creation on indigenous</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Home visits</td>
<td></td>
</tr>
</tbody>
</table>

With the support of community members, the worker could implement all planned activities for reducing the poor sanitation status of the villages. He emphasized on indigenous preventive measures for reducing the poor sanitation quality of the village. He tried to convey that without community participation these types of problems can never be sorted out. Worker has demonstrated few activities like pond cleaning, use of boiled water, water should be kept clean and covered, cleanliness of the surroundings etc. He told that waste martial should not be scattered here and there and that it should be thrown in a particular place. Worker could convey the essence of the particular activities.

**Evaluation**

Evaluation of the entire process was done with the support of qualitative and quantitative approaches. Various tools were used such as observation, interview schedule, focus group discussion, nominal group technique and time series analysis.

**Observation**

Worker has observed that through his intervention community people were more aware about employment and sanitation. Certainly the level of knowledge among the community members were increased on the both problems as observed.

**Interview Schedule**

Villagers gave good and positive feedback with this belief that they will carry forward the work which worker did during the last few days. Interview schedule was administrated to evaluate the whole process and to find out the outcome of the study. In this regard trainee had an interview session with forty one members of the village
who had participated willingly in the intervention programmes. Few questions were asked to the respondents which include:

Q1. Are you satisfied with the intervention?
Q2. Was intervention beneficial to you?
Q3. Are you interested to enhance the knowledge level through such interventions?
Q4. What was your key learning from the performed activities?
Q5. How will you attempt to solve the community problem?

Mostly respondents replied that they were fully satisfied with intervention strategies, definitely they have benefited from the intervention made, and they are ready to update their knowledge level through such kind of innovative intervention. The key learning for them was to become independent and solve their own community problems by themselves. They were ready to solve their problem through own attempt. The overall evaluation of the entire process was satisfactory as presented in Table 7.

<table>
<thead>
<tr>
<th>Sl.</th>
<th>Major Problem Identified</th>
<th>Objectives</th>
<th>Planned Activities</th>
<th>Major Outcome</th>
</tr>
</thead>
</table>
| 1.  | Unemployment             | - To provide the basic knowledge of local employment opportunities  
- To make them aware about the benefit of indigenous employment | - Capacity building  
- Rally  
- Awareness creation on indigenous employment  
- Group meeting | - Change in Behaviour  
- Ready to adopt local livelihood opportunities  
- Will try to become local entrepreneur by enhancing the skills. |
| 2.  | Sanitation                | - To provide the basic awareness about the sanitation  
- To make available few very indigenous preventive measures for sanitation | - Awareness creation through rally  
- Group meetings  
- Awareness creation on indigenous preventive measures  
- Home visits | - Ready to use the homely preventive measures  
- Willing to work for the community betterment at any rate |

**Conclusion**

The study examined the strengths of Community Organization as a method of social work by reaching out to the villagers by enabling them to examine their problems and implementing activities towards finding solutions within their own means. The proposed three dimensional approach for community practice (Ref. Figure 1) was
found to be very effective in enabling the people of the village to find the solution for their own problems within their own means.

References


Thomas, G. (Ed. 2010). *Community organization management for community development*. New Delhi: IGNOU.


Strengths-based Approach to Social Work Practice with Older Persons

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ABSTRACT

Strengths-based approaches generally conceptualize strengths in two distinct ways. First, assets, resources, and abilities that can be used to assist in helping an individual to continue to develop. Accordingly, strengths are used as building blocks for service planning and programme development. Second, some strengths can be developed or enhanced. Consequently, changes in the availability of various assets, resources, and abilities for an individual can be viewed as a service delivery outcome. In working with older persons, the strengths-based approaches can prove to be extremely useful in view of the fact that most elderly have an enormous repertoire of knowledge, practice wisdom and a wide range of skill sets and by and large, helping professionals approach the whole issue of working with the elderly from a perspective of dealing with dependency and burden of care associated with it. Particularly, social work interventions, in order to be effective, need to be offered from the standpoint of strengths-based approach rather than other paternalistic models of care. There is a strong emphasis of the 'elderly as a resource' perspective in the field of ageing and various international bodies such as the United Nations have been advocating this paradigm shift among all stakeholders including the older persons themselves. Almost all nations have included this as an important aspect in their national policies and programmes for the elderly the most significant ones being China’s National Programme on Ageing and India’s National Policy for Older Persons. The authors examine the relevance of strengths-based approaches to social work practice with older persons from a global perspective, provide strategies for social work interventions and discuss the challenges for the profession.

Keywords: Strengths-based Approach, Old Age and Social Work.
Introduction

Strengths-based approach is a manner of working with individuals, families, and organizations grounded in the principle that those individuals: have existing competencies; have resources; are capable of learning new skills and problem-solving; can use existing competencies to identify and address their own concerns; and can be involved in the process of healing and self-health. A strengths-based approach is more than a set of hard and fast rules. It is a perspective. It strives to lead with the positive and values trust, respect, intentionality, and optimism. It is based on the idea that people and environments interact and change each other in the process. Each has the ability to build the other’s capacity (Hirst et al., 2011). Health care and human service professionals may utilize a strengths-based perspective in their work with individuals. While they do not explicitly follow a particular model, they view and define individuals “by their values, strengths, hopes, aspirations, and capacities, regardless of the stressful or burdensome nature of the situation around them” (Peacock et al., 2010).

A strengths-based perspective is collaborative and reduces the power differential between professionals and individuals/families (Anuradha, 2004; Greene, 2000; Rashid and Ostermann, 2009). A strengths-based perspective includes guiding concepts such as empowerment and social justice (Anuradha, 2004; Chapin and Cox, 2004). While practitioners utilizing a strengths-based perspective may refer to the influence of solution focused therapy, positive psychology or health and human care professionals’ emphasis upon individual strengths, their descriptions suggest that they are influenced by such approaches, rather than by actually utilizing the models (Hirst et al., 2011).

To effectively meet the mental wellness needs of older adults and those with disabilities, a strengths-based approach is recommended. This perspective suggests that there is a need to find out what has helped the older adult/individual with a disability get to where he or she is in life. A strengths-based approach operates on the assumption that people have strengths and resources for their own empowerment. Traditional health intervention models concentrate on deficit based approaches, ignoring the strengths and experiences of the participants. In a strengths-based approach, the focus is on the individual not the problems or concerns. Drawing on strengths-based approaches does not ignore problems. Instead, they shift the frame of reference to define the issues. By focusing on what is working well, informed successful strategies support the promotion of mental wellness in older adults with mental illness or in adults with a disability (Hirst et al., 2011).

Strengths-based and empowerment-oriented interventions simultaneously focus on client strengths and environmental strengths and strategies that include education (transfer of knowledge and skills, often among individuals in similar circumstances), self-help, enhancing social networks, advocacy, and social action. Empowerment oriented practice maintains special focus on consciousness-raising (regarding the personal and
political dimensions of issues), multi-level intervention strategies and change, and collectivity in problem solving and action. Both perspectives strongly support client participation in all aspects of the decision-making processes affecting their lives and seek egalitarian working relationships between social worker and client (Chapin and Cox, 2002). The strengths approach provides techniques and tools to help social workers focus on and identify older adult’s strengths and abilities as well as strengths of families, and communities (Fast and Chapin, 2000). Strengths assessment and goal planning is anchored in the belief that people can survive and perhaps even thrive, despite difficult circumstances. Listening to people’s stories, exploring alternative meanings of their stories, and affirming their successes, and future possibilities, is key. The social worker acts as collaborator, supports the elder’s choices, and actively works to make sure adequate resources are available for the older adult (Chapin and Cox, 2002). A strengths-based approach appears to be consonant with the selective optimization with compensation model described above and thus may be one example of a helping strategy that can promote successful ageing (Sullivan and Fisher, 1994). Strengths-based or competence perspectives on human functioning offer a different vantage point to view older adults (Weick, Rapp, Sullivan, and Kisthardt, 1989)

Elderly as a Resource—Emerging Perspectives

Older people are said to be a resource for family and society because they have lot of strength and potentialities within them. Several sources indicate trends internationally. For example, older persons workforce (in USA) has doubled in the past 50 years, from 62 million in 1950 to 141 million in 2000. By 2050, the labour force is projected to reach approximately 194.8 million. Older cohorts are expected to make up a larger proportion of the future labour force, with those 55 years and older growing from 13% in 2000 to (with modest projections) at 19% by 2050 (AARP, 2005), and more robust percentages projected at 23% (Purcell, 2000). Older workers, those between 65 and 74, will account for approximately 9 million (Purcell, 2000). Simultaneously, the labor force will become more diverse, with larger proportions of women and minorities. According to recent reports released by the Singapore Ministry of Manpower, the profile of the population age 50 and over in Singapore shows the following interrelated characteristics (MOM, 2007a, 2008, 2010).

Education

Although better education has helped drive the employment rate of older workers in recent years, in general, the older population in Singapore is still comparatively less educated within the general population because of early years of little opportunity for higher education. There has been an improvement, though: in 1991 78% of older workers had less than a secondary education, while in 2007 that percentage had dropped
to 55%; and the percentage of those with a tertiary-level education increased from 4.3% in 1991 to 14% in 2007. This is however still substantially lower than the below 50 age group, where 44% had a tertiary education.

**Employment Status**

Older workers are more likely to be self-employed (where in Singapore (26.7%), which also means that they are not restricted by a mandatory retirement age and may work for more years than salaried workers. While 90% are in full-time employment, older workers are more likely to be in part-time work (10.4%) than are younger workers (4.8%). Older workers tend to concentrate in lower-skilled non-PMET jobs (67%) due to their lower educational attainment (68%). They include cleaners, laborers, and related workers, plant and machine operators and assemblers, service and sales workers. Only 10% are working as professionals or associate professionals and technicians (15%) (MOM, 2008). 77% of older workers were employed in the service sector, including community, social and personal services, wholesale and retail trade, transport and storage, hotels and restaurants. Land transport and supporting services have the highest incidence (such as taxi drivers who are among the self-employed), followed by administrative and support services (such as cleaners and security guards) and restaurants. The incidence was lowest in IT and other information services, followed by electronic products manufacturing and financial institutions. This is expected as the hotel and restaurant sectors and the transport and storage sectors both have a relatively high median age of 47 and 46 respectively, while the information and communication sector and the financial services sector have the lowest medium age, at age 35 and 36 respectively (MOM, 2010:19). Older workers are less likely to change jobs than younger workers: 14% of older workers changed jobs in 2007 compared to 25% of those in their 30s and 34% of those younger. They seem more settled in their jobs, with longer years of work experience. The lesser opportunity available to older workers in the job market may also deter them from switching to another job (MOM, 2008). Older workers tend to work an average of 50 hours a week in full-time jobs, which is a higher average than the younger workers in their 20s and 30s. They work an average of 20 hours a week for part-time, which parallels with other age groups. Older workers are also more likely to work on term contracts: 16% of older workers, compared to 9% of the 25–49 age group, are contract workers (in the MOM, 2008).

HelpAge International (2000) found that older people in Africa have to shoulder the burden of caring for orphans ranging from 12 to 17. Research in Uganda (Williams and Tumwekwase, 1999) found that it was impossible to focus only on HIV/AIDS. In the village, 30 older people were looking after 58 grandchildren, of whom two-thirds were orphaned for reasons other than AIDS. A report by WHO (2002) states that older people having ‘taken on new roles by providing care and financial support to orphaned children and playing child-rearing roles within their extended families’. However, the
idea that the role is ‘new’ is debatable. In many communities, older people, particularly older women, traditionally played an important role in the care and upbringing of children. Studies from Tanzania (Urassa et al., 1997) provide evidence of the many and varied care arrangements that existed within the community, with orphaned children cared for by various family members and ‘foster-care’ arrangements common when one or both parents moved away for work or other reasons.

Older People and Volunteering

Volunteering is an activity that is of benefit to the community, is done of one’s freewill and is undertaken without monetary reward. The ABS survey into voluntary work in Australia found that whilst volunteer rates increased in all age groups and both sexes, it increased the most in the 18–24 (17% to 27%) and the 55–64 (24% to 33%) years groups (ABS, 2001, 3). Whilst the number of volunteers was highest in the 35–44 age group (40%), older Australians tend to volunteer more time (Onyx and Warburton, 2003, 65; ABS, 2001, 6–7). The ABS survey found that amount of time spent in volunteering increases with age such that the 65–74 age group median hours were 2.5 per week compared to the overall median hours of voluntary work of 1.4 per week (ABS, 2001, 6–7). Further, older people tend to stay with organisations longer (Onyx and Warburton, 2003, 65). Also, the amount of informal volunteering was not recorded by the ABS, thus perhaps underestimating the amount of older volunteering with respect to other age groups.

Older people tend to volunteer more in community and welfare based organisations that would particularly affect organisations in the areas of emergency services, sporting and recreation, and education, training and youth development (Productivity Commission, 2005, 93–94). Older people can and do volunteer in a diverse range of fields. In Australia older volunteers are ‘more likely to volunteer for community or welfare organisations than other age groups’ (Onyx and Warburton, 2003, 65; ABS 2001, 23) (this was true of all age groups over 55). They also volunteered in sport/recreation, education/training/youth development, religious organisations and health but (in descending order) in fewer numbers (ABS, 2001, 23). One American study of 55–74 year olds found that those who volunteered did so in religious organisations (29%), educational organisations (7%), political organisations (7%), senior citizen groups (13%), and other (17%) (Mutchler, Burr and Caro, 2003). The review of the English Home Office Older Volunteers Initiative found that older people can (with encouragement) volunteer in a large number of areas where they do not traditionally do so (Rochester and Hutchison, 2002, vii). The areas they were involved in included health promotion, community education, social welfare, child protection, education, social welfare, crime prevention, heritage, and overseas development (Rochester and Hutchison, 2002, 14).
Family and Friends

Older people place great value on their relationships with spouse, family and friends. Since added years of life prolong a person’s relationships with others whose lives are also extended, the result is an important and continuing source of fulfilment (Hooyman and Kiyak 1988). This belies the myth that older people are typically lonely and alienated from family and friends. Older people play an important role in supporting and maintaining informal social networks and thus provide the ‘social glue’ that binds three and even four generation families. ‘Family ties, the giving and receiving of support, having fulfilling family roles, and caring are core family concepts for older Australians’ (Minister for Aged Care 2000, p 9). Over 70 per cent of older people live with others usually a spouse, 20 per cent live alone, and the eight per cent who live in non-private dwellings including residential care are mostly aged 75 years and over (Australian Institute of Health and Welfare 2002b).

Older People Caring for Older People

Married couples expect to enjoy their retirement years together. Earlier research suggested that retirement involved some marital dissension, given the scenario that the man retires from work to become an intruder in his wife’s domestic domain, but times are changing. First, longitudinal studies show that the initial conflict following retirement resolves as a couple re-negotiates territorial issues and the majority of both men and women report experiencing the same or greater marital harmony a few years after retirement (De Vaus and Wells 2003). Second, an increasing number of older women are in the workforce, which may blur the traditional division of labour where the wife runs the home, considering it ‘her domain’, and resents the intrusion of her retired husband and the disruption he causes. However, time use surveys indicate no significant re-working of gender roles among the current generation so far, and no greater equality in the way domestic tasks are performed. With their increased leisure status, retired married men spend more time on outside domestic work and other leisure pursuits but do very little extra housework, while women increase the time they spend on domestic work and other leisure pursuits (Healy 1988; De Vaus and Wells 2003).

The Australian Survey of Disability, Ageing and Carers estimated that most primary carers of older people were over the age of 65 years, with 39 per cent aged 65 years plus and 82 per cent aged 45 years. According to the ABS definition, these people provide informal assistance to someone with a disability who has needed help with self-care, mobility or verbal communication for at least six months (Australian Institute of Health and Welfare 2002b, p.42). Most carers aged 65 years and over provide care to another older person, 75 per cent care for their partner and ten per cent for a parent. Over two-thirds of primary carers of older people are women, partly
because of their socially conditioned role as carers and partly because they outlive men so that an elderly wife is likely to look after her husband when he is disabled or terminally ill. Increasing life expectancy does make it more likely that one partner will outlive the other and be left alone at more advanced years.

**Older People Helping Adult Children**

According to a large Sydney survey conducted in 1981 (Kendig 1986), older people were more inclined to be the providers rather than the recipients of many kinds of support. They were more likely to have given financial support, were twice as likely to have been providers as recipients, and nearly half helped someone outside the household with the tasks of daily living. Data from a more recent survey of Australian families also show that adult children are more likely to receive help from their older parents than to give it (De Vaus and Qu 1998). The ages between 55–64 years are the peak years for providing financial support to other family members (Minister for Aged Care 2000). On an average, people aged 65–74 are net providers of private financial transfers, only becoming net receivers when past the age of 75 years. Families therefore establish patterns of reciprocity for financial, practical and emotional help between older and younger family members, with the balance changing over the life course. American studies, for example, have found that parents are the most important sources of support for adult children coping with a variety of life crises such as divorce, early widowhood and grief (Hooyman and Kiyak 1988).

**Grand Parenting**

Families with grandparents are now the norm rather than the exception as was the case a century ago. With an extending life span, older people generally expect to become grandparents although they have fewer grandchildren. Conversely, children in increasing numbers of families now have the advantage of contact with grandparents. Australian statistics are not available, but the majority of older people in the US are grandparents and over 75 per cent see at least one grandchild every week or so (Hooyman and Kiyak 1988). The increasing importance of grandparents has meant that this long-neglected role is beginning to receive some research attention both in Australia and internationally. Contemporary grandparents are more active, healthier and wealthier than their own grandparents were and have more time, energy and money to devote to their personal interests including grandchildren. Although few grandparents now live with grandchildren, they are often called upon to ‘help out’ with their care. Further, studies report that grandparents generally offer grandchildren unconditional love, which their parents, perhaps because of their parental roles and other responsibilities, may be less able to do (Hooyman and Kiyak 1988).
Enhancement of the Strengths of Older Persons

Empowerment-oriented and strengths based practice with older adults who face physical, mental and resource related challenges in late life have gained recognition in recent decades (Chapin and Cox, 2002). Cox (1999) noted that social justice provides an overall guiding principle for empowerment-oriented practice. Most proponents of this approach stress a knowledge base that includes a historical view of oppression; an ecological view of individual and group functioning; ethnic, class, and feminist perspectives that illuminate the political aspects of issues; and a cultural perspective that enhances understanding of values, beliefs, behaviors, and an overall critical perspective (Lee, 2001; Breton, 1994; Estes, 1999). Strengths and empowerment-oriented practitioners and other advocates for effective services for older adults have designed programs that attempt to modify the medical model by calling for increased client participation in service design and implementation. Review of current literature suggests the following guidelines for programs to assure quality of service for frail elders: (a) living environments that support independence; (b) consumers determine timing and intensity of services; (c) understanding that disability and care arrangements are transitory; (d) environmental supports for ageing in place (social and formal support network members); (e) effective care coordination; (f) ongoing assessments; and (g) monitoring of outcomes (Marek and Rantz, 2000).

Empowerment-oriented practitioners have suggested program characteristics that: (a) make possible transfer of knowledge and skills useful in self-care to clients, their families, and communities; (b) transfer expertise to clients that will increase their policy and program skills; (c) use intervention strategies that help clients understand their personal problems in a broader perspective as public issues; (d) provide training and motivation for clients to critically analyze their life situation and take part in consciousness-raising experiences; (e) emphasize cooperative and interdependent activities for accomplishment of mutual goals and provide respected societal roles for elders; (f) establish worker/client relationships that essentially represent partnerships, or are egalitarian in nature; (g) enable clients to develop or maintain personal support networks; (h) enable groups to take more active roles in decision making that affects their environment; (i) evaluate service provision in terms of its contributions to empowerment and social justice; and (j) inclusion of clients in the evaluation process (Cox and Parsons, 1994). The strengths approach provides techniques and tools to help social workers focus on and identify older adult’s strengths and abilities as well as strengths of families, and communities (Fast and Chapin, 2000). Strengths assessment and goal planning is anchored in the belief that people can survive and perhaps even thrive, despite difficult circumstances. Listening to people’s stories, exploring alternative meanings of their stories, and affirming their successes, and future possibilities, is key. The social worker acts as collaborator, supports the elder’s choices, and actively works to make sure that adequate resources are available for the older adult.
Relevance of Strengths-Based Approach for Social Work Practice

Gerontological practice can be viewed as a tool for helping people meet basic human needs. As with empowerment-oriented practice, social work practitioners, faculty, and students around the country have been exploring methods for actually integrating the strengths perspective into gerontological social work practice, policy, and research (Fast and Chapin 2000, 2001; Perkins and Tice 1995). Potentially, integration of the strengths perspective and empowerment-oriented interventions into gerontological social work can provide practitioners with new tools for conceptualizing social needs or problems, a more inclusive approach to formulation of the helping process, and an expanded array of empowering practice options. Strengths-based practice proponents stress values that encompass human potential to grow, heal, learn, and identify wants. Individual uniqueness, self-determination, and strengths of person and environment are also strongly acknowledged (Fast and Chapin, 1997). Systems theory and ecological perspectives are frequently relied upon knowledge bases (Saleebey, 1997). The philosophical values base and knowledge bases of both practice models support a strengths approach to assessment and intervention.

When clients are viewed as people with strengths rather than as pathological or deficient, then the absolute necessity of their inclusion in problem definition at both the direct practice and policy practice level cannot be denied. Social workers can then clearly see that efforts to assure that client voices are heard and understood are fundamental to effective practice. The importance of ensuring inclusion of clients’ voices becomes clear when the problem definition process is viewed in this way, and the focus is on the strengths rather than the deficits. Assertive outreach and efforts to ensure resource acquisition sufficient to create an environment supportive of individual and community strengths are key to strengths-based practice. The elders that social workers see are typically ones with needs that the elder cannot meet, often due to disability and or serious lack of economic resources, including health care access. Additionally, elder client populations are becoming more ethnically diverse as noted by Torres-Gil in his article in this special edition (Chapin and Cox, 2002). The strengths approach provides techniques and tools to help social workers focus on and identify older adult’s strengths and abilities as well as strengths of families, and communities (Fast and Chapin, 2000). Strengths assessment and goal planning is anchored in the belief that people can survive and perhaps even thrive, despite difficult circumstances. Listening to people’s stories, exploring alternative meanings of their stories, and affirming their successes, and future possibilities, is key. The social worker acts as collaborator, supports the elder’s choices, and actively works to make sure adequate resources are available for the older adult. Potentially, integration of the strengths perspective and empowerment-oriented interventions into gerontological social work can provide practitioners with new tools for conceptualizing social needs or problems, a more inclusive approach to formulation of the helping process, and an
expanded array of empowering practice options. Strengths-based practice proponents stress values that encompass human potential to grow, heal, learn, and identify wants. Individual uniqueness, self-determination, and strengths of person and environment are also strongly acknowledged (Fast and Chapin, 1997).

Challenges for Social Work Profession

Social workers face a most demanding and challenging task as we struggle to develop gerontological practice for future decades. The development of empowerment-oriented and strengths approaches have increased the complexity of this challenge. Works to reframe practice issues so that needs of the older adult are normalized rather than pathologized, is central to this process. Social workers can take the lead in this reframing process. Gerontological social workers who are following the philosophical value, and practice directions of these empowerment and strengths approaches are faced with the demanding task of integrating the personal, interpersonal, and political components into their intervention strategies. For social workers who are committed to supporting client autonomy, an approach to policy practice and direct practice that is based on collaborating with consumers of service is critical. New strategies are required in order to achieve more egalitarian client/worker relationships and client participation in policy and program development (Chapin and Cox, 2002).

Conclusion

The strengths perspective emphasizes the personal and community assets of a client rather than their deficits and offers possibility, promise and hope for the future. The approach is flexible and can be applied to a wide range of interventions including disability, family and old age support services. Strengths-based and empowerment-oriented interventions simultaneously focus on client strengths and environmental strengths and strategies that include education, self-help, enhancing social networks, advocacy, and social action. Health care and human service professionals utilize strengths-based perspective in their work with individuals. Strengths-based assessment tools provide practitioners with positive methods to assess strengths and competencies, and thereby develop a strengths-based intervention plan. Strengths-based interventions are designed to enhance the strengths of particular populations. Such interventions are tailored to the specific needs of the elderly population. To help the elderly rediscover their strengths and abilities, social workers are encouraged to convey a positive and optimistic attitude, and use strengths-based approaches. The strengths approach provides techniques and tools to help social workers focus on and identify older adult’s strengths and abilities as well as strengths of families, and communities. Gerontological practice can then be viewed as a tool for helping the elders to meet their basic human needs. The strengths approach provides techniques and tools to help social workers focus on and
identify older adult’s strengths and abilities as well as strengths of families and communities.

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Women Infected with HIV/AIDS in Urban Community—Implications for Social Work Practice

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ABSTRACT

HIV/AIDS is one of the burning issues affecting mankind has now emerged as a global challenge. Women represent almost 50% of the global infection totals. Women are more susceptible to HIV because of biological and socio cultural factors. Solution focused Counselling approach has proved beneficial in dealing with women infected with HIV/AIDS.

In this paper the researcher made an attempt to know the social, psychological and economic impact of HIV/AIDS on the lives of women living with HIV/AIDS and to understand the implications for social work practice to enable them to cope up with the psycho—social problems.

Keywords: HIV/AIDS, Infected Women, Psycho-Social Problems, Social Work Practice.

Introduction

Gender is a prime cross cutting issue for increasing the vulnerability of women in the context of HIV/AIDS due to the lack of women’s equality and the consequent gender vulnerabilities to HIV/AIDS. This is one of the major obstacles in mitigating the spread of the disease among women in India. Existing social and gender norms stemming from the caste system and a patriarchal dominated society have a profound effect on the sexual activity and risk behaviours of men and women, which ultimately further marginalize women. Such systems increase women’s vulnerability to HIV by denying those rights inherent to them such as education, inheritance, protection from violence and access to appropriate prevention and health services.

HIV/AIDS has profound effects on individuals and the society. Barnett, Whiteside and Desmond, 2000 reviewed several studies on the social and economical impact of HIV/AIDS in poor countries and concluded that most of the social aspects can be observed at micro and macro levels. Many social and economic determinants such as
poverty and societal marginalization render groups of individuals and their families susceptible and vulnerable to HIV infection. Stigma, discrimination and collective denial associated with HIV infection make the life of the individual and that of family members agonizing. Even in the daily lives PLHA’s (people living with HIV/AIDS) are faced with severed relationships, desertion and separation from family members or relatives, even physical isolation at home. Disclosure of HIV infection can lead to lot of stress. Such stress may arise due to the perceived discrimination, disgrace and disharmony, concern about insurance and employment, a desire to protect on self and others emotionally and from violence. The choice of disclosure is a complex decision and varies in different cultures from revealing HIV status to friends and sharing this with family members.

Hackman (2002) conducted a study on psychological symptoms among 50 years of age and older patients living with HIV Disease. Twenty five per cent of respondents reported moderate or severe levels of depression. A hierarchical multiple regression analysis revealed that HIV infected older adults who endorsed more psychological symptoms also reported more HIV related life stressor burden less support from friends and reduced access to health care and social services due to AIDS related stigma.

Studies have revealed that there is a definite relationship between HIV/AIDS and economy. In other words HIV status of an individual has an impact on productivity. In a study of 500 truckers in Zimbabwe by Rosina, Clainos, Joseph and Jilson, 2011 on “The Haulage of HIV/AIDS and the Economic Impact on the Productive Age in Zimbabwe: The Role of Truckers” it was revealed that truck drivers play a major role in the spread of HIV and AIDS. The most vulnerable are the married and economically active people between the ages of 30–50 years.

Women are facing devastating impact of HIV/AIDS in world over. In India women are already economically, culturally and socially disadvantaged lacking access to treatment, financial support and education. They are outside the structures of power and decision-making. They lack the opportunity of participating equally within the community and are subjected to punitive laws, norms and practices exercising control over their bodies and sexual relations. They are perceived as the main transmitters of sexually transmitted infections (STIs) referred generally as women diseases. The traditional beliefs about sex, blood and other type of disease transmission, these perceptions have become fertile ground for the stigmatization of women within the context of HIV/AIDS.

- Women are increasingly infected with HIV/AIDS than infected men.
- Women are being infected significantly at a younger age than men.
- Young girls in their teens and women in early twenties are becoming infected than women in any other age-group.
Cultural norms favoring early marriages and early pregnancies or discouraging the use of condoms make women more vulnerable.

Rape, sexual abuse and coercion, exchange of sex with older men for favours, sexual exploitation by teachers increasingly make women more vulnerable to HIV/AIDS.

Among women alcohol and drugs are often linked to the exchange of sex for drugs or money increasing the risk of HIV.

Having looked at the studies pertaining to impact of HIV/AIDS on women it is essential to understand why women do not seek treatment. Based on these observations the following reasons are spelt out:

**Reasons Why Women do not Seek Treatment include**

- Low self-esteem and abusive relationship.
- Fear of being recognized and ostracized from the community.
- Distrust in health care system.
- Partner’s failure to disclose status.
- Women are restricted by household responsibilities and lack of mobility.
- There is restricted access to prescribed treatment due to poverty.
- Women oriented health services do not include STD related services.
- Services that only focus on STD treatment carry a greater stigma than integrated services.

**Empowering Women**

Women have the right to say ‘NO’ to unsafe sex and to share needle and syringes but it does not happen in India since India being a patriarchal society and women being vulnerable to HIV/AIDS. Empowering women is the need of the hour. The following measures need to be taken up:

- Insisting the male partner to use condom always for sex.
- To have sex with one partner who they know is not infected with HIV/AIDS and who is not engaging in high risk behaviour.
- To have regular sexual health care checkups to prevent STDs.
- To use sterile needle and syringe each time to inject.
- Finding a way to talk to the partner about HIV/AIDS prevention helps to feel good about the relationship.

These measures when undertaken will certainly bring down the incidence of women infected with HIV/AIDS.

It is seen that the major brunt of all social inequalities has to be borne by the most disadvantaged persons in any community. Women with HIV infection being such
persons—increasing HIV epidemic would affect them in all aspects of life (Kulkarni, 1999).

The direct impact of AIDS on women in the developing world is particularly devastating. Not only does the disadvantaged position of women make it much difficult for them to choose safer sex in their own lives, but a lack of prenatal care also makes it difficult for pregnant women with HIV to reduce the chances of infecting their children. Women bear a disproportionate burden of caring for the ill in the home. In many parts of the world, women whose husbands die of AIDS may be left with children but without access to inheritance. Areas with high AIDS—related mortality are seeing an erosion of the extended family structure that often provided such women with their only support (Dutt, 1998).

Women desperately need methods to prevent heterosexual transmission of HIV that are under their control and do not depend on the male partners. HIV infection in women often represents the threat to two or more people—a mother and her progeny. In fact HIV transmission from mother to child is responsible for a very large number of new cases in HIV infection in children.

Against this background we can say that women need counselling on reproductive health issues, family planning and safe infant feeding. There is a need for active networking for comprehensive healthcare and social support for positive women and their family. Pregnant women and infants should be tested who are in high-risk category. There should be rapid assessment for anti-retroviral therapy. Other supportive treatments should be given side-by-side for their rehabilitation.

**Social Work Practice in HIV/AIDS**

HIV/AIDS crosses all fields of practice. Social work practice in this area continues to evolve, as social workers provide support to persons living with HIV/AIDS and those affected by the disease through direct counselling, treatment intervention and social justice activities.

HIV/AIDS affects millions of individuals and families world-wide. The epidemic continues to shift toward women and young people. It has been estimated that around two in five adults living with HIV in India are women (UNAIDS, 2004), and in 2004 it was estimated that 22 per cent of HIV cases in India were housewives with a single partner (Heffernan G., 2004). The increasing HIV prevalence among women can consequently be seen in the increase of mother to child transmission of HIV, and infections among children. In short we can say that in India, the rate of infection continues to rise. Those at risk include youth, women, men who have sex with men, and heterosexual men who engage in high-risk activities such as unprotected sex and sharing of needles.
While there is no cure for the disease, people are living longer with all the accompanying joys and challenges this entails since they are left with no other choice. Some of these challenges include dealing with the side effects of anti-retroviral medications, coping with grief and loss, and dealing with the continued stigma of HIV/AIDS.

Social workers possess the knowledge and skills to work effectively with individuals who are living with HIV/AIDS and those affected by the disease, including family members, friends, partners and children. Social workers bring the unique skill of working with people within the context of their environment and advocating change that best meets the needs of clients.

On an individual level, social workers provide a broad range of services and supports to those living with HIV/AIDS such as counselling, referral services, collaborating with support groups, etc. Social workers also play the role of a Liaison/Mediator trying to connect between needs and resources. Social workers are familiar with community resources such as income support bureaucracies, education/training programs and career planning, prescription drug programs and policies, short- and long-term disability programs, housing, human rights legislation, addictions services, legal services, services and resources for people who are gay, lesbian, and bisexual, and nutrition and food security. Social workers often work with those living with HIV/AIDS to navigate these systems, while empowering clients to make informed decisions affecting their health.

Social workers also provide therapy and counselling for concerns such as new diagnosis, disclosure, intimate partner violence, depression, fertility, anxiety, relationships (intimate and familial), grief and loss, and addictions. Often, they work within the context of a multidisciplinary team in providing support for those living with a chronic illness. Team members may include a nurse practitioner, physician, pharmacist, psychologist, psychiatrist, immunologist and a representative from public health. Therefore the social worker is an important member of the team and contributes to the well being of his clients.

In the community context, social workers continue to advocate on behalf of those living with HIV/AIDS through community organization and policy development. They also provide education to reduce the incidence of HIV through harm reduction and health promotion. Social workers understand that health care is more than medical care.

**Implications for Social Work Practice**

A successful AIDS prevention Programme requires appropriate social work response (Thomas, 1994). The most sensitive aspect of this disease is that since acquiring it is
associated with sexual behaviour, social and ethical. In the absence of a preventive vaccine or a curative drug, prevention by education and counselling is the only major means of reducing or even stopping the spread of HIV infection and learning to live with HIV and AIDS. While working with women infected with HIV/AIDS there is a need for social work practice so as to enable them cope up with the Psycho-social problems faced by them.

Thousands of HIV infected people live in isolation and loneliness, looking towards care and human touch which professional social work methods can offer (Thomas, 1994). Some of the problems faced by the HIV/AIDS victims in India include:

- Identity crisis
- Social denial
- Denial of health care
- Low self image
- Guilt feeling and
- Family disintegration.

The social worker plays a vital role in Information Dissemination. To educate people about AIDS, it is necessary first to overcome denial. Until the fact that there is a problem is acknowledged, modifying risk behaviours is not possible. The role of a social worker in a medical team is as important as, that of a physician (Thomas, 1995). While the medical practitioner’s role is limited to treatment of a patient, the social worker deals with the social, physical, psychological, economic and environmental aspects of the patient who is under treatment. The social worker is the right person who is professionally trained to understand all these aspects of a patient who needs care and treatment.

The social worker helps in coordinating the work of the entire team. He/She prepares the patient to accept the treatment prescribed by the physician. In certain instances, particularly cases like STD/HIV/AIDS and cancer, the social worker explains to the client the need for undergoing laboratory tests. The very decisions to go for an AIDS test require counselling by a Social worker. In several cases, the social worker may have to receive the result of the test and convey the same to the client. Given the present situation, when no cure is available for AIDS patients, a positive test result is a death sentence. The client, his/her family and relatives need to be psychologically prepared for receiving the test results. It is in fact a stupendous task for a social worker in India to handle AIDS cases because of the taboos attached to some of the means of transmission like sex and drugs (Thomas, 1995).

The NGOs and Professionally Trained Social Workers have a rich experience of working with people at the grassroots level through community organization programmes. Their accommodating nature helps them to respond quickly to local situations and needs. They can easily have access to marginalized groups, which are
not reached through government programme. Further, the NGOs and PTSWs can help in raising the self-esteem and confidence of target groups to deal with problems in their own way (Thomas, 1997). They also could organize training programmes for various target groups, on STD/AIDS, means of prevention and control of HIV infection, self protection from infection, dispelling wrong notions, counselling techniques and care of the sick, and psychologically and human rights aspects is an important area where professional social workers need to concentrate.

By itself, information increases knowledge but does not change behaviour. Professional social workers who are specialized in human behaviour and who are experts in using various techniques of purposefully interacting with individuals, groups and communities can act as catalysts in disseminating information on AIDS.

Advocating Health Policies is another important role which the NGOs and professional social workers could play. (Thomas, 1995) Formulation of specific HIV/AIDS discrimination legislation, and guaranteeing that public health measures of AIDS prevention such as confidentiality of HIV antibody test information are effective. The policy for avoiding and overcoming AIDS—related discrimination has a firm base not only in the public health rationale, but international human rights. The professional social workers, NGOs and AIDS activists should pursue their struggle for initiating new policies needed for the benefit of HIV/AIDS cases by raising and addressing legal, ethical and human rights issues in public press and Parliament.

The Social Work Activities

Thomas (1995) has classified six major categories of Social Work Activities in relation to HIV/AIDS which are stated below:

1. Social Case Work: A professionally trained social worker is able to go deep into the pains of an HIV infected person and enable the client to face up to problem by using the method of social case work counselling.

2. Social Group Work: The HIV infected individuals are much in need of group help. In an HIV support group, group work focuses the HIV infected Individual in the group. The group itself is a platform where the HIV/AIDS clients are able to freely express themselves and share their problems and help one another. The Social worker, who is instrumental in organizing the HIV support group, guides the group work process. Mutual acceptance is the basis of social group work. It is easier to help an HIV infected person to change his/her attitude to the rest of one’s life in a group setting than to change one through social case work counselling. Social case work prepares an HIV infected client to join the HIV support group for meaningful living with HIV in the given situation.

3. Community Organization: The social worker who is experienced in dealing with the individuals and groups through the case work and group work process can
very well bring about the people of a particular community for necessary action to prevent and control the spread of AIDS. The very programme of awareness campaign can be meaningfully executed by a social worker who knows the language and pulse of the people in a given community.

4. **Social Welfare Administration:** In providing services to the HIV/AIDS patients the social agencies handling any programmes related to this pandemic should have professionally trained social workers to man the service delivery system.

5. **Social Work Research:** For the effective implementation of any HIV/AIDS related programme, the role of social work research is as important as any other scientific and medical research. The issues surrounding HIV/AIDS are very sensitive to individuals, groups and communities. A social worker is the most ideal person to assess these social issues, the type of people most affected or vulnerable and suggest the most appropriate action plan which is effective and acceptable to the community.

6. **Social Action:** The present HIV/AIDS scenario in the country may probably require a lot of social action activities. At present, no social action programmes on AIDS related issues are seen in the country. Given the lackadaisical approach of the central and state governments in the country, social action is the only method that may bring about changes in the HIV/AIDS prevention and control programmes and the care and treatment of the already infected in the country.

Focusing on individual, group and community levels, social workers could attempt to change their predisposition towards single partner sex, safe sex, drug-behaviour, blood transfusion and the like. Research brings out the inter-connection between sense of self efficacy and beliefs, attitudes and behavioural patterns, Blood donors, CSWs and IDUs may be less bound by social concerns and personal health, and be more rebellious and risk-taking individuals. Social workers could strengthen their sense of self-efficacy. A viable intervention strategy has to incorporate a better understanding of human behaviour and group dynamics (M.Z. Khan, 1994).

**Aim of the Study**

This study aims to know the social, psychological and economic impact of HIV/AIDS on the lives of women living with HIV/AIDS in urban community and to understand the implications for social work practice to enable them to cope up with the psycho—social problems.

**Objectives of the Study**

The objectives of the study are:

- To understand the impact of social issues on women living with HIV/AIDS in urban community.
• To know the impact of psychological issues on women living with HIV/AIDS in urban community.
• To assess the impact of economic issues on women living with HIV/AIDS in urban community.
• To understand the implications for social work practice in working with women living with HIV/AIDS in urban community to enable them to cope up with the psycho—social problems.

Research Methodology

Systematic random sampling method was adopted by the researcher and 150 respondents were selected for the study where every second women living with HIV/AIDS was drawn from the list of these women from the urban community namely Vombay colony. The data pertaining to 100 respondents were analyzed through diagrams and fifty respondents' data were interpreted through case studies to depict the wide range of social, psychological and economic issues pertaining to HIV/AIDS. The data was collected through interview schedule. Here three case studies would be presented.

Results and Discussion

Figure 1 shows the impact of illness on the social life. It was observed that 72% of the respondents suffered from stigma, followed by 14% who were neglected by the society, 9% of them are discriminated while 5% of them were accepted by the society.

![Graph showing impact of illness on social life](image-url)

**Fig. 1: Impact of Illness on the Social Life**
Regarding social impact of HIV/AIDS as presented in Figure 2. It was observed that a vast majority of the respondents that is 81% of them said they experienced stigma and discrimination, 9% of them expressed that their children had to discontinue their education on knowing their HIV positive status 8% of them were unable to attend to work, and the remaining 2% revealed that they were not attending social functions.

Figure 3 reveals about the psychological feeling when stigmatized and discriminated due to HIV status. A vast majority of the respondents that is 87% of them suffered from depression, followed by an equal number of 5% who expressed feelings of anger and loneliness and the remaining 3% who are frustrated.
Monthly income of the women living with HIV/AIDS is presented in Figure 4. More than half of them that is 53% of the women earned an income ranging between ₹1000–4000, 43% of them are housewives and hence they are financially dependent on their husbands or parents in case of widows, 3% of them earned a monthly income between ₹4000–6000 and the remaining 1% earned less than ₹1000 per month.

![Fig. 4: Monthly Income](image1)

With regard to property ownership it is clearly seen in the Figure 5 that a good number of the respondents that is 69% of them did not own any property while the remaining 31% of them owned some property. This clearly indicates the economic impact of the illness.

![Fig. 5: Property Ownership](image2)

Figure 6 reveals data pertaining to the main issues faced by women infected with HIV/AIDS. It was observed that a majority of them that is 49% of them experienced a decrease in income levels and become highly food insecure, 29% of the respondents
were suffering from psychological problems, 11% of them were worried about their
dependence on their old parents, 5% of them were harassed by their in-laws and
husbands, 3% of them are victims of separation from husband or divorced, 2% of
them had to forego their property rights due to their illness and the remaining 1%
were experiencing anxiety due to change of occupation due to the HIV status.

Impact of HIV/AIDS in the community is seen in Figure 7. More than half of the
respondents that is 58% experienced stigma and discrimination, 32% of them opined
that the problem is getting worse, 6% of them said that not much of information is
available to them with regard to how to face the situation and the remaining 4%
expressed that people are too scared of the disease.

Case Studies

1. B. Subhadra aged 32 years is working as a daily wage labourer. Her monthly
income is ₹ 4,000. She has a daughter and a son. This HIV positive woman is a
widow and to add to her agony her daughter is also tested HIV positive. Her
health condition does not permit her to go for work regularly and hence she finds
it difficult to make both ends meet. Her daughter too is of frail health and requires a lot of attention. The child becomes distraught if she misses her school. So far she has not informed the school authorities about her daughter’s condition fearing discrimination and expulsion.

2. Twenty eight year old T. Prameela Rani is a mother of three daughters. She is suffering from HIV for the last 8 years. Her husband is a brain stroke patient. She has contracted HIV through her husband. She is working in a company and is earning ₹3,000 per month. At her young age, she has had to face many problems. Because both husband and wife are HIV positive, it has been an uphill task to keep a brave front and get on with life. Looking after her husband takes a heavy toll on her. She wonders why she is cursed to lead such a painful life. Her daughters are growing up and she is worried for them. She worries all the time about them when she is away at work and constantly prays that nothing unfortunate befalls them. Another constant thought on her mind is what would happen to them all if both the parents fall seriously ill.

3. A. Sathyavathi 31 years is HIV positive and is a house wife. Her husband works as a mechanic. His promiscuous behaviour led to him being diagnosed as HIV positive. Sathyavathi is also tested positive. She has two children. She is from a poor family. Her health condition is also not satisfactory. Gradually his health deteriorated and her husband is unable to attend his duties regularly. So he lost his job. Now she is forced to find work because of her husband’s illness. What she earns is insufficient to meet their monthly needs.

Conclusion

The present study’s objective is to analyze the social, psychological and economic impact of HIV/AIDS on the lives of women living with HIV/AIDS in urban community and to understand the implications for social work practice to enable them to cope up with the psycho-social problems. The total sample consisted of 150 respondents (100 for the quantitative study and 50 that are studied through case studies) who are women living with HIV/AIDS from Vombay colony an urban community in Vijayawada, Andhra Pradesh, India. Both quantitative and qualitative research techniques were used for the study. The data that was collected through interview schedule revealed that nearly three fourths (72%) of the respondents suffered from stigma due to the illness, with regard to the social impact of HIV/AIDS it was reported that a vast majority of the respondents (81%) of them said they experienced stigma and discrimination, the psychological impact of HIV/AIDS suggested that more than three fourths (87%) of them suffered from depression, more than half (53%) of the respondents earned an income ranging between ₹1000–4000, 69% of them did not own any property, majority of them (49%) of them experienced a decrease in income levels and become highly food insecure and more than half of the
respondents (58%) experienced stigma and discrimination. The case studies clearly indicated a wide range of psycho-social and economic impact of HIV/AIDS on the women infected with HIV/AIDS calling for social work intervention.

The social worker plays a vital role in dealing with women infected with HIV/AIDS in an urban community. The role of a social worker in a medical team is as important as, that of a physician. While the medical practitioner’s role is limited to treatment of a patient, the social worker deals with the social, physical, psychological, economic and environmental aspects of the patient who is under treatment. The social worker is the right person who is professionally trained to understand all these aspects of a patient who needs care and treatment. The situation of AIDS in urban community has proven that there is an implication for social work practice. The social worker can practice the six methods of social work namely social case work, social group work, community organization, social welfare administration, social work research and social action depending upon the individual client.

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Creating Supportive Communities in Mental Health: The RFS (I) Experience in Bangalore, India

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ABSTRACT

The article deals with the need for and ways of creating supportive communities for persons with mental illnesses, in the context of the work of the Richmond Fellowship Society (India). The concept of psychiatric disability is discussed in detail, emphasising the role of medication and psychosocial rehabilitation in recovery from mental illness. Some of the challenges facing the Indian mental health scenario are outlined, notably the acute shortage of trained manpower and its impact on mental health services.

Stigma concerning mental illnesses is a major barrier to recovery, both for the ill person as well as the entire family. This unfortunate reality, combined the lived experience of mental illness erodes personal dignity in several ways. The restoration of dignity as a key focus of rehabilitation and processes by which this is achieved are discussed.

The Therapeutic Community (TC) approach practised at the RFS(I) and how it fosters dignity and recovery through various therapeutic elements is elaborated. Early intervention and treatment, collaborative and supportive partnerships with family caregivers, professional involvement in care through a multidisciplinary service team are practice aspects that are described further.

Community-based rehabilitation in mental health care and the role of the community are delineated using the RFS(I) experiences in urban and rural areas. The various community resources such as volunteers are discussed. The lessons learnt in terms of creating and engaging community support in rehabilitation are culled out from the 25 years of experience of the organisation.

Keywords: Richmond Fellowship, Psychosocial Rehabilitation, Community, Mental Health, Therapeutic Community.

Introduction

Mental illnesses are obscured by myths, misconceptions and stigma. At the same time, they are not uncommon and often go unrecognized. Our understanding of
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mental disorders has evolved over the centuries crossing difficult and uneven paths, often influenced by the dominant social, economic and religious views and beliefs of the time. Superstitious explanations of mental disorders were followed by the emergence of medical concepts. As the spirit of scientific enquiry appeared, the inhumane treatment of people with mental disorders was questioned. With the recognition of a need for special treatment of persons with mental disorders, came the founding of various “asylums” all over the world. However, institutionalization in the name of special treatment came with a cost. Isolation and maltreatment of patients became widespread. As this situation was recognized, efforts were made to help individuals with humane treatment in the 18th century (Kalyanasundaram and Ramaprasad, 2012).

The first half of the 19th century was marked by the flowering of moral treatment where mentally ill patients were treated with compassion and concern. By the end of the 19th century most of the state hospitals had become primarily custodial. In the early part of the 20th century, the emphasis was on the need to understand the role of the social environment and biological factors in determining psychopathology. This was in tandem with the mental hygiene movement, whose goals included rehabilitation and whose tenets anticipated many of the principles of the community mental health movement (Lamb, 1994). The introduction of antipsychotic medications in the 1950s paved the way for the modern era of psychopharmacological advances and management of the mentally ill.

Consequently, our understanding of what associated disability sets in with mental illness, has undergone significant changes over time as we have been able to understand mental illnesses in better light than before. Accordingly, the notion of psychiatric disability also has undergone a sea change from being viewed as a handicap, to a concept incorporating personal, social and environmental dimensions. Till recently mental illness was conceptualized and treated only from a medical perspective.

However, the new perspective on mental illness, represented by the WHO’s International Classification of Functioning, Disability and Health (ICF) conceptualises a biopsychosocial model of disability, and understands the person’s level of functioning as a dynamic interaction between her or his health conditions, environmental factors, and personal factors. Functioning and disability are multi-dimensional concepts, relating to the body functions and structures of people, and impairments thereof; the activities of people and the activity limitations they experience; the participation or involvement of people in all areas of life, and the participation restrictions they experience; and the environmental factors which affect these experiences (WHO, 2001).

Though psychiatric disability is devastating, it is only in 1995 that it got recognition and was included as one of the category in the Persons with Disability Act, in India. (Government of India, 2002). Because of mental illness, people with psychiatric
disabilities are not able to attain typical, age-appropriate goals for extended periods of time (Corrigan et al., 2008).

Along with medical intervention, a vital component is psychosocial care offered at rehabilitation centres or through community outreach services. Psychosocial care involves training and retraining ill persons in areas such as personal care, daily living, work habit, money management, social skills, vocational skills, and they also help them adjust better with their environment and reintegrate them meaningfully into their families and society. In the case of severe mental illnesses such as Schizophrenia, the rehabilitation focus thus is on maximizing functioning while minimizing disability. Through rehabilitation interventions, we seek to create supportive communities for persons with mental illnesses. This in turn helps to tackle stigma by fostering empowerment through user participation in a facilitative social environment.

The Indian Mental Health Scenario

Psychiatric disorders are widely prevalent, irrespective of the sex, age group and social class. It is estimated that close to 10% of the population would need some form of psychiatric intervention (Gangadhar, 2008). In the Indian context, the ‘treatment gap’ for mental disorders is large all over the country, but especially so in rural areas, northern states and amongst the socially disadvantaged. Mental health has, for decades, ailed from being low-priority as far as health planners at state and central levels are concerned. This is well reflected in the quantity and quality of mental health services in India. The needs of patients and families far outstrip the availability and accessibility of services for those with mental disorders (Thara and Patel, 2010).

Addressing this huge treatment gap is essential. Unless timely action is taken to bridge the gap, we will be nowhere in ensuring or protecting the human rights of these individuals. Children, women and the elderly constitute the most vulnerable groups, who turn out to be victims of the worst forms of neglect and violation of human rights (Mishra, 2008).

The Indian mental health service scene thus is far from satisfactory. One of the nagging ailments is the acute shortage of trained manpower in mental health in the country. India’s scarce mental health resources, such as mental health specialists, are largely concentrated in some states (mainly in the south) and in urban areas and a large proportion are solely in the private sector (Thara and Patel, 2010). The number of psychiatrists currently available translates to one psychiatrist for every 300,000 population. Even this small number is not equitably distributed—75% are located in urban areas and only the remaining 25% cover the rural areas that account for 75% of the population. The number of allied mental health professionals such as psychologists, social workers and nurses who have special training in mental health, is even smaller (Gangadhar, 2008; Murthy, 2011).
Stigma of Mental Disorders

Establishing supportive communities for mentally ill will be meaningless if we do not address the phenomenon of stigma. Stigma is an important barrier to mental health care (Thara, 2007; Thornicroft et al., 2009; Wig, 1997). Stigma of mental illness affects also those closely associated with mentally ill person i.e. family members, friends, providers and others. This phenomena is alternatively called ‘courtesy stigma’ (Goffman, 1963) or ‘associative stigma’ (Mehta and Farina, 1988). Impact on family members could be in terms of impeding the quality of relationships, diminishing their self-esteem, being avoided by others, embarrassment caused by the behavior of the ill person in social situations. Stigma of mental illness needs to be understood both at personal and social levels and in its socio-cultural context. Gender bias has also been reported in stigma due to mental illness (Phelan et al., 1998; Thara and Srinivasan, 2000).

Social isolation and stigma (Loganathan and Murthy, 2008) are an unfortunate familiar reality in the lives of individuals and families battling mental illnesses. Very often, in the Indian context, persons with mental illnesses are denied various citizenship rights and services that are rightfully due to them. These include discrimination in employment, housing, health, education, community services and social welfare benefits. These are what (Huxley, 2003) outlines as indicators of social exclusion and this prevents access to the help that is needed.

The stigma associated with schizophrenia represents a challenge for effective mental health care. Researchers have suggested public awareness and education as important strategies to reduce stigma (Raguram et al., 1996, Corrigan et al., 2001, Holmes et al., 1999). Dealing with stigma should be part of treatment and psycho-educational programmes. Better treatment and rehabilitation for the illness and its symptoms is important, but so is educating members of the community, who are viewed as the primary source of stigma and discrimination. (Shrivastava et al., 2011)

An impact-assessment research study on implementing an intervention strategy to reduce stigma associated with mental illness was carried out in 50 rural and semi-urban areas of Karnataka state in India. The results indicated that while stigmatizing attitude was prevalent among both rural and semi-urban groups, caregivers had less stigmatizing attitude than the other members of the community. An education package developed on the basis of the findings was implemented in these communities. The post-intervention assessments revealed significant changes in the direction of reducing stigma in the views of both the community and the caregiver groups (Kalyanasundaram and Ramaprasad, 2012).
The RFS (I) Experience in Creating Supportive Communities in Mental Health Care

The work of the Richmond Fellowship Society (India), an NGO with five branches in India represents an effort to rehabilitate persons with severe mental illnesses using the Therapeutic Community approach. It is a national-level mental health organization offering:

- rehabilitation care facilities for persons with mental illness,
- manpower development through training,
- working for rights of persons with mental illness through networking, advocacy and public awareness.

At the Indian Fellowship, the emphasis in care and training has always been promoting user (client and family)-led decision-making and choices regarding recovery. This is rooted in the rehabilitation process adopted by us, which seeks to restore dignity and self-worth of the client. Some of the key essential elements in our practice of PSR are outlined below:

Dignity and Recovery in Mental Illness

In the following section, we present some of our observations relating to dignity as perceived by users, culled from our experience, both at the clinical level as well as our close observations from our rehabilitation centres. Dignity is an essential and a core social characteristic of being human. Our awareness of our dignity is directly proportional to our sense of self-worth and self-confidence. Dignity is a feature that lies at the very core of the individual’s and the family’s identity.

Restoring dignity is an essential and basic ingredient in the culture of healing, offering hope and consequently, recovery-oriented services. Unfortunately, the lived experience of mental illness, constantly battling stigma and discrimination at various levels often strips the person of his/her self-worth and identity.

In this illness, the chemistry of the brain goes awry due to malfunctioning in certain parts of the brain and these results in manifestations of the symptoms of the disease (Prasad et al., 2004; Sim et al., 2006; Keshavan et al., 2008; Nasrallah, 2005; Nasrallah et al., 2011). Severe mental illnesses, by virtue of their symptoms, result in a distorted perception of reality for the ill person. This condition could have immense frustrating consequences in negotiating day-to-day transactions—such as maintaining the thread of a social conversation, taking the bus home from the office, drawing cash from an ATM, buying provisions from the neighborhood grocer’s, etc—which are taken for granted by non-sufferers. This is doubly unfortunate because while on one hand, there is immense subjective distress (or apathy, in case of being out of touch with
reality), there is also the misunderstanding of the difficulty/condition by others around. Unlike physical disability, where the impairment is visible, the mentally ill person shoulders an invisible impairment. Because they are in reasonably good physical health, their abnormal behaviour is attributed to either wantonness or irresponsibility. Non-acknowledging of suffering from others, be it family, employer, peer, or even treating professionals, is in itself a dignity-depriving experience.

Studies on pathways to mental health care cite the non-availability of mental health services, penury, poor literacy levels, stigma, and superstitions and widely prevalent magico-religious beliefs associated with mental as the main contributory factors that pose significant social obstacles in seeking appropriate health care for psychiatric patients (Lahariya, 2010; Trivedi 2011).

Doctors, psychiatrists or other mental health professionals are consulted rather late—on an average, six months to a year after onset of the illness. By then, the patient and the family have suffered a near-total loss of dignity, fuelled by the misunderstanding of the illness per se and the unscientific ‘practices’ indulged in that are believed to offer ‘treatment’ or ‘cure’ that slowly chip away and erode the dignity and self-respect of the individual. Unable to fathom what is happening, the family undergoes great distress and is. Families begin to isolate themselves as well from neighbors, relatives and their immediate environment or community. They avoid going to social functions for fear that their loved one may be shamed in public. Because of this isolation, the family begins to lose its social identity also.

**Restoring Dignity**

With the focus on restoring dignity, the first step is in psychiatric care is to reduce the symptoms and bring the person back to an acceptable level of functioning when people no longer look at them strangely or shun them. This involves making the right diagnosis, prescribing the required medication, ensuring medication compliance and regular follow-up.

Keshavan *et al.* (2010) underscore the evidence basis for the rationale for early interventions. Firstly, poorer outcomes due to treatment delay, also referred to as Duration of Untreated Psychosis, (DUP) may be potentially reduced by early detection and intervention in developing countries. Secondly, neuroimaging studies using Magnetic Resonance Imaging (MRI), reveal an association between prolonged untreated illness duration or illness chronicity, with more prominent structural brain abnormalities especially during the first few years after the onset of psychosis.

Not all who start treatment early and comply diligently with the doctor’s advice respond well. Roughly, two thirds of all patients of mental illness have relapses, function below par and need medication, rehabilitation, therapeutic intervention and social support
lifelong to prevent their lives and their families’ from falling apart. Nevertheless, adhering to treatment—which includes complying with the medication prescribed, attending therapists’ appointments regularly and being actively involved with the rehabilitation measures advised—have been shown by some authors to retard the disease process (Osterberg and Blaschke, 2005; Lacro and Glassman, 2004).

**Involving Families in Care**

Recovery and healing is needed not only for the patient but for the family members as well. Being in support groups has multiple benefits for the caregivers (Ponnuchamy *et al.*, 2005; Shihabuddeen and Gopinath, 2005). Families are now more active participants in the recovery process and far more aware of their rights, fuelled by the better access to illness-related information that they can access from the internet world. These elements and interventions, when incorporated into the rehabilitation programme, certainly boost the creation of support in the community for both direct users as well as family caregivers.

**Professional Teamwork in Creating a Supportive Community**

The journey back to dignity cannot be a top-down approach. It is meaningless to talk about dignity if the rehabilitation team works in a hierarchical fashion. The psychiatrist, the therapist and the rehabilitation professional collaborate, and engage as a seamless multi-disciplinary team to rally around the patient (or the “client”) in a facilitative helping mode. This is possible once the abnormal behavioural symptoms have been brought under control through medication and the client has reached a degree of emotional and cognitive stability to lead an assisted but autonomous daily schedule.

**The Therapeutic Community (TC) Approach at RFS (I)**

The Richmond Fellowship, through the Therapeutic Community (TC) approach, strives to achieve the goal of recovery by working closely with the clients and their families. To quote our founder Ms. Elly Jansen, O.B.E., “Four themes are basic to the operation of therapeutic communities: democracy, permissiveness, reality confrontation and communalism. These four principles may not feature overtly in the political and social life of the neighborhood or the society at large, and so the process of offering Richmond Fellowship Mental health services in each country requires subtlety in adapting the services to meet local conditions while remaining true to the principles which we have demonstrated as very effective for over thirty years, in enhancing the mental health of those with whom we work in countries all over the world” (Jansen, 2011).
In the TC approach, which is based on ideas of collective responsibility, citizenship and empowerment, activities are structured in a way that encourages personal responsibility and avoids unhelpful dependency on professionals (Campling, 2001). Neither the therapist nor the rehabilitation professional tells the client what to do. Instead, the clients assume their share of responsibility for recovery alongside the therapist or rehabilitation professional, who merely facilitates the process. Issues with which the client is struggling are discussed in a democratic manner, often brought into the community meeting for discussion. The onus for sustainable change in the client comes for the community, not from the therapist or staff team. Accountability for one's behaviour similarly, rests with the community. The community, comprising of peers and staff, thus represents a supportive environment where the client is encouraged to reflect on, explore, and experiment with different and better modes of behaviour, reinforced socially by the community. Group forces, mainly peer influence, are what keep the community dynamic and therapeutic.

The client gets involved in the community as rehabilitation progresses, and he/she becomes increasingly involved in his/her own recovery, with the help of peers (other users) in the TC set-up, who are at various stages of recovery themselves. The client’s active involvement is accompanied by a gradual gaining of insight, which in turn translates into the client’s awareness that he/she has a psychiatric illness, to control which medication is a must. The client, by virtue of the living-learning experience (Campling, 2001) in a therapeutic set-up, recognizes that, without maintenance treatment, they are bound to have a relapses and suffer drastic setbacks in their intrapersonal and interpersonal functioning, and this eventually reduces their quality of life. Gaining insight is a gradual process which paves the way for better outcome.

**Role of the Community in Care**

It is important that the larger community also be involved in caring for its mentally ill members. One of the objectives of Community-Based Rehabilitation (CBR) is to activate communities to promote and protect the human rights of people with disabilities through changes within the community, for example, by removing barriers to participation (WHO, 2004). CBR is touted as a very effective and efficient strategy especially in developing countries which have limited resources, to ensure coverage of services at affordable costs.

CBR has gained more relevance with the adoption of the International Classification of Functioning and Health (ICF) by the WHO. This is especially relevant in the context of mental illnesses, where the social aspects of disability are accounted and the ensuing disability is not seen only as a ‘medical’ or ‘biological’ dysfunction. Changing the attitudes of non-disabled persons in the community to accept people with disabilities and promote their social integration is a very significant component
of CBR. It is also important to promote community control and ownership of CBR programmes. This can be achieved through the community supporting advocacy and lobbying efforts to mainstream persons with mental illnesses.

In reality, mental health needs have been largely absent in established CBR programmes in India, and has a low priority on the development agenda and for society in general (WHO, 2010). Historically, mental health has also been excluded from CBR programmes. People with mental health problems have extremely limited access to support and health services particularly in low-income countries.

Our centres have been deliberately located in residential areas of the city, and are not impenetrable ivory towers. Clients are not rehabilitated within the four walls of our centres, rather they are encouraged to interact and negotiate in the outside real world as part of their recovery process.

In the process of establishing ourselves in the local communities, we have had to deal with stigmatising attitudes and rejection, sometimes hostility to our presence in the neighbourhood. Such attitudes and resistance were won over with awareness and creating transparency in what we do, by inviting neighbours to be part of our House committees and programmes so they can first-hand see what happens within the four walls of the centre. The involvement of individuals drawn from the community has helped in opening up the doors of mental health care institutions. The use of volunteers and other non-mental health persons builds bridges and helps eradicate the stigma and misconceptions that plague mental health care facilities. Such involvement of “people” in activities of care agencies has facilitated the therapeutic environment in the centres in terms of preventing it from degenerating into closed institutions.

Using Community Resources

The Richmond Fellowship has moved from strength to strength over the years encouraged by the heartening trend of growing involvement of non-professionals and lay individuals who have no association with the field whatsoever, and yet help in the various activities of the agency. The members of the Governing Council of the agency are drawn from different backgrounds have been a great source of strength. They have provided the agency with the necessary vision, support and guidance bringing with them their diverse expertise.

People from different strata of society have come forward to help and encourage the various activities of the fellowship and to join hands with us to provide the help and support that is needed in innumerable ways.

Employers form a crucial link in reaching out to the larger community. Vocational rehabilitation interventions are woven into the psychosocial rehabilitation activities with our clients at the RFS (I). Interaction with employers and potential employers is
a challenging yet rewarding area of work. The prevocational training model (Bond, 1992) is followed at our centres. Our experience has been that job-oriented interventions have various benefits for persons with psychiatric disabilities, especially given the age profile of our day care users—predominantly male, in the age group of 25–35 years. In the Indian context, the need for help in finding occupation and employment is a significant felt need in rehabilitation (Prafulla et al., 2010).

The vocational rehabilitation services we offer fall along a continuum (Jacobs, 1998) that includes assessment of vocational skills, adjustment to work (prevocational skills), job skills training, sheltered employment, transitional employment, finding a job, and job maintenance/retention. The preferred exit avenues for clients are open/competitive employment, but there is the undeniable reality of stigma towards employment of persons with severe mental illness, exclusionist and discriminatory practices in employment (Brohan and Thornicroft, 2010). The goal of placement is to find the ‘right fit’ or match (Craig et al., 2002) between the client’s abilities and the type of job, so as to facilitate a mutually satisfying experience for both user and employer. The process relies on individualised placements, with an emphasis on client’s preference for the type of job, so as to facilitate successful job retention, an effective indicator of the rehabilitation outcome. The placement and follow-ups involve extensive liaison with the treating psychiatrist/team, family and employer (subject to client and family consent regarding disclosure of illness to the employer).

Sheltered employment in the form of sheltered workshops are often the only viable alternative for some of our more disabled clients who have difficulties interfere with their ability to adjust in a normal work environment. There are obvious advantages of a sheltered workshop, the most notable one in this context being the creation of a supportive community of users at the workshop, characterized by acceptance, dignity and self-help. It is difficult, however, to generalize the employment scenario as there is a dearth of scientific research data regarding employment and employer attitudes towards mental illness in India.

One key future direction is to work with employers and foster a more positive attitude among them towards employing persons with mental illness. Employers’ attitudes reflect the sentiments of the larger community. If these stigmatizing attitudes need to be changed, it is crucial to look at providing employers with experiential learning—of the first-hand experience of employing mentally ill persons—facilitated by an ongoing liaison with the rehab team to ensure a smooth transition to employment. Additionally, in our branches functioning in the rural areas, various community groups were mobilized for spreading awareness and orientation about early symptoms of mental health.

Since its inception, the agency has been receiving invaluable help at all its service facilities from people from varied educational and occupational backgrounds, professional as
well as non-professionals who have volunteered to help our clients. Each has contributed to the growth of the Fellowship in his/her unique way by bringing in new ideas, knowledge, skills and talents to educate and improve the skill sets of the staff as well as clients.

The organization has had the fortune of working with students from different fields like engineering, psychology, social work, sociology, science, etc. who have come to work as volunteers. There have also been individuals from different non-governmental organizations at the national as well as the international level. In addition, housewives from different socioeconomic and educational backgrounds have helped us by giving their quality time.

These people have reached out to us by knowing about it by word-of-mouth from friends or other volunteers, mental health professionals, medical professionals, media (newspaper articles about the organization) and through our website.

The Fellowship has a record of several such individuals who began as volunteers and later have joined as staff in administrative, financial and clinical responsibilities. The sensitive nature of personal as well as familial issues involved, and keeping in mind ethical issues such as confidentiality places limitations on the extent of therapeutic involvement and care that non-professionals can undertake.

Mental health professionals act as facilitators in the entire process of engaging volunteers and others who are not familiar with this area of care. They are also engaged in assessing the suitability of candidates, allotting work/roles in the centre based on skills of the volunteers and level of comfort of the individual. Orienting and sensitizing them to the area of work, guiding them in teaching new skills required for working with emotionally disturbed individuals, thereby channelizing their skills and translating them into care components also form part of the training offered.

Lessons Learnt

While the agency gratefully acknowledges the services and participation by the volunteers, one does come across lack of consistency in their working due to fluctuating levels of motivation.

Individuals who are in a professional job elsewhere may find it difficult to juggle roles while handling a full-fledged career simultaneously with volunteering for some cause. Sometimes their services can be unavailable in the wake of their own personal commitments and preoccupations. Professionals stepping in to help them to realistically assess initially the kind of time and commitment they can offer will be helpful.

Sustaining motivation levels over a period of time can be challenging in the rural areas, as per our experience. There have been instances of well-meaning individuals...
looking forward for some gain like monetary rewards and fame, which can work at cross purposes with the work of the agency. This can be handled by acknowledging and giving credit where it is due, and through open appreciation at regular intervals, so as to sustain their interest and involvement and sense of belonging in the agency’s activities. It has been difficult to involve youth in the community, especially in the rural areas. Motivating the neighbourhood also has been a significant challenge at times. An important aspect has been that it is highly impossible to depend on skilled professionals alone to provide mental health care consistently due to the inadequate numbers and high staff turnover in the rehabilitation centres.

Conclusion

If one is left wondering whether our understanding of the rediscovery of dignity applies only to our clients and not to us, one must understand that the mental health professional—irrespective of professional disciplines—equally embarks on his own parallel journey. The process of rediscovering dignity is tied to increasing one’s awareness and personal growth. It should become part and parcel of our day-to-day lives. This has to become a model for others to imbibe and grow.

As surrogate caregivers, it means that we double up as nurses. When seeking employment options for clients, it means advocacy. When raising funds for our programs, it means asking for financial and other support without egoistic qualms. It means rediscovering the dignity of those recovering from a devastating illness and this is amply rewarded by the smiles of relief, happiness and satisfaction. We find the clients and their families a great gift in helping us in our own transformation as they trustingly open up and offer their lives and experiences to us to learn and make better human beings of ourselves.

On a parting note, it is important to imbibe “people-first” language in the context of working with persons with mental illnesses—it is imperative to make a distinction between the person and the illness. One should strive to discourage people from using colloquial terms like “crazy,” “wacko” or “loony”. Instead of labeling the person by his illness, example, saying someone is “a schizophrenic,” we must learn and teach others to say he or she “is a person with schizophrenia.” They are people with an illness and not the illness itself! If you can make begin to make this impact on people this message will gradually spread and provide them the dignity that they deserve.

The Richmond Fellowship has worked hard to maintain the dignity, individuality and improve the quality of life of its users. The journey has been arduous and tricky, and yet challenging and satisfying. Personally, we have learnt a lot from these patients and their families; they remain the best teachers one could have had. The simple, honest, guileless, transparent conduct of those diagnosed with chronic mental illness can set an example for all of us to emulate. We can learn from them the resilience
and their ability to swim against the tide, and look at life with a positive attitude whilst working against all odds.

References


Resilience and Strengths among Children Exposed to Intimate Partner Violence

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ABSTRACT

Children around the world are exposed to violence on a daily basis. Exposure to violence taints children’s well-being and social interactions. While childhood exposure to Intimate Partner Violence (IPV) has serious consequences, a growing body of research has shown that these negative outcomes are not inevitable. Children’s personal and environmental strengths are essential for them to mobilize their resilience and lead satisfactory lives. Resilience is a universal human capacity which emerges from the interplay between adversity and individual and environmental resources. It is fundamental for professionals working with children exposed to IPV to identify personal and environmental protective factors in order to foster their resilience. The Strengths Perspective provides a theoretical and practice framework for social workers and other professionals to promote resilience by identifying, mobilizing, and even discovering strengths in individuals, families, and communities in the midst of adversity. The quality of the helping relationship is essential in this process as it provides the atmosphere for individuals to assess attainable goals, secure resources to promote change, enhance hope in the future, and regain their personal power (Rapp and Goscha, 2006; Saleebey, 2009). This paper provides an overview of the literature regarding childhood exposure to IPV, resilience and strengths perspective. It highlights the importance of the helping relationship and the need of a contextual understanding of internal and external resources as well as goals and aspirations in order to break the cycle of violence. Implications for social work are discussed.

Keywords: Strengths, Resilience, Children Exposed to Intimate Partner Violence, Personal Protective Factors, Environmental Protective Factors.

Childhood Exposure to Intimate Partner Violence

Intimate Partner Violence (IPV) is a pervasive and undeniable social problem around the world. IPV is defined as persistent coercive behaviors that may include physical and/or psychological abuse, sexual assault, stalking and intimidation, perpetrated by a past or present intimate adult partner with the purpose of controlling the other partner (Welland and Ribner, 2008). Because of its prevalence, IPV has been recognized as a
worldwide epidemic and a public health issue that threatens the human rights and lives of millions of women (Garcia-Moreno, Jansen, Ellsberg, Heise, and Watts, 2005). A multi-country study conducted by the World Health Organization (WHO) and collaborators collected data from over 24,000 women and revealed that the prevalence of physical and/or sexual partner violence ranged from 15% to 71% for lifetime reports (4% to 54% for past-year reports) (Garcia-Moreno et al., 2005). However, IPV remains largely silent inside homes, hidden behind closed doors (UNICEF, 2006).

Although there are female perpetrators of IPV, most IPV cases are perpetrated by men against women (Garcia-Moreno et al., 2005). Consequently, for the purpose of this paper, IPV will refer to male-to-female violence in the context of an intimate adult relationship. IPV is a global phenomenon; with no geographic, socio-economic, or ethnic boundaries (UNICEF, 2006). However, some socio-cultural factors have been found to be associated with childhood exposure to IPV, such as gender inequality and cultural attitudes accepting of violence (Garcia-Moreno et al., 2005). Gender inequality is likely to impact laws, law enforcement, services and community attitudes (Frazee, Noel, and Brenneke, 1997). Also, low education, history of child maltreatment and exposure to IPV, and harmful use of alcohol have been identified as risk factors associated with IPV in international studies (Garcia-Moreno et al., 2005; UNICEF, 2006).

Unfortunately, IPV also impacts the lives of the children in violent homes. In this paper, any child under 18 years of age who was living in the victim’s home when an intimate partner perpetrated a violent episode will be considered exposed to IPV (Saltzman, Fanslow, McMahon, and Shelley, 2002). Childhood exposure to IPV includes watching or overhearing the assault, experiencing the aftermath, observing the initial effects, protecting the abused parent, calling the police, participating coerced, or being abused themselves (Fantuzzo and Mohr, 1999; Holden, 2003). Children are likely to be exposed to multiple incidents of IPV and many children witness domestic homicides (Osofsky, 2003).

According to UNICEF (2006), between 133 and 275 million children worldwide are exposed to IPV every year. Seemingly, these estimates are conservative. For instance, the U.S. estimates are far lower than those found in the literature: While UNICEF (2006) estimates of children exposed to IPV in the U.S. range from 339,000 to 2.7 million, other studies estimates range from three to 15.5 million (McDonald, Jouriles, Ramisett-Mikler, Caetano, and Green, 2006; Wolfe and Jaffe, 1999). Thus, the prevalence of this problem is likely to be much higher. Research findings in the U.S. confirm the presence of children in 35% to 50% of the households where IPV occurs (Child Welfare Information Gateway, 2009; Fantuzzo and Mohr, 1999); these children are typically young (Osofsky, 2003). Unfortunately, this exposure tends to have serious consequences.
Several studies have described the harmful consequences of childhood exposure to IPV on children’s health, mental health, and social interactions (Graham-Bermann and Perkins, 2010; Lundy and Grossman, 2005). Children exposed to IPV are approximately two to four times more likely than non-exposed children to display psychopathological symptoms in the short term (Martinez-Torteya, Bogat, von Eye, and Levendosky, 2009). They are more likely to experience increased levels of depression, anxiety, suicidal ideation/behaviors, traumatic distress symptoms, phobias, and behavior and discipline problems (Aymer, 2008; Margolin and Gordis, 2000).

Exposure to IPV may taint children’s worldview, their self-concept, moral development, and perceptions regarding life purpose and meaning (Margolin and Gordis, 2000). Thus, the consequences of childhood exposure to IPV may persist throughout adulthood. Retrospective studies with adults exposed to IPV during childhood found higher levels of adult psychological distress, post-traumatic stress disorder, depression, antisocial behaviors, and alcohol and substance abuse (Bair-Merritt, Blackstone, and Feudtner, 2006; Henning, Leitenberg, Coffey, Bennett, and Jankowski, 1997; Maker, Kemmelmeier, and Peterson, 1998).

Additionally, early exposure to IPV may be harmful to children’s overall health and the plasticity of their brain. Inadequate sensory stimulation may compromise the functions of specific brain regions and overstimulate certain brain structures, resulting in abnormal neurological development (Anderson, 2010; Lundy and Grossman, 2005). Also, these children tend to get lower scores in verbal, motor, and cognitive tests and often experience difficulties concentrating and doing schoolwork (Fantuzzo and Mohr, 1999). Studies also show that these children tend to have deficits in social cognition (Margolin and Gordis, 2000), difficulties making friends, and problems in their current and future interpersonal relationships (Henning et al., 1997).

Furthermore, children exposed to IPV are at higher risk of physical, psychological, and sexual abuse (Bancroft and Silverman, 2002; Garcia-Moreno et al., 2005; Gardner, Kelleher, and Pajer, 2010; Maker et al., 1998; Osofsky, 1999; UNICEF, 2006). Dual victimization of children increases the likelihood of negative developmental outcomes in terms of their physical, psychological and social functioning (Fraser, Kirby, and Smokowski, 2004). Further, some children who live in violent homes reproduce IPV in their adult relationships (Bancroft and Silverman, 2002; Fantuzzo and Fusco, 2007; Osofsky, 2003). This highlights the pervasive nature of violence.

However, the negative consequences of exposure to IPV are not inevitable. In fact, the negative impact of childhood exposure to IPV depends on the children’s developmental stage, gender, cultural background, magnitude and frequency of the exposure, and available personal and environmental resources, such as the presence of caring adults (Anderson, 2010; Bancroft and Silverman, 2002; Humphreys, 2001). The impact of exposure to IPV is also mediated by parenting practices, maternal mental health, and
available resources and support in the environment (Holden, 2003). For instance, a child exposed to IPV who faces additional challenges, such as maternal depression, would be expected to have worse outcomes. However, this association is not linear (Margolin and Gordis, 2000). Indeed, many children are able to overcome the potential deleterious consequences of violence, develop resilience, transform their experiences and lead satisfactory violence-free lives.

Resilience among Children Exposed to Intimate Partner Violence

For over fifty years, literature has identified personal and environmental protective factors that contribute to the development of resilience. Resilience refers to “a normal or even exceptionally positive developmental outcome in spite of exposure to major risk for the development of serious social or health problems” (Fraser et al., 2004, p. 22). Resilience is the result of the “ordinary magic”, characteristic of normative human development, which emerges as children and adolescents mobilize, discover, use, and transform personal and environmental protective factors in a dynamic interplay with the risk factors they confront (Masten, 2001, p. 235). Thus, at least a “normal” developmental outcome and the presence of serious adversity are necessary to determine whether individuals are resilient (Masten, 2001). However, the cultural context (e.g. developmental expectations, cultural patterns and standards, spiritual and social beliefs, social support, and other factors related to child rearing) determines the meaning of the adversity faced by individuals and the quality of their developmental outcomes (Fraser, et al., 2004; Masten, 2001).

Risk factor refers to predictors of an increased probability of poor developmental outcomes which are based on statistical evidence (Fraser, et al., 2004; Masten, 2001). On the other hand, protective factors are internal and external assets, resources, and strengths that modify risk, and increase the probability of a positive outcome when, in regular circumstances, a negative outcome is expected (Fraser et al., 2004; Rutter, 1988; Saleebey, 2001). Benard (2004), in a summary of the empirical research, identified strengths associated with resilience both in the individual (personal protective factors) as well as in families, school, and communities (environmental protective factors). She proposed a model of four domains of personal strengths, including social competence, problem solving skills, autonomy and a sense of purpose and bright future. Her model included caring relationships, high expectations, and opportunities for participation as environmental protective factors (Benard, 2004). In addition, turning points—life circumstances or unexpected events that can alter an individual’s development—have been associated with resilience (Fraser et al., 2004).

Consistently, adult daughters of batterers report having developed strengths and strategies to resist violence (Anderson, 2010) and lead rewarding lives despite the pervasive violence, fear, tension and concerns about stigma and retribution that they
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Experienced in their childhood (Anderson, 2010; Humphreys, 2001). Several studies identify personal and environmental protective factors that contribute to positive outcomes and the development of resilience among children exposed to IPV. For organizational purposes, these findings will be presented using the domains proposed by Benard (2004).

**Personal Protective Factors**

*Social competence* refers to the ability and attitudes necessary to create and maintain satisfactory relationships. The ability to recruit and engage caring adults (Martinez-Torteya, *et al.*, 2009) as well as empathy and compassion are often reported in the literature (Aymer, 2008; Luna, 2009; Anderson and Danis, 2006). Both women and men exposed to IPV as children felt that it was their responsibility to protect and comfort their mothers and siblings from the perpetrator (Anderson, 2010; Aymer, 2008; Luna, 2009).

*Problem-solving skills*, as shown in safety planning, increase their sense of control and hope for the future (Benard, 2004; Humphreys, 2001). Some adult daughters of batterers, for instance, developed safety plans (Anderson and Danis, 2006), others created physical and mental escapes (*e.g.* reading), while others tried to organize chaos in the family (*e.g.* picking-up) (Anderson, 2010; Aymer, 2008; Luna, 2009). In addition, research finding show that IQ and a person’s Intelligence Quotient (IQ) and competence are negatively associated with behavioral problems among children exposed to IPV (Kolbo, 1996). While most exposed children initially saw the abuse as a normal part of life, through interactions with peers, they understood that IPV was not normal (Anderson, 2010; Anderson and Danis, 2006; Humphreys, 2001) nor their fault (Humphreys, 2001).

*Spirituality and sense of purpose* refers to human search for meaning, connection, and understanding of our limitations that allow the transformation of suffering and provide emotional strength to cope with daily life (Benard, 2004; Canda and Furman, 2010). Consistently, qualitative studies report that adult children of batterers display optimism and hope for a better future as well as a deep commitment to breaking the cycle of family violence (Anderson, 2010; Anderson and Danis, 2006; Humphreys, 2001; Luna, 2009).

*Autonomy*, as manifested in adaptive distancing is commonly identified as among children exposed to IPV. Several qualitative studies of adult children of batterers consistently report their ability to differentiate themselves from the batterer whether by maintaining a sense of oneself as unique and different (Humphreys, 2001) or by detaching from the perpetrator or the whole family (Luna, 2009). Adaptive distancing allows these children to detach themselves from dysfunction and envision a different future (Benard, 2004; Wolin and Wolin, 1993). For instance, spontaneous reactions
led adult daughters of batterers to develop resistance strategies (withstanding and opposing strategies), fostering their resilience (Anderson, 2010; Anderson and Danis, 2006). In addition, these women were perseverant and had an inner drive to push forward (Humphreys, 2001), characteristic often associated to an internal locus of control, which increase their sense of power and hardiness (Fraser, et al., 2004).

Environmental Protective Factors

Caring relationships, characterized by a sense of compassion, positive regard, kindness, and availability (Benard, 2004), have been consistently identified as protective factors (Werner and Smith, 2001). A close relationship with at least one caregiver (e.g., nurturing parenting) was related to higher levels of resilience, discouraging drug use and gang involvement (Aymer, 2008). Positive parenting has been also associated with fewer externalizing behaviors (Levendosky, Huth-Bocks, Shapiro, and Semel, 2003).

In addition, connections to caring adults in the family and environment, such as extended family members, neighbors, teachers, and mentors, can have a positive impact on youth’s academic achievement, interpersonal relationships, and pro-social behavior (Benard, 2004; DuBois, Doolittle, Yates, Silverthorn, and Tebes, 2006; Fraser et al., 2004; Hawkins, Catalano, and Arthur, 2002; Werner and Smith, 1992). For instance, grandmothers and other relatives became part of these children’s safety planning, intervening in IPV, and protecting mothers and siblings (Anderson and Danis, 2006). Strong sibling and peer relationships also contributed to higher levels of resilience (Luna, 2009).

High expectations refer to “clear, positive, and youth-centered expectations” (Benard, 2004, p. 45) and create a sense of structure and safety. High expectations from caring adults guide these children and encourage them to achieve their personal goals. While these children grew up with constant violence at home, their resilience, derived from their mentors and teachers’ support, allowed them to create a new path toward academic success and a better future, without violence (Luna, 2009). When high expectations are based on the strengths, hopes, dreams and interests of children, they encourage children to fully develop their potential (Benard, 2004).

Opportunities for participation and contribution in terms of available external resources and social support, allow children to participate in enriching activities, to voice their realities, and to support self-determination, self-control, and autonomy (Benard, 2004). As Benard (1998) states as children have responsibilities, they receive a clear message: “they are worthy and capable of being contributing members of the family” (p. 10). Some children find opportunities for participation through traditional socialization agents, such as schools and church which may act as protective factors against antisocial behaviors in youth (Hawkins et al., 2002). Adolescent males exposed to IPV used community resources (e.g. sports programs) to release their rage resulting from their
exposure to IPV and use their unique talents (Aymer, 2008). In addition, the availability of community resources provided them with the opportunity to heal their wounds from this exposure (e.g. school counselors) through a helping relationship (Aymer, 2008). The quality of the helping relationship is a fundamental component of the Strengths Perspective.

**The Strengths Perspective**

The Strengths Perspective facilitates the process of resilience leading people toward a healthy development and the fulfillment of their potential. It helps clients to identify, appreciate, and use their available strengths (Weick, Rapp, Sullivan, and Kisthardt, 1989), including talents, knowledge, abilities and aspirations. In doing so, opportunities are created for clients to reclaim personal power in their lives and make decisions that impact them (Rapp and Goscha, 2006; Saleebey, 1997). This perspective has basic assumptions at its core, which provide a different approach to social work practice. For instance, for the Strengths Perspective, every individual and every environment have strengths that can help them achieve their aspirations (even a violent environment, a batterer or a battered mother). Also, humans have innate health and self-righting capacity. People facing adversity usually develop useful ideas, capacities, and strategies. In this sense, people almost always know what is right for them. A positive future orientation helps the healing process, as practitioner and client collaborate to achieve the client’s dreams and aspirations (Saleebey, 2009).

Social workers who engage in strengths-based practice are compelled to “search out and account for the considerable assets and resources that people have within and around them, especially those elements of character that have ripened as a consequence of coping with dire circumstances” (Saleebey, 2001, p. 13). Instead of using diagnoses as labels, this perspective proposes a complete and holistic assessment of the person which believes the individual, gives preeminence to her desires and her understanding of the facts, uses language he can understand, discovers his uniqueness, assesses personal and environmental strengths (multidimensional), and avoids blaming, cause-effect thinking, and diagnosing (Cowger, 1994; Saleebey, 1997). Internal and external strengths become the social worker’s resources for the individual’s change. However, personal and environmental strengths can only be identified when considering the context in which they emerge.

The Strengths Perspective allows us to see “possibilities rather than problems, options rather than constraints, wellness rather than sickness”, which, once seen, can be achieved (Rapp and Goscha, 2006, p. 34). According to Saleebey (2009), it is necessary to explore a variety of experiences to find what people have learned about themselves, others, and their environment, what people know about their world and how they learned it,
individuals’ personal qualities, traits, virtues, and talents, spirituality, and cultural and personal stories, lore and pride as well as the community and its resources.

The belief in the client’s experiences and realities is essential in strengths-based practice as well as the belief that a person’s life goes beyond a problem (Saleebey, 2009). For the Strengths Perspective, social workers should focus on creating enabling niches, as they assist people in transforming their lives by individually tailoring case management to each person’s unique needs and by “identifying, securing and sustaining” the personal and environmental resources needed (Rapp and Goscha, 2006, p. 54).

The quality of the helping relationships is essential in this process (Saleebey, 2009), as it provides the atmosphere to assess attainable goals, secure resources to promote change, and enhance hope in the future (Rapp and Goscha, 2006; Saleebey, 2009). Indeed, a personal, empathic, and accepting relationship provides the atmosphere for healing and resilience (Saleebey, 2009). Rapp (cited in Saleebey, 2009), considers an effective helping relationship “as purposeful, reciprocal, friendly, trusting and empowering” (p. 80). This relationship creates positive expectations for the individual’s future (Rapp and Goscha, 2006). Positive expectations and hope communicate the practitioner’s belief in the client’s inner power to transform his or her reality (Saleebey, 2001), mobilizing mobilizes hope and the possibility of a different future (Saleebey, 2009). Also, by identifying opportunities for participation and involvement in community programs and using resource, social workers collaborate in the pursuit of the client’s goals and future aspirations.

Implications for Social Work

Violence is an evident reality in the lives of children around the world. The indicators of this social problem are alarming and its consequences are serious. Its impact spreads to several areas of social work practice. For instance, children in families with higher levels of cumulative risk are ten times more likely to be placed into foster care (Child Welfare Information Gateway, 2009). Children’s externalizing and internalizing behaviors may call the attention of school social workers. Also, IPV is the main cause of injuries among women in the U.S. and 35% of women who visit emergency rooms are there due to IPV (Luna, 2009). In addition, practitioners providing substance abuse treatment are most likely to listen to histories of IPV. About half of the men and around 75% of the women in treatment for substance abuse are in violent intimate relationships (Welland and Ribner, 2008). Social workers in corrections will often encounter histories of childhood violence (Luna, 2009). Thus, the social problem of childhood exposure to IPV is relevant to social workers in all areas of intervention.

Empowerment and strengths-based practices challenge social workers to learn from the realities of clients, especially those who are oppressed and facing inequalities. As a theory of empowerment, the Strengths Perspective is oriented to social action and focus
on social justice, oppression, and discrimination (Robbins, Chatterjee, and Canda, 2006). From this perspective, we understand that IPV results from the societal failure to meet its members’ needs (Robbins et al., 2006). Considering that the voice of children exposed to IPV is often silenced behind a curtain of secrecy, social work practice with families experiencing IPV is a matter of social justice.

Social justice has become a central value of our profession worldwide (Barusch, 2002). The Strengths Perspective builds on people’s aspirations, strengths, resources, and resilience and it can be used to engage in actions pursuing social justice and personal well-being by helping individuals and communities to identify circumstances and actions that promote change, human empowerment, and liberation (Robbins et al., 2006). Resilience theory and the Strengths Perspective share a common faith in human beings that characterizes a possibility-focused paradigm, even when strengths seem hard to find. Through an empowering relationship, strengths-based practitioners and clients mobilize resources and assets, toward the fulfillment of each client’s promise. Nevertheless, social workers who are interested in this perspective need a paradigm shift; they are compelled to explore their attitudes, beliefs, biases and their own selves. In short, they need to believe in their own strengths, the possibility of their own change, and their own resilience.

References


Resilience and Strengths among Children Exposed to Intimate Partner Violence


ABSTRACT
A central issue for non-governmental organisations (NGOs) in Nepal is building the capacity of both staff and organisations themselves in a sustainable and professional manner. Yet what does ‘capacity building’ really mean? Within the international development sector it has lost its true meaning and become just another piece of jargon bandied about. Part of truly building staff capacity is ensuring that it is the staff themselves who are driving both their own and their organisation’s overall development. Organisational development is for many NGOs a challenge. For staff, project management and field work are far more interesting to work on in contrast to the everyday running of an organisation at the centralised level.

This paper examines some of the strength-based practices employed when working to build the capacity of staff using the Feminist Dalit Organisation (FEDO) of Nepal, a national-level NGO established to advocate for the rights of Dalit women, as a case study. It discusses some of the strength-based practices used in the leadership development of FEDO’s Board, staff and activists. Through enhancing the capacity of individual staff and the organisation, the value of one on one interaction, supporting individuals in learning to find solutions to their own challenges and putting people at the centre of organisational development in the professional context will be explored. The positive effects of this strength-based approach has helped FEDO to implement sustainable organisational change in such a way that it enhances many aspects of FEDO’s work with marginalised Dalit women and gives hope to what true ‘capacity building’ may yield.

Introduction
Capacity building as an organisational development tool in international development is a widely accepted term used throughout the world (Hildebrand, 2002; Lusthaus et al., 1999). Over time the understanding of capacity building has changed from that of it being a human resources tool, to an understanding viewing ‘capacity’ more holistically,
considering social, organisational and educational aspects in the working environment (Enemark, 2007). It is now recognised as central to achieving economic growth, reducing poverty and bringing about equal opportunity (Whyte, 2004:4).

UNDP (1998) defines capacity building as ‘the ability of individuals and organisations or organisational units to perform functions effectively, efficiently and sustainably.’ From this definition, it can be seen that the ability for organisations to develop their organisational capacity rests on the ability of its people, and how effectively, efficiently and sustainably they conduct their roles. People-centred development strategies that incorporate the values of sustainability and inclusiveness have become widely accepted within the international development community.

Since 2000, the Millennium Development Goals have become a key driver of capacity building (Whyte, 2004) prioritising working with people to develop their own capacity to contribute to overall organisational change. Through this Whyte (2004) discusses how there is new emphasis on participatory organisational development practices, improving Information Communication Technology (ICT) based knowledge networks for increased communication with the world, ongoing learning and reflective practices, trying to balance short-term development projects demanding results-based management and donor expectations with long-term sustainability, and improved donor coordination.

Why then, if there is the acceptance of a people-centred approach to organisational development, do donors continue to work on projects and partner with organisations that are lacking in institutional capacity, resulting in project outcomes and targets not being met, and millions of dollars being wasted? Why is there a lack of recognition of what working with people—putting people at the centre of development—of what that really means? People are living, breathing individuals, who think about things other than work, have personal lives, a million and one different thoughts throughout the day, never staying in a passive state. Yet so often, capacity is treated as a static concept (Brown et al., 2001) to be scrutinised carefully. Then, after some time, it is decided an intervention is required to build that capacity. However that capacity being analysed will have changed, because people, their motivations and their abilities, are ever-changing.

Capacity building is not a linear process (Enemark, 2007). Nor it is something to be analysed in isolation to everything else occurring in an organisation. It is multidimensional and interrelated to other organisational aspects; staff relationships, roles, organisational structure and culture, mission and projects (Whyte, 2004). Building capacity means building the learning of an individual, a means of sharing knowledge between people, which is particularly crucial for those individuals working for organisations like FEDO that are small, lack funding, visibility or are excluded by those in power (Craig et al., 2002; Ellis and Latif, 2006; Yeung, 2009 as cited in Netto et al., 2012).
Methodology

This paper is based on qualitative research undertaken by myself, Matilda Branson, through six months of working with FEDO. Therefore participant observation and informal daily interaction with FEDO’s 18 Central Office staff in Kathmandu and being involved with their organisational development and capacity building strategies form the basis of this paper’s findings. Communication and conversations with former FEDO employees, both Nepali and expatriate, and FEDO staff at the District Chapter level, UN agencies, international NGOs, Dalit organisations and women’s rights organisations have given further insight and external perceptions of FEDO’s organisational capacity. Given the short timeframe in which research was conducted, the anthropological and observational nature of findings, it is important to note this paper is dedicated towards documenting the researcher’s considerations of the effectiveness of capacity building with FEDO in Nepal. These considerations were formed through daily face to face interactions and through strong relationships forged with people over the six months working with FEDO.

Capacity Building in Nepal

A central issue for NGOs in Nepal is building the capacity of both staff and organisations themselves in a sustainable and professional manner, in what is a fluid and volatile environment. Whilst the fundamental tenets of capacity building individuals and organisations apply in Nepal as they do elsewhere, it is crucial to understand the social, economic and political situation of Nepal and its culture holistically, in order to reach a nuanced understanding of what capacity building entails in the Nepali context.

Within Nepal, this paper puts forward that there are many factors seen as important when implementing any organisational development strategies. Firstly, Nepal is still largely a patriarchal society upheld by rigid social structures, norms and values which support an unequal caste hierarchy. Gender norms, men and women’s traditional roles and responsibilities within a patriarchal society are very strong. Secondly, age hierarchy and respect must be given to one’s elders, reinforced by a culture based on the collective, not the individual. Thirdly, there are many influences existent in Nepali society which may affect any organisation’s work; political influences, family connections and ‘who you know’ in positions of power, endemic corruption at every level which can make everyday business frustrating with much bureaucratic red tape when operating ‘by the book’, as well as frequent bandhs (general strikes) which means the closure of public amenities making any organisation’s program delivery and communications difficult at times, particularly to more remote areas of Nepal (FEDO, 2012). Religion, caste and ethnicity also play a strong influence; Nepal’s 2001 Census identified 102 castes and ethnic groups throughout the country (Government of Nepal, 2009). Caste,
religious and ethnic tensions often result in political tension and unrest, and there is often overlap between the three. Fourthly, a weak government, lack of government support or services and the transitional phase in which the government has been in recent years creates an uncertain and unstable political system. This has partially contributed to the ‘brain drain’ of Nepal, where educated Nepalis have the opportunity to study or work professionally abroad due to lack of opportunities in Nepal creating deficits in certain business areas.

Other factors that have also been observed as important to organisational development in Nepal is the relaxed attitude to work and punctuality shared by the majority of the Nepali population; the catch-phrase ‘ke garne?’ (what to do?) attitude which pervades every facet of Nepali life can also affect work environments. The modernisation of Nepali society, which has brought change to traditional family structures and division of labour is also a factor to be considered. Now-a-days it is quite common for a husband or wife to be working or studying overseas, while the other remains in Nepal working and caring for their family, which can put additional pressures on employees. Finally, a practical factor is that of electricity shortages and ‘load shedding’, which means in a typical eight hour work day in many Nepali organisations, the power will be off for four hours, affecting staff productivity. These are all elements to consider when implementing organisational development strategies.

Whilst it would be easy to label such factors as ‘challenges’ to capacity building in Nepal, to do so would be to take the road of ignorance and pessimism; labelling such factors as hurdles to be overcome and problems to solve would be neither constructive or astute. Such approaches yield little progress. A study in 1995 evaluating the effectiveness of ten Asian Development Bank (ADB) advisory technical assistance projects for the government of Nepal for capacity building in the social sector (ADB, 1995), in order to make similar future technical assistance projects more effective identified budgetary constraints, management neglect, lack of government commitment, and inadequate ADB supervision as the main factors contributing to the ineffectiveness of the projects (ADB, 1995). The cause to mention a study conducted 17 years ago stems from the fact that conversations with other practitioners revealed very similar, if not identical reasons, for why development projects have not produced meaningful or intended development outcomes, resulting in wasted money. It seems that few lessons have been learned by the development community as to the importance of investing the time and energy into local Nepali organisations, to monitor and support them actively and personally, to truly build individuals’ capacities, and through this, organisational capacity.

A widespread issue with building organisational capacity in Nepal is that ‘capacity building’ and ‘training’ are treated synonymously. Every day Nepal and India’s national newspapers are filled with tenders put out by international donors; ‘Policy Advocacy and Capacity Building for Women’s Political Inclusion’ (TendersInfo, 2011) or
‘Energy Sector Capacity Building’ (TendersInfo, 2011); all calls for capacity building through trainings in every sector imaginable. Yet training as an isolated event does not build an individual’s or an organisation’s capacity sustainably (Gurung, 2009). In an increasingly technological world in which knowledge-based economies are growing in influence, organisations, even those in the development sector, must become adept at a range of skills; marketing, finance, innovation, fundraising, marketing and communications (Whyte, 2004), in order to compete for funding and opportunities at the national and global levels. Nepal’s non-profit sector is no exception. In every NGO and organisation, there are urgent organisational development needs which trainings alone cannot solve. Training can only be one tool of capacity building, which must be viewed as a comprehensive methodology with many tools, one of which is training and education, used with other tools to ‘build’ the capacity of an individual and an organisation’s capacity in a holistic and sustainable way.

In order for this to happen, this paper argues that the focus of capacity building now, more than ever before, needs to become people-centric. In an age where the ‘brain drain’ of developing countries is an unfortunate offshoot of globalisation (Stark and Fan, 2007) and many educated Nepalis will embrace the opportunity to study or work overseas in a developed nation, it is imperative that shifts in organisational cultures will create incentives in Nepali work environments, in which employees are exposed to meaningful work roles and responsibilities, professional development opportunities, mentoring and support, recognition and a sense of mission (Whyte, 2004:5). Bearing this in mind, the next section of this paper considers FEDO and its dedication towards becoming more professional and competitive in a fast-paced NGO environment, whilst adhering to its strong feminist principles and advocacy rights-based approaches.

**Feminist Dalit Organisation**

The Feminist Dalit Organisation (FEDO) is a national level non-governmental organisation of Nepal, founded in 1994 by a group of dedicated Dalit women with the unique aim to fight for the rights of Dalit women (FEDO, 2012). The term ‘Dalit’ means ‘ground,’ ‘suppressed,’ and ‘broken’ in Sanskrit, which reflects the low social status they hold in Nepal and in many South East Asian countries, including India, Bangladesh, and Sri Lanka, among others. Traditionally, Dalits are viewed as part of an ‘untouchable’ caste, the lowest of four castes in Nepal, and regarded as ritually impure and unclean. Despite the abolishment of caste laws in 1963, Dalits are discriminated against because of this notion of untouchability, socially, culturally, economically and politically.

In Nepal Dalit women constitute 10% total population and are treated as ‘second-class citizens’ (FEDO, 2012). They are found on the bottom rung of every sphere of society. Dalit women are predominantly landless and without property. They are
particularly vulnerable to gender-based violence; impunity is widespread due to limited access to justice. Approximately 80% Dalit women are illiterate (FEDO, 2012). They are often accused as ‘boksi’ (witches) and tortured and murdered. 60% of all trafficked women are Dalit in Nepal (FEDO, 2012). Dalit women have five to seven children on average each and have the lowest rates of access to health facilities and lowest health outcomes generally.

In understanding the nature of FEDO’s work, it is useful to consider Crenshaw’s (1989) sociological theory of intersectionality—how categories of identity such as gender, class, ethnicity, and ability—can create, through their interrelation, an intersection of multiple forms of discrimination that can create debilitating forms of oppression for an individual. In Nepal, the intersections of caste, gender and poverty means that many Dalit women face triple forms of oppression and discrimination in their everyday lives. In this way, FEDO works to promote Dalit and Dalit women’s rights, fighting to eliminate caste and gender-based discrimination and to promote justice and equality in Nepalese society.

FEDO works at the local, national and international levels, with emphasis placed on the advancement of women’s participation at the decision-making level, as well as protecting and promoting the civil and political rights of Dalits and Dalit women (FEDO, 2012). They run specific projects and programs in a range of thematic areas, including health and sanitation, advocacy and lobbying, stopping violence against women, education, economic empowerment, peace building and institutional development, funded predominantly by international donors. FEDO places great emphasis on reaching out to Dalit women who are the most hidden, the most vulnerable and the most inaccessible, living and working in the remotest parts of Nepal. In this way, FEDO works in 53 districts throughout Nepal, with more than 2000 active women’s groups in communities, with approximately 50,000 women directly involved (FEDO, 2012).

Working in the context of the patriarchal, highly hierarchical caste-based society of Nepal as a self-proclaimed feminist organisation fighting and aggressively advocating for Dalit women’s rights is not without its challenges. Since 1994, the organization has witnessed discrimination against Dalits and Dalit women at every level of society. Imprisonment, rape, torture, political intimidation, arrest, harassment, slander, bureaucratic barriers, marginalization, murder and exclusion are just some of the tools of discrimination FEDO has encountered whilst carrying out its work, advocating for the social, economic, cultural and political rights, the basic human rights, which all Dalit women and Dalits are entitled to (FEDO, 2012).

The organisation’s Central Office and site of research for this paper is based in Lalitpur, Kathmandu. One of the fundamental principles of FEDO’s employee recruitment processes is to hire Dalit women wherever possible, and actively prioritise Dalit women, then Dalit men, before any other candidates. Whilst meritocracy is
valued, these affirmative action policies are prioritised above anything else, meaning
the organisation is almost entirely staffed by Dalit women and Dalit men. Each Dalit
staff member in FEDO’s Central Office can recount stories of discrimination they
encountered throughout their lives. Most senior staff members, including the Founding
Board Members and President, were from remote rural areas in Far-Western Nepal,
where discrimination is far worse. Denial of access to education, public water sources,
temples, markets, health services or people’s houses are common. Staff struggled first-
hand to reach where they are, and many are the first generation of educated Dalits to
advocate for their own rights. It seems that is this personal passion and a continued
politicised agenda combined with a simple approach to capacity building, which
makes FEDO’s organisational development strategies effective and sustainable.

Capacity Building with FEDO

The driving force behind FEDO’s desire to improve its organisational development
resulted from two main factors. Firstly, a generational gap was identified between the
old guard, the founding members of the organisation, strong Dalit women from Far-
Western Nepal who make up FEDO’s Executive Board in their forties, and the new, the
younger Dalit women in their twenties beginning to participate in FEDO’s programs,
who were not receiving the opportunities to be as involved with external stakeholders
and activism as the old guard had had at their age. Secondly, as gender has become
more mainstreamed within international development, it has also lost its edge as a
punchy analytical and operational tool (World Bank 2005, UNDP 2006), and whilst
more mainstream and accepted, in some senses has become ‘a bland and depoliticised
concept’ (Magar and Storer, 2009:434). As a feminist and rights-based organisation for a
marginalised social group, FEDO needs to retain that edge, and it was decided shrewd
organisational development would aid to hone it. Whilst some strategies had been used
on and off in previous years, this was the first time a concerted and formalised effort was
being committed to with a results-oriented focus.

In early 2012, an organisational assessment and Action Plan assessing individual, project
division and general organisational needs, and ways for everyone to work more efficiently
and effectively together, was developed with input from all staff members. Through this
process, some of FEDO’s key priority areas for capacity building in 2012/2013 were
identified:

• Leadership development of FEDO’s Board.
• Increased engagement of younger staff.
• ICT development.
• Improved monitoring, evaluation and reporting of programs.
• Improved management of documentation.
• Human rights monitoring and documentation.
The way in which to build staff capacity in these areas was based on the following tenets:

- The leaders of FEDO need to lead organisational change and lead by example.
- One-on-one training and interaction for staff on a regular basis over time.
- Enhance communication, sharing of knowledge between staff and meet all needs of staff, giving recognition and reward for hard work.
- Define staff roles and responsibilities with greater clarity, and give more responsibility to younger staff.
- Ensure staff ‘buy in’ and participation in organisational development strategies.

Over a period of six months, the implementation of these organisational development strategies through capacity building began, to continue through until the end of 2013. Slowly it became apparent, through small everyday tasks, that FEDO was successfully building its individual staff and organisational capacity through each of its priority areas.

**Leadership Development of FEDO’s Board:** One of the main barriers to leadership of FEDO’s Board members, older Dalit women, was lacking confidence in their English skills to liaise with potential donors and participate in international forums on Dalit issues. Most of this had previously been done by the President. The Board, who work in FEDO on a daily basis, began taking English lessons and public speaking five times a week for an hour a day during their lunch breaks in order to improve their language skills, and soon were taking the initiative to speak publicly at more of FEDO’s events in place of the President. They would come into work and talk about the English homework they completed with their children at home. One Board member said she knew her English was getting better, because her eight year old son could find few faults in her homework!

**Increased Engagement of Younger Staff:** FEDO’s senior staff and Board began to give younger staff more responsibilities, and to use their different competencies in their work more, such as English language skills, that older staff lacked. Several younger staff were promoted from administrative to project roles and given more opportunities to represent FEDO externally.

**ICT Development:** To inform the outside world of FEDO’s work and the situation of Dalit women in Nepal, FEDO funded a new website, and started to promote itself in social media. Building on the Communication Officer’s knowledge of media and communications through print, the Organisational Development Officer and Communications Officer worked together for half an hour a day, slowly improving the Communication Officer’s skills, whilst simultaneously orientating staff as to FEDO’s new ICT systems.

**Improved Monitoring, Evaluation and Reporting:** Training workshops held on the basic fundamentals of these three areas, with the Organisational Development
Office working with all Central Office staff daily on their individual reports, started to produce small but tangible outcomes—improved English grammar in media releases and reports, decreased negative donor feedback from progress reports, improved email content clarity and better working relationships with donors overseas.

**Improved Management of Documentation:** In response to hundreds of request for information on Dalit women each year, FE DO funded the construction of a new Training and Resource Centre, furnished through funding by the Australian Government, in order to organise 18 years’ worth of documentation into a categorised system, with training of staff on the new system. The new Centre was promoted to local and international organisations and academic institutions as a research hub on Dalit women.

**Human Rights Monitoring and Documentation:** FE DO established a three month practical training program for monitoring and documenting the human rights violations against Dalit women, as well as a centralised database to compile cases from FE DO’s District Chapters in the one place. The database is used for research, advocacy and marketing.

**Discussion**

Over six months of research and work with FE DO, the success of their capacity building, though slow, was tangible. Through daily interactions it could be seen, through changing attitudes and a changing work culture, that it was real organisational change. Whilst the small changes detailed above are only a few small examples of many witnessed—of capacity being built almost imperceptibly—those actions were the direct result of the organisation deciding to dedicate itself to becoming more professional, efficient and effective in a highly modernising world, whilst retaining its fundamental principles.

There are two main reasons why FE DO’s organisational development strategy has been successful thus far in its beginning stages. Firstly and somewhat inevitably, the first reason rests on the sense of purpose and mission FE DO’s employees have. Everyone is Dalit; they have experienced discrimination first-hand, and actively seek to fight for Dalit rights, so their children, and generations to come, will not experience what they had to. It is the strength of FE DO’s mission, to eliminate gender and caste-based discrimination, which has permitted the organisational change in and motivated people to embrace it. Dalit identity across Asia is an evolving one; many organisations portray Dalits as pitiful, downtrodden and voiceless victims needing support and charity from others. Others, like FE DO, see Dalits as suppressed revolutionaries engaged in political activism, fighting for their rights. This utter belief in its right to exist, not just as an NGO, but as a self-proclaimed social movement, sustains its employees and
motivates them to want to improve not only themselves professionally, but the organisation as a whole, to further the Dalit cause.

The second reason for the success of the capacity building lies with the strengths inherent within Nepali culture, which are drawn from the prior mentioned potential factors to consider when capacity building in Nepal. The factors some practitioners perceived as ‘challenges’ ironically create the strengths-based approaches underlying FEDO’s success. It is a patriarchal culture based upon gender and caste-based inequalities which gave rise to an organisation dedicated to only employing female Dalits wherever possible, and it is this very identity which motivates FEDO’s employees to work hard in comparatively low-paid jobs, instead of seeking work or study opportunities overseas. In contrast to many disillusioned Nepalis, FEDO’s leaders strongly believe that one day Nepal will form a government whose Constitution includes Dalit rights, and that until that day, they must continue to advocate and run programs to replace the services for Dalit women the government cannot yet deliver. Donors must be treated with care and respect, but Dalit women’s priorities are always paramount. FEDO’s affirmative action for employing Dalit women or Dalits is rarely negotiable. Load shedding is seen as a nuisance, but days of work are arranged around it so there is always something for staff to do when the power goes off. In this way, there are some aspects of Nepali culture that have influenced FEDO’s organisational development strength and its staff’s dedication to their work and to the organisation.

Conclusion
Ensuring true and sustainable capacity building requires considerable effort and time, particularly in the international development context. Whilst only observed through a limited timeframe, it can be seen that through examining the work of FEDO in Nepal, the importance of individual motivation and dedication towards an organisation’s goals and mission can be seen as paramount to the successful implementation of organisational change. This case study highlights the importance of one-on-one interaction and that the drive for change must come from within and be sustained internally by an organisation’s members. It also considers that it is those exact ‘challenges’ often encountered in developing contexts which have motivated FEDO to build the capacity of its staff and of the organisation. Through small and slow steps building the capacity of individuals, FEDO demonstrates the value of what true capacity building and people-centred strategies may produce.

References


The Rights Context: Women and Children in Nepalese Communities

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ABSTRACT
This article, written in the context of everyday-life settings of Nepalese children and women living in oppressive circumstances, addresses the complex and diverse discourse concerning various concepts of human rights. It goes beyond the conceptual disputes and the dilemma of international social work resulting from the occasional inconsistency between local perceptions and international ideas. This article emphasizes the diversity in terms of universalism and suggests some ways and means of enhancing understanding and advocating for human rights in local societies such as in Nepal. As Nepalese society has more recently chosen a political and economic collective ideology that differs by many ways from Western worldview, the article takes into account the strong effect of community in individuals’ lives. By strengthening the communities, there are more possibilities to advocate human rights of children and women in Nepal. By recognizing the complexity and multifaceted nature of communities, this article argues for the prioritizing the voice of the most vulnerable people in advocating human rights.

Introduction
This article discusses the concept of human rights that is often taken in granted in social work research, education and practices. Human rights discourse is strongly infused in social work literature, and practitioners deal with it in many aspects, even though it is not always articulated as such (Harrison and Melville, 2010). Defining itself as a ‘global voice’ of social work, the International Federation of Social Worker’s (IFSW, 2012) has stated that ‘principles of human rights are fundamental to social work’. However, this wideness and fundamentality is questioned in debates concerning the contents of human rights and international and local, universal and contextual tensions. As human rights runs the risk of remaining embedded in social work’s value base rather than being translated into practice (Dominelli, 2007), this article suggests also the voices of the most vulnerable people are being dominated by academic and political discourse concerning human rights. By focusing on this aspect, the article, written in the context of everyday-life settings of Nepalese women and children living in oppressive
circumstances, addresses the discourses on international and local, as well as conceptual and practical levels.

This article stems from ongoing dissertation examining human rights and social justice of women and children in Nepalese communities. Research is conducted with strong commitment to respect of locality and the ethics of researching with people rather than on people. Women and children living in oppressive circumstances, abandoned by their original communities, have the role of ‘co-researchers’ and their knowledge is prioritized to fulfill the hole that human rights discourse has. Data is collected across two years with ethnographic methodology by researchers’ participation and observation in Nepalese communities, and complemented with ethnographic interviews and discussions. Interviewees consists of eight children living on the streets and in children’s homes in Kathmandu, the capital of Nepal (Mikkonen, 2010). In the future (2012–13) women from rural communities, often the original roots of abandoned children, will also be interviewed.

The conceptual framework of this article is formed by human rights’ debate, deepened with illustrations and interpretations of the excerpts of data from ongoing dissertation as well as appropriate political statements and documentaries. First, this article discusses the tension of universalism and difference in international and local social work’s human rights discourse. Secondly it addresses the concept of human rights within Nepalese communities from the perspectives of women and children. The article suggests appropriate ways for advocating and practicing human rights in contexts such as Nepal.

Teasing Universalism and Difference

In a world of hierarchies and differences the idea of universalism is challenging. However, by aiming at recognizing people living under oppressive structures (e.g. Healy, 2001), it penetrates the ideas of social work. Also internationality has characterized social work through the profession’s history (e.g. Midgley, 2006): Since Jane Addams’ settlement movement gained inspiration from travelling in Europe in early 20th century (e.g. Xu, 2006), to current global interdependence enabling social workers to engage in international activities (Healy, 2001). Universalism and internationalism also refers in this article to global responsibility that social work research carries in relation to promoting social issues getting worldwide. This embraces international social work’s vision about ‘borderless world’ (e.g. Midgley, 2006, 14) and emphasizes the need to exchange the knowledge from different contexts to open new aspects appropriate on international discussion.

This article crosses borders and envisions a “borderless world”, which includes the need to respect differences. In coming from another continent and different social arrangement
aiming to create a social work research project, the examples of exporting professional ideas from one country to another are worth scrutinizing. As Qingwen Xu (2006) argues, social workers perform vastly different tasks in different countries, and to spread their methods and values can be complicated and socially incongruent. There are examples of attempts to penetrate social work’s Western patterns to indigenous cultures after Second World War with no success, as local colleagues found them partly inappropriate (ibid.). To avoid this kind of professional imperialism, this article is based on compromising different world views rather than imposing professional viewpoints (e.g. Midgley, 2006) and respecting local cultures, knowledge, practices, values, languages and institutions (Ife, 2005).

Children and women in Nepalese communities face specific challenges that are intertwined with each other. Problems leading children away from their homes often continue inside the walls of institutions, where malnutrition, discrimination and physical, sexual and mental violence still might hurt the rights of the children (see Mikkonen, 2010; Terre des Hommes and Unicef, 2008). To prevent this circle to move on, change is needed on number of levels. In finding the roots of this particular issue, one path leads towards the political and structural level and global inequalities, which may enable some people to use unjust ways to ensure one’s own economic power. Understanding the relationship between global issues and local challenges opens crucial aspects in effecting the change (e.g. Nash and Munford and Kieran, 2005). Another path leads to scrutiny of children’s original homes and communities, many of them located in rural villages. The idyll of those villages is often broken by poverty, natural catastrophes, political instability (see Terre des Hommes and Unicef, 2008) or discrimination across social hierarchies. These reasons might leave only unfavorable options for families looking for better future to their children. Single mothers and their children are especially vulnerable in these communities, as low social status and poverty of a single mother, either divorced or widow, often forces her to send the children away hoping for better opportunities from different institutions. This shows the relevance of parallel examination of children’s and women’s rights.

This article embraces Gai Harrison’s and Rose Melville’s (2010) argument of globalization and the movement for global citizenship providing a new impetus for examining the role and utility of human rights in social work. Recently IFSW’s (2012) statement carried the title “Para-Olympic Games opens with a celebration of human rights and diversity”: When diversity is celebrated, it raises the dilemma of being linked to universalism; respecting differences refers to individual freedom, self-determination and self-expression. It is worthwhile asking the question as how some of the above ideas fit into the collective ethos and social coherence of Asian cultures?

Through the complex discussion of the human rights in terms of universalism and differences, this article supports social work’s basic values such as to increase people’s self-determination, empowerment and participation, to treat people holistically and to
recognize people’s strengths (e.g. Harrison and Melville, 2010). People do not need internationally accepted concept of human rights to realize that their basic needs are not being fulfilled or that their physical, mental or psychological sense of self is being violated. The discourse of human rights is dynamic and should not consist of top-down, imposed legal or abstract principles (Ibid). By focusing on people’s own experiences and feelings, the debate gets the voice that should be the final target of international declarations and conventions as well as basis of social work.

The Rights Context with Children and Women

Numerous international non-governmental organizations in Nepal use human rights discourse within their ideologies and actions. Nevertheless, understanding human rights of children and women in Nepal meets with the dilemma that international social work has struggled with: local perceptions does not always match with international ideas (e.g. Xu, 2006). Cultural relativists argue that human rights are not “one size fits all”, but “vary according to culture” (Mapp, 2007, 20). In this article being culturally sensitive, the debate of human rights is used as a framework for the scrutiny of the lives of Nepalese children and women. This framework contains of different ‘generations’ of United Nations Universal Declaration on Human Rights (UDHR), post colonialist and Asian critiques of UDHR, as well as feminists’ and Asian Human Rights Commission’s arguments (Harrison and Melville, 2010; Mapp, 2007; Stivens, 2000; Amirthalingam, 2005).

Many of human rights’ promotions in Nepal are based on globally leading determination (UDHR), which is seen to form the universal conception of dignity, respect, rights and freedoms that concern all humans regardless of nationality, political system, religion, or any other grouping, simply by the fact of their humanity (e.g. Mapp, 2007; Dominelli, 2007). Yet dispute on ideological and political differences between different states has led into two separate ‘generations’ of UDHR: one on civil and political rights (right to vote, right to movement, freedom of speech and right to fair trial) and another on economic, social and cultural rights (right to the expression of cultural identity and right to be adequately housed, fed, schooled and employed) (Harrison and Melville, 2010; Ife, 2008). Besides these two generations, for instance Susan Mapp (2007) and Jim Ife (2008) has pointed out the third generation of human rights, which focuses on the ideas of collectivism. These rights are only loosely framed in the Article 29 of the UDHR (ibid.) but in the context such as Nepal, these ‘solidarity rights’ are necessary to examine.

Social work discourse needs to mind also the third generation of rights, as IFSW (2012) fails in recognizing them in social work mandate, when referring to assist people to maximise their ‘civil, political, economic, social and cultural rights’. Conceptual background for the respect of collectivism in this article is based also on Asian critiques
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of UDHR claiming that its contributions to individual expression would undermine the moral and social cohesion and collectivism in Asian countries (Harrison and Melville, 2010; Mapp, 2007). Asian critiques have parallels to post-colonialist arguments of human rights being predominantly a Western invention based on individual values, which are inappropriate in some cultural contexts. The relevance of collective stance on human rights in Nepal is illuminated by an example of interviewing the children living on the streets and children’s homes (Mikkonen 2010): When discussing children’s rights, it is characterized by discourse of ‘us’. The question of a child’s perception of his/her rights turned, for example, into ‘how we find a place to sleep’ or ‘how we were afraid of getting beaten by other gang’ (ibid., 77). Among children living in this particular context, the ‘us’-discourse refers to the importance of peer-group, but also to a collective ideology (e.g. Rachael Baker, 1998). Collectivism is even more unique and dense in a context like Nepal, were statistics refer to 100 different ethnic groups and unknown number of local languages within them (Dahal, 2002).

Besides ethnic groups the communities in Nepal can be defined as joint families, typically including grandparents, their sons, sons’ wives and children. Marriage is a strong institution in Nepal, especially impacting on women’s self-determination: marriages are still mostly arranged by families (parents/other relatives), and, especially in rural areas, girls are married at a young age. As there is demand of dowry from a girl’s family, to get into ‘a good marriage’ might be economically challenging. This leads often to abrogate a girl’s education. After the wedding a girl/woman usually settles down in husband’s family, which causes new social arrangement by women sharing a responsibility of housework, which comes together with concept of ‘duty’. According to Asian social coherence, individuals own a position in society which includes certain duties. In a woman’s life, it refers to being a ‘good wife’ who keeps husband and his family satisfied and carries out ‘women’s’ work.

Duties also concern children, apparently not always matching with UN’s Convention on the Rights of the Child (CRC), even though Nepal has ratified it in 1990 and adapted its ideas to national Children’s Act in 1992 (e.g. Garujel, 2007). This refers to a stance where the child is seen mainly as a community member with the duties of his/her own. For example in a family struggling with poverty, a child’s duty is to participate in earning, as child-labour is still common especially in carpet industries, construction sites, farms or families having housemaids (Kotilainen and Kaitila, 2002). As Nepal is ranked by United Nations Human Development Index on 157th position out of 187 countries with economical situation as one indicator (HDR 2011), the link between duties and poverty is apparent. Poverty increases inequality (e.g. Blakemore and Griggs, 2007), and its different faces in terms of rural and urban areas in Nepal make the gap between people even wider. As poverty gets different shapes also beyond economical dimensions (e.g. Blakemore and Griggs, 2007), women’s and children’s poverty is specific due to their social position.
As religion is one strong determinant of individual’s social position in Nepal, it is also necessary to discuss the duties specified by caste-system based on Hinduism (e.g. Raju, 2010). Illegalized caste-system still effects in people’s attitudes and beliefs in Nepal. The highest castes hold the powerful positions in politics, army and civil service (Askivk, Jamil and Dhakal, 2011). The ‘untouchable’ castes have been excluded, and even though their legal rights have been improved since 2006, reaching those rights in practice takes time. Castes do not often get mixed as inter-caste marriages still lead to a risk to be excluded from community: for example, a woman remaining widowed after an inter-caste marriage was abandoned from her original community as well as husband’s family. The social security that community usually ensures, was crashed due to caste-system’s inflexibility, and this woman finally found herself working in construction site with her children within inappropriate and dangerous working conditions. In terms of duty and caste-system, the perceptions of Indian leader Mahatma Gandhi are relevant. Due to the promotions for equality and the rights of ‘untouchables’ (Raju, 2010), his ideas can be distinguished from discriminative and restrictive duties that the caste-system contains in Nepalese communities. His perceptions refer to the duties supporting the good of entire community, not oppression or domination of some individuals in certain social position.

In talking about the entire community, this article suggests that communities are not static, permanent units, but rather, dynamic combinations of traditions, social order and beliefs. Thus the discussion gets new dimensions from the disagreement of ‘Asian critiques’ by Asian Human Rights Commission and feminists. When Asian Human Rights Commission argues ‘Asian critique’ to be invoked by governments to justify the suppression of political and civil freedoms (Harrison and Melville, 2010), feminists continue that the critiques of Western individualism is used to justify the discrimination based on gender argued by social cohesion and communality (Amirthalingam, 2005). This critiques are related to questions, who presents the accounts of victims or who has the right to talk about whom, and how (Sen, 2000). The same questions can be asked when discussing children’s and women’s rights together. Addressing human rights in communal settings there is a challenge to recognize specific social hierarchies and power-relations among people. With regard to weaknesses of ‘Asian critiques’, this comes together with the necessity of hearing a voice of the most vulnerable people and lowest social positions in communities.

Besides criticizing ‘Asian critiques’, feminists argue also that the first generation of UDHR (civil and political rights) is gender blind and inadvertently perpetuate existing inequalities between men and women. Those inequalities in Nepal still appear to be taboos, even though upgrading position of women has been on political agenda and in development of educational system. According to Tek Nath Dhakal (2002), Nepalese women are still silenced, oppressed and discriminated against in their communities. Their problems are culminated in early marriages, high birthrates, illiteracy, poor health
care, discriminative traditions and discrimination of law (ibid.). Also the Indian Women’s Movement arguments for women victims of dowry, domestic violence, liquor, rape, prostitution and custodial violence (Raju, 2010) are apparent in Nepal. The lists disregard trafficking, as numerous Nepalese girls are sold to India as prostitutes (United States Department of Labor 2005). Regarding feminist critiques of the UDHR being gender blind, there are more specific conventions to protect women: the UN Convention on the Elimination of All Forms of Discrimination against Women (1979) and the Declaration on the Elimination of Violence against Women in (1993) (Harrison and Melville, 2010).

As critiques of human rights address the significance of communities but also the complexity of them, this article argues that Nepal cannot be discussed as one united culture due to its wide diversity in geographic, ethnic, religious and linguistic terms (e.g. Dahal, 2002). After this multifaceted discussion and debate, a wider question arises; how can traditional order of a society and the universal human rights both be respected (Mapp, 2007)? The United Nations has stated that these two ideals are not in opposition. Human rights declarations are minimum standards, and each culture can choose the most appropriate manners to realize them (Ibid.). Addressing human rights within the Nepalese context gives appropriate views to respect local specialities, but as Harrison and Melville (2010) state, by strictly adhering to cultural relativism one might become blind to the harmful practices in people’s lives. Even though this article argues for the importance of polyphonic discussion in human rights, its basis arises from social work’s core: ‘promoting well-being, empowerment and liberation’ (IFSW, 2012). From that basis, this article goes where the conceptual discourse turns into practice.

### Conceptual Discussion to Practice

This article continues with suggesting relevant ways and means to advocate human rights in context such as in Nepal. Taking into account Nepalese specialities and polyphonic debate concerning the concept of human rights, this article claims strengthening of entire communities to be the core of advocating the rights of children and women. As praxis of ‘radical community development’ combines feminist and anti-racist orientations with community work (Ledwith and Asgill, 2007), it matches with the conceptual framework addressed in previous chapter. When for instance Indian-American research partners developed social work practices with Asian migrants in USA, they found four essential ingredients in working: cultural authenticity, use of local knowledge, connectedness and creativity (Nimmagadda and Martel, 2008). In this chapter, these ingredients with ‘radical community development’ form a basis for the ways to go from conceptual level to practice.

As cultural authenticity urges to start ‘from where the people are’, to understand the context, meaning and culture in people’s lives, (Nimmagadda and Martel 2008, 151), it
starts with small steps and encounters, and includes entering into the local rhythm of life instead of imposing outside agendas and timetables. It demands prioritizing people’s need and hopes before social worker’s ideological interests. Advocating human rights in Nepalese communities opens new viewpoints, parallel to Nimmagadda’s and Martel’ (ibid.) argument of making appointments (common in Western social work) being inappropriate in Indian sub continental cultures. Cultural authenticity arises from ‘tuning into’ communal life-style in Nepal, with the example of local teashops being the meeting points of community, where political highlights or miseries and joys of families are shared. Those teashops form the ‘heart of community’, which make them relevant and reasonable places to encounter people also in terms of human rights advocacy. Nevertheless, with regard to the complexity of communities, this is not sole way to meet the most vulnerable people, as women or children abandoned by their communities might be restricted to join these public spheres.

Recognition of differences within the culture and making space for everyone’s voice in communities match with Nimmagadda’s and Matrel’s (2008) argument of using local knowledge. In community work, the role of expert is with the clients and the knowledge used as a tool for change is formed in shared process (e.g. Nash and Munford and Kieran, 2005). Paulo Freire in the seventies argued for liberation to be achieved with people, not for people. This includes a paradox: sometimes human rights violations are not determined as such from a Nepalese woman’s or child’s perspective. For instance according to traditional beliefs in Nepal, a woman is not allowed to cook or sleep in the same room with her husband during menstruation period. In universal human rights’ terms this appears as restricting the freedom and self-determination. However, this stance provides a new viewpoint, telling a woman to enjoy that time, being free from typical ‘duties’. This example shows the importance of building a trust and increasing the understanding of different worldviews. This meets also with Nimmagadda’s and Martel’s (2008) argument for connectedness.

Besides different world views of people across cultures, people within the same culture may also have different understandings and experiences (Harrison and Melville, 2010). Similarly, oppressed people are not homogenous group with same kind of experiences (Freire 2007, [1970]). In mountainous and hilly Nepal, a valley might separate people into different ethnic backgrounds or cultural inheritances. As Nimmagadda and Martel (2008) emphasize, connecting the world views of the social worker and client, this article widens the concept of connectedness to people within and across the communities. In advocating human rights within communal lifestyle and community development, the starting point is uniting different perceptions, and to get the entire community to have the same goal. Uniting includes also people of higher positions being involved in human rights advocacy, besides the women and children themselves. Having a same goal among the people of entire community is particularly challenging when allowing the same rights to all makes higher positions to lose some benefits. Those might be too
fine-grained and difficult for person from outside to recognize. That’s why in-depth scrutiny of power structures inside the communities is a key strategy in community development and connecting people.

This article emphasizes also connectedness between women and children. Many of the children living on the streets or children’s homes in Nepal have a mother (Mikkonen, 2010). The children are prioritizing mother among other adults in their lives, even though many of them may not be able to meet her for a long time (ibid.). Reasons leading children apart from their mothers are various, but reconnecting them is possible in spite of those reasons, and essential as one’s original roots are the key ingredients of identity. Connecting children with their mothers and empowering women promote expands to include peers, with children living on the streets emphasizing the meaning of peer-group (ibid.). Peer-group and unions enhance also forming an affirmative environment to empower and find one’s strengths, one ingredient in culturally relevant social work (Nimmagadda and Martel, 2008). When the peer-groups’ supportive atmosphere, in which all parties could feel comfortable enough to express themselves honestly and fully (ibid.), has been reached, advocating women’s and children’s rights gets a move on a broader scale.

Being culturally authentic and connecting people introduces continually new situations in spontaneous life-settings. This requires creativity, which does mean the ‘need to think outside the box’ and use of imagination to develop culturally authentic interventions. In Nepal, creativity also takes into account the meaning of religion that forms social orders, beliefs and perceptions of good. ‘Person in context’ discourse finds a new dimension in strongly religious communities, such as in Nepal (e.g. Kee, 2008). When the perception of context has to expand to supernatural or spiritual level, the language of local religion is essential also in human rights advocacy. In so doing, for example Gandhi’s ideology is relevant. In religious discourse the concept of duty is essential, which worked for example in India where social workers developed a supportive family program for the families where the head of the household has had an alcohol problem (Nimmagadda and Martell, 2008). Similarly in the Indian context Gandhi in his promotion of the rights for ‘untouchables’ did not talk about advocating the individual rights but rather ‘an ethic of the community, responsibility and loyalty’ (Raju, 2010), his ideas can be turned into local terms in Nepal to increase well-being of entire community, also the most vulnerable members of it.

By starting from ‘where the people are’ (Nimmagadda and Martel, 2008, 151), radical community development aims finally at influencing oppressive structures as a target of action with communities. As structures are formed by people within institutions, policies and cultural procedures, uniting communities to change them is one essential tool in advocating human rights. Failures of forming a constitution and recent civil war in Nepal has kept the political environment unstable. People’s dissatisfaction of the political
situation has caused numerous demonstrations and strikes by different actors. Similarly, the dissatisfaction of the low position of social work motivate scholars to bring their message to the local authorities, politicians and communities, as social work’s academics-professors, teachers and students-see political activism as part of the profession in Nepal. This activist mentality can be turned into human rights advocacy as well, filling social work’s perennial lack of embracing rhetoric to political action (e.g. Harrison and Melville, 2010). Human rights form a relevant language for activism to change oppressive structures, after taking into account cultural specialities discussed in this article.

Conclusion

Addressing the complexities of advocating human rights is relevant not only in Nepal but brings visions also to wider discourse in terms of internationality and locality and diversity of communities. This article has addressed universal concept of human rights through the current debate concerning it. Critiques of universal perception of human rights (e.g. Asian, post colonial and feminist critiques) have parallels in advocating the rights of Nepalese women and children. Community having a strong effect of individuals in Nepal, the meaning of collective rights, duties and responsibilities in terms of rights-discourse are emphasized. In advocating human rights prioritized in Western world, many contradictions occur. However, by committing to social work’s basic idea of promoting people’s well-being, culturally explained oppression has to be examined critically and deconstructed.

After examining and understanding the oppressive structures that violate human rights, there is time for action. As social work has been argued to address human rights on rhetoric level rather than implementing them into education, practices and policies, conceptual dispute is essential to be turned into action. The main finding of this reflection turned into action in Nepalese society is ‘radical community development’, including the combination of the ideologies of different human rights’ critiques and local specialities. Radical community development gives space for cultural authenticity, use of local knowledge, connecting people and creativity. By keeping on focus what women and children themselves feel and need, advocating human rights within the diversity of communities is multifaceted, but essential task.

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Positive Aspects of Caregiving in Caregivers of Children Living with HIV/AIDS

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ABSTRACT
The occurrence of a life threatening illness like HIV/AIDS during childhood has a profound effect on the physical, psychological, social and spiritual integrity of the caregivers. While AIDS has garnered a significant amount of attention, little consideration has been directed towards caregivers’ population in India. Positive aspects of providing care to children living with HIV/AIDS were studied in a family caregivers (n=206) in Regional Paediatric ART centre in Bangalore. In this study majority of the caregivers were parental caregivers. After the parents demise, it was mostly the grandparents, siblings and relatives who took the responsibility of caring for the HIV infected children. Majority of the primary caregivers were females, only 19.9% of the caregivers were males. Most of the children in the study had been infected, primarily, through mother-to-child HIV transmission. Only 14.6% of the children knew that they were infected with HIV. Majority of the caregivers were providing more attention and would never feel the burden in looking after the HIV infected children in the family. The caregivers were willing to go to any extent to provide treatment for the child. The impact of HIV reported was less. The positive aspects of caregiving can be strengthened by psychological support and practical assistance with problem solving from Social work professionals. There are a number of implications from the research findings that are relevant to India from a strengths based perspective. We need to develop and adopt, in partnership with government and health and human service agencies, a standard framework for developing strength-based services/programs. Encourage and support research on strength-based approaches in assessment, intervention, programs and service delivery to promote psychological well-being for caregivers of children living with HIV/AIDS.

Keywords: Parental and Non-Parental Caregivers, HIV Infected Children, Positive Aspects.

Introduction
Family members and significant others find themselves in the role of caregiver for a multitude of reasons. The demand for caregivers continues to rise worldwide as a result
of an increasingly aged population, multiple co-morbidities, people who survive traumatic injuries and the results of the HIV/AIDS epidemic (WHO, 2002). Caregivers represent an important network of persons that struggle to meet the daily needs of HIV-infected individuals (Theis et al., 1997). Caregivers are responsible for enabling HIV-infected children live and thrive in home-based rather than in institutionalized communities of care. While family members have always played a significant role in caring for other ill family members, changes that have occurred both culturally and medically have made the role of caregiver more difficult (Zarit, 2004).

Increasing number of children are being diagnosed with the HIV/AIDS. In 2009, an estimate of 25 lakh children under the age of 15 are living with HIV infection worldwide (UNAIDS Global report 2010). India has an estimated 1, 00,000 (4% of adult infections) children living with HIV (NACO 2010). In Karnataka, a cumulative of 10,915 children living with HIV/AIDS are registered in various (Anti Retroviral therapy) ART centers and of these 3330 children are on ART and are being followed up regularly in these centers. Earlier most of the HIV infected children were not able to see their second birthday as they would have had developed complications and died even much before they could be tested and treated. But with the initiation of Pediatric ART, most of the children are growing up in to their adolescence and beyond (NACO 2010). HIV disease is now considered a chronic illness.

In spite of the dramatic declines in pediatric HIV incidence and death rates, caregivers of HIV-infected children and adolescents continue to face innumerable challenges with regard to the availability, access and utilization of non-medical supportive social service care needs. To this day, HIV/AIDS in the family presents unique challenges for the infected children as well as the non-infected family members of HIV-infected children (Fair, Spencer, and Wiener, 1995). And as Turner and Cantania (1994) reported, caregiving in the case of HIV disease is exceptionally challenging—mostly because considerable demands are placed on caregivers of HIV-infected children.

In fact, until recently, most research concerned with AIDS epidemic focused on persons who are themselves infected with HIV/AIDS. Even then, no other disease evokes such a devastating social impact or threatens the family unit as HIV/AIDS does. The disease’s sphere of influence on families is far-reaching, manifold and deeply felt, particularly, by primary caregivers. Hence, caregivers have been characterized as AIDS ‘Unseen Victims’ or ‘hidden patients’ of the epidemic (Joslin and Harrison, 1998; Lesar, Gerber, and Semmel, 1996; Bonuck, 1993; Schuster et al., 2000).

Pediatric AIDS is both stressful and frightful for the child as well as its caregiver. AIDS in the family devastates the family at least on three fronts: It undercuts family relationships, resources and resilience. As for the primary caregivers who bear the greater burden of HIV/AIDS both physically, emotionally, psychologically, economically, culturally and socially (Knodel and VanLandingham, 2000), HIV has profound impact
on them, too. As a result, increased attention must be directed at tackling AIDS impact on primary caregivers. Notwithstanding their invaluable service for HIV-positive children, many caregivers are largely invisible to the health care system; some are isolated, powerless, impoverished, unsupported, unappreciated and persistently trapped in a myriad of unmet supportive service needs that could easily minimize the extraordinary burden of care placed on them day after day (Katz et al., 2000).

Many family caregivers report positive experiences from caregiving, including a sense of giving back to someone who has cared for them, the satisfaction of knowing that their loved one is getting excellent care, personal growth and increased meaning and purpose in one’s life. Some caregivers feel that they are passing on a tradition of care and that by modeling caregiving, their children will be more likely care for them if necessary. Many caregivers also report that they find benefits in their role and activities through positive reappraisals, spiritual beliefs, or other adaptive coping mechanisms in the face of stress. This is increasingly seen as a positive form of coping with stressful circumstances and situations. Caregivers who perceive more benefits from caregiving report lower levels of depression (Haley, et al., 2003).

Existing studies on positive aspects of caregiving have used a variety of operational definitions, such as satisfaction, as in the caregivers’ appraisal of the caregiving experience (Cohen et al., 2002; Lawton et al., 1989), gratifications and meaning of caregiving (Haley, LaMonde, Han, Burton, and Schnetter, 2003; Motenko, 1989), personal gains or benefits (Braithwaite, 1996; Pearlin et al., 1990), and uplifts and enjoyment of caregiving (Kinney and Stephens, 1989). Overall, these studies suggest that in addition to the stresses of caregiving, the caregiving experience involves a number of positive aspects perceived as satisfying and meaningful. Cohen et al. (2002) reported that they had positive feelings toward at least one aspect of their caregiving experience. Reported positive feelings included companionship, fulfillment, enjoyment, and the satisfaction of meeting an obligation and providing quality of life to a loved one. Compared with the large number of studies on the effects of caregiver burden, the role of positive aspects of caregiving has received little attention (Allen et al., 2003; Kramer, 1997).

In India there has been limited research in the area of caregivers and more so on children living with HIV/AIDS. Most of the studies have focused on the impact of HIV/AIDS on the CLHA and his/her family, ART adherence, institutionalized infected children and quality of life etc. which were presented in the first national conference organised by National AIDS control Organisation 2010. As there are a dearth of Indian studies, an attempt was made to understand the positive aspects of caregiving in the present study.
Methodology
Caregivers of HIV infected children aged 4–16 years, being followed at the Regional Pediatric ART center, Indira Gandhi Institute of Child Health, were recruited during 2010–11. Caregivers were approached during their regular, child’s clinic appointment. An explanation of the research procedures, its purpose and expected duration was given to each caregiver. Sufficient time to examine the consent form and ask any questions regarding the study was provided. The inclusion criteria were caregiver’s consent and willingness to participate and children aged 4 to16 years with confirmed HIV positive status. All caregivers (n=206) were administered the socio demographic questionnaire, personal profile of the infected child, information related to the HIV infection, caregivers reasons for taking up the responsibilities of the HIV infected children and positive aspects of caregiving. The data was analysed using SPSS version 14.0 for Windows. Descriptive statistics such as frequency mean, percentage and standard Deviation were used for understanding the profile of caregivers and children.

Results
Socio-Demographic Profile of Caregivers
Nearly 68.9% of the caregivers were parents (of them 1.9% were adoptive parents) of the HIV infected children. After the parents’ demise, it was mostly the grandparents (17%) and relatives (14.1%) and few siblings who took the responsibility of caring the HIV infected children. Majority of the caregivers in the study belonged to the productive age group of 21–40 years were mainly the biological parents. Most of the caregivers in the age range of 41–50 years were other relatives like uncles, aunts, from maternal and paternal side, and only few of them were parents of the infected children. More than 11% of the caregivers were grandparents in the age range of 51 to 70. Very few caregivers were in the age group of 16–20 years, of which three of them were siblings of HIV infected children. Majority of the primary caregivers were females (80.1%), they had the primary responsibility of looking after children at home. Only 19.9% of the caregivers were males, mainly they were fathers, maternal/paternal uncles and grandfathers of the HIV infected child. They accompanied children for regular check-ups and treatment at the ART center. Majority (61.7%) of the caregivers had attended school, 4.9% had studied up to primary school, 18.9% had studied up to middle school and 37.9% of them had studied up to high school. Almost one fourth of the caregivers (24.7%) were illiterates. Only 13.6 % of them had attended college education. With regard to the marital status, majority (96.6%) of the caregivers were married. Out of which 35% were widows and the rest 2.9% were separated from their spouse. Only 4% were uncles and siblings who were not married. Three fourth of the caregivers (73.8%) were living in Nuclear families. Little
more than one fourth of the CLHA (26.2%) were living with relatives and grandparents in joint/extended families.

One third (34.5%) of the caregivers were housewives and 1.5% of the grandparental caregivers were economically dependent on others. Little over one third (37%) of the caregivers, that is 21.4% of them were coolie workers, 15.5% of them were self employed and were not having regular monthly assured income. Around 22.9% of caregivers had assured monthly income to meet the expenses.

Generally caregivers did not wish to disclose their income as this was a Government program where they were beneficiaries and the treatment and services was free of cost to all. The caregivers feared that revealing their true income might hinder the benefits they were getting from the Regional Pediatric ART Centre. This may be the reason for more number of caregivers (84%) in the income range of ₹ 1000 to ₹ 5000. Pensioners and salaried employees (16%) had income above ₹ 5000. Most of the caregivers were following Hinduism (84%), Islam (8.3%) and Christian (7.8%) religion. Majority (89.3%) were living in urban and Semi urban areas and only 10% were living in rural areas.

Profile of the HIV Infected Child

Children were evenly distributed across three age groups classified for the purpose of the study. 32.6% were in the age group of 3–6 years and most of the children got enrolled for ART treatment during this age. 32.5% of the children were in the age group of 7–10 years and 35.4% were in the age range of 11–16 years. This shows that the children once on treatment did have a longer life. 55.3% of the CLHA were male and 44.7% were female children. Majority (89%) of the children were going to school. 18% of the children were attending preschool, 37% primary school and 33.8% middle and high school. Because of the frequent opportunistic infections, few of the children had to repeat the same class after long hospitalization. Around 3.8% of them had discontinued school as they were not interested or had to take care of the family. 15% of the children were yet to be put in school or parents could not afford to put them in preschool/kindergarten. Majority (80.1%) of the children liked going to school and were performing satisfactorily in the school. Only 8.7% of the children were not doing well in their studies. And around 11% of them were not attending any formal school.

Illness Related Information Regarding the HIV Infected Child

Of the total 206 HIV infected children, only 22.3% of them kept falling sick often and kept coming to ART center frequently or more often than their scheduled monthly visits. The remaining 77.7% of the children were in good health and were
able to do other activities like other children of their age. Majority (62.6%) of the children were on Pediatric Anti-Retroviral therapy and 37.4% were on co-trimoxazole treatment. The route of transmission for majority of the children was vertical, from mother to child. In 3 children, it was through blood and blood products and for few children the route of transmission was not established in their case records. Couple of children were also infected through use of infected needles.

The person who was first tested for HIV in the family: 35.4% of the fathers and 32.5% of the mothers were tested first and once diagnosed, the entire family was screened. In the present study 29.6% of the children were tested first in the family. In nearly 30% of the children, it was the CLHA who was tested first for HIV when he was presented with clinical symptoms and was frequently falling sick and could not be cured for his/her illness. Once the child was tested the other family members were screened and tested for HIV. In 2.4% of the children, it was the sibling of the child who got tested first and then the other family members were screened for the illness. This shows that the illness would have had transmitted to many of the family members and by the time the index person was tested, the entire family was infected.

Knowledge of the Child Regarding His/Her HIV Status

Only 14.6% of the children knew that they were infected with HIV. Majority of the infected children (75.7%) were not aware of the HIV infection. Most of the caregivers did not want to reveal the status to the children. They would want to shield the children by saying they were too young, may be later etc. Some of the children (9.7%) knew that they were suffering from a chronic illness like TB, or they just knew the name of the disease. Only 14.6 percent of the children in the study had complete knowledge of the illness i.e., they knew that they were infected with HIV, routes of transmission, implications of the illness and treatment.

Knowledge of the CLHA regarding parents’ HIV status: Most of the children (79.2%) were not aware of the parents’ HIV status. Only 9.2% of the children were partially aware that their parents were suffering from TB, or were chronically ill. Only 15 (7.3%) children had complete knowledge of the HIV infection and its implications and they were also infected due to vertical transmission. For 9 (4.3%) of the caregivers this question did not apply as the children were either adopted or parents were negative or the child was infected either through blood and blood products or infected needles or biological parents.

Positive Aspects of Caregiving

In this study majority of the caregivers were parental caregivers. After the parents demise, it was mostly the grandparents, siblings and relatives who took the responsibility of
caring for the HIV infected children. In few families, HIV infected children were being looked after by grandparents as they would want to reduce the burden on the parents as multiple members in the family were HIV infected and on ART medicines. The non-parental caregivers had got to know the HIV status of the parents during their final stage and had taken up the responsibility of caregiving without prior information. The psychological problems of the caregivers was less, despite having multiple members infected with HIV illness in the family. Majority of the caregivers were providing more attention and would never feel the burden in looking after the HIV infected children in the family. The non-parental caregivers would say how they could find the child who is so small a burden. The caregivers (parental and non-parental) were very regular on follow-up and majority of them had more than 95% adherence to ART. The caregivers were hopeful of permanent cure for the illness and were willing to provide treatment for the child even if was very expensive.

Even though majority of the caregivers were female, they had good support from family members. The male members in the family would always accompany the child during their regular visits to the ART center. The relatives and grandparents of the infected children had disclosed the HIV status of the child only to selected few members. They had learnt to avoid stigma by telling others only partial information about the illness. The caregivers would avoid sending children during annual medical examinations to the school, so that the child does not reveal his illness or his medications. Most of the children were attending formal school despite repeated exacerbations in the child’s infection. The caregivers would also visit the Paediatric ART center during Saturday afternoon, so that the child’s school was not missed. The caregivers have revealed the child’s HIV positive status to only 14% of the children. The caregivers would always try to postpone the decision of CLHA disclosure stating that it might have a negative impact on the child. The child might start internalizing and it would affect the child’s relationship with peers and others.

All the children had emotional difficulties irrespective of the age group. Both parental and non-parental caregivers perceived that their children had very good prosocial behaviour, high hyperactive/inattention behaviour, high emotional symptom behaviour and minimal conduct problems and peer problems in their children. Females had more emotional symptoms when compared to male children. Some of the behavioural difficulties experienced by the caregivers (n-72) includes CLHA fights with other children, bites them, complaints from school, asks money from teacher to sit in school, otherwise threatens to walk out, defiance to mother, grandmother, steals small amounts of money, watches TV for long hours, goes away from home without informing anyone for short periods and has very poor eating habits etc. The caregivers denied that these problems distressed them or the child and said these difficulties would go, once the CLHA grows up. Most of them would turn to spiritual means to overcome their fears and worries of the future. The caregivers by
their strong belief in God found it easier to accept the child's illness and cope effectively with the current situation.

Discussion

HIV/AIDS is an illness that affects whole families and challenges them to call upon their deepest resources. However, for many complex reasons, family members may often feel that the illness must not be discussed/disclosed within the family. The caregivers of HIV infected children despite facing many challenges like undergrowth in children, frequently falling sick and having not to reveal the HIV status of children to others was having less psychological problems and burden.

In India, The National AIDS Control Organization (NACO) has been implementing HIV/AIDS program where in, all adults and children infected with HIV/AIDS have been provided with free ART medicines, treatment, care and support and follow up. The WHO, UNICEF, UNAIDS and other funding organizations are providing for the gaps in services for children, like nutritional support, advocacy for stigma free environment and travel costs, so that the treatment is continuous and they are not irregular with their medication. The children and families are also provided with psychosocial support based on their needs through the multi-disciplinary team. The confidentiality is also maintained in the ART centers, where the caregivers are able to discuss the issues affecting them. If the need or issues cannot be handled at the ART centers, appropriate referral services are made and followed up. So, this would reduce the psychological and economic burden of the caregiver and the family to a large extent.

Despite having many positive aspects of caregiving, there are certain difficulties which needs to be addressed with the caregivers. The study shows that more than 75% of the infected children were not aware of their HIV status and nearly 10% of the children had partial knowledge of the HIV infection in them. The caregivers would always try to postpone the decision to reveal their HIV status because of fear of internalizing and having a negative impact on the growth of the child and stating that the child is psychologically not prepared and would always try to avoid by saying that they would disclose the issue once the child completes his 10th standard exams. Caregivers concerns like what would the future of the child be? As to how they have to deal with his age appropriate attraction towards the opposite sex. How to ward off the proposals for marriage for their HIV infected wards, what if his illness becomes more severe? are issues which always will be worrying for the caregivers. Our study corroborates with the findings of Bhonsle, Gabhale, Kulkarni, Laddha, Pokharna and Mangalani (2010) who assessed the parental knowledge regarding disclosure, their concerns and explanations to the child about disease prior to the disclosure and their perception about the appropriate age of disclosure. The results revealed that among 65 children, 15.4% were aware of their status were in the 12–15 year age
group, whereas 84.6% were not. Seven of these children were also aware of their parental status. 60% of the children who were aware of their status also had the discussion regarding possibility of death and separation. 16.9% children had started questioning about the disease from the age of 8–10 yrs, 18.4% of them between the ages of 11 to 15 years. 64.6% children however never inquired about their illness. According to parents, what the child feared most, were death, 6.15% had fear of being bedridden, and 29.2% were concerned about hospitalizations. 40% children had no specific fears.

Many of the caregivers of HIV-positive children still do not receive the attention and funding they actually need (Huairou Commission at the International AIDS Conference, 2010). Fonseca et al., 2006 stated that integrated health services which include: physical and psychosocial treatment continue to be largely inadequate for caregivers. These issues of caregivers need to be addressed using strengths based perspective. Overall, our findings underscore the importance of studying positive aspects of caregiving and future research should assess caregiving benefit and characteristics of the caregiver-care recipient relationship.

Many of the positive aspects of caregiving can be strengthened by psychological support and practical assistance with problem solving from Social work professionals. There are a number of implications from the research findings that are relevant to India from a strengths based perspective. We need to develop and adopt, in partnership with government and health and human service agencies, a standard framework for developing strength-based services/programs for caregivers. Encourage and support research on strength-based approaches in assessment, intervention, programs and service delivery to promote psychological well-being for caregivers of children living with HIV/AIDS.

The strengths perspective demands a different way of looking at individuals, families and communities. All must be seen in the light of their capacities, talents, competencies, possibilities, visions, values and hopes, however dashed and distorted through circumstance, oppression and trauma. A strength-based case management program can be implemented focusing on key goals such as child safety, keeping families together, proving home based services and identifying family strengths effectively, mobilized and directed by social work professionals. Caregivers who know and understand their children can design strategies that truly motivate their kids to succeed and identify the positive resources and abilities that children and families have.

A variety of group work interventions are suggested like using resiliency information to make positive changes, strengths assessment, personal planning, resource acquisition, confront environmental challenges, improve quality of life, or simply adjust to or meliorate the effects of a devastating, chronic condition. Using community organisation method to create awareness, to organize, analyze the risks, problems and deficits in their communities, planning community-based programs needed to lessen the risk factors
involved, increase the protective factors and guide to a new asset-based approach to community building. The strengths perspective posits that the strengths and resource of people and their environment should be the central focus of the helping process to reformulate social policy development.

Conclusion
The impact of paediatric AIDS on the families and on the society at large is only beginning to be fully appreciated. The life threatening illness adds additional challenges to the caregivers’ family where multiple family members are often infected, ill, dying or dead. HIV/AIDS is found to place severe psychosocial, financial and practical stressors on the family. The caregivers play an important and difficult role, especially when their wards have HIV/AIDS.

Countries with rapidly expanding caregiving needs such as India, and several countries in Africa deserve the attention, since only minimal research studies has been published about caregiver related issues from these regions. Because the demand for caregivers will continue to rise in the next several decades, and because caregivers’ concerns and burden is a typical result of caregiving, there is an ongoing need for strength based interventional research to assess and provide interventions to help alleviate the burden and strengthen positive aspects of caregiving. Caregivers must not only be honoured in the AIDS-affected countries but also be given priority when allocating resources and planning intervention strategies.

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Positive Aspects of Caregiving in Caregivers of Children Living with HIV/AIDS


Does Marriage Strengthen the Life of Women with Epilepsy?

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ABSTRACT
From a strength based social work perspective, entry into quality marital relationships by women with epilepsy was hypothesized to have significant bearing on improving healthy coping with psychosocial effects of the illness, since marriage provides critical opportunities to develop stable emotional bonding and psychosocial support from within an intimate relationship context. In a cross sectional design, a total of 80 married women aged between 18–45 years with the diagnosis of Idiopathic Generalized Epilepsy by a certified Neurologist, were selected using probability sampling procedure. Apart from socio-demographic profile, marital quality, dyadic adjustment, psychosocial effects of epilepsy and coping pattern were measured using standardized measurements. Data were analyzed by using descriptive statistics and Spearman’s Rho for correlations. When matched with normal population, women with epilepsy reported lower quality of marital life but better knowledge about the illness among family members including spouse significantly improved the quality of marital life. Coping patterns and social effects of the illness were significantly correlated. The age at onset and duration of epilepsy have significant bearing on marital adjustment and coping patterns whereas healthy coping pattern significantly improved the quality of marital life and reduced social effects of epilepsy. The study discusses the need for conceptualizing the psychosocial effects of epilepsy, coping and marital adjustment from the perspective of strength based social work practice. Finally, the study concludes by highlighting the implications of the results in guiding clinical interventions for persons with epilepsy from the strength perspective.

Keywords: Women with Epilepsy, Marital Quality, Marital Adjustment, Social Effect, Coping.

Introduction
The dominant discourse on marriage of persons with epilepsy is conceptualized within the classical tenants of problem perspective (Dansky, Andermann and Andermann, 1980; Batzel and Dodrill, 1984; Agarwal, Mehdiratta and Antony, 2006). This discourse views woman with epilepsy, her marriage, quality of marital life and marital
adjustments as human problems (Prakash, Shreedevi, and Preeti, 2004; and Prakash and Shreedevi, 2007). Such studies were found to be keen in producing comparative evidences of marital quality and adjustment of individuals with epilepsy and general population (Prakash, Shreedevi, and Preeti, 2004; and Prakash and Shreedevi, 2007). Little attention is devoted to examine the direct relationship between the quality of relationships and survival of individuals with chronic illness, irrespective of the amount of stress they experienced (Berkman and Syme, 1979; Loucks, Berkman, Gruenewald and Seeman, 2006; and Thoits, 1983a, b). Through a protective, safer and intimate relationship context, marriage extends personal and social network of relationships which improves women's socio-economic status, strengthen social support systems, promotes healthy lifestyles, behavioral choices and psychosocial well-being (Umberson, 1992; August and Sorkin, 2010; Wyke and Ford, 1992; and Ross, Mirowsky and Goldsteen, 1990; and Peterson, 1996). Furthermore, intimate relationships are central contexts for health and well-being and are critical components in healthy family functioning (NICD, 2006; and Greeff, 2000).

There is a compelling evidence base that supports the benefits of being married with chronic illness. These factors includes but not limited to socio-economic status, behavioural factors such as addiction behaviours like alcohol and smoking, psychological distress and psychopathology (Robles and Kiecolt-Glaser, 2003; Lee, et al., 2005; and Molloy et al., 2009).

However, there is little evidence on how do marriage benefit women with epilepsy. Does marriage enable women with epilepsy to better cope with psychosocial effects of epilepsy? In order to answer these research questions, the current study as made an effort to conceptualize quality of marital life of women with epilepsy and their coping with psychosocial effects of illness from the strength based social work perspective. Thus, we hypothesized that women's entry into marriage have significant bearing on improving healthy coping with psychosocial effects of the illness. This is because marriage provides critical opportunities to develop stable emotional bonding and psychosocial support from within an intimate relationship context (Berkman and Syme, 1979; Loucks, Berkman, Gruenewald and Seeman, 2006; Thoits, 1983a; Thoits, 1983b; Holden and Smock, 1991; and Waite, 1995). Further, evidence suggest that the specific aspects of marital life were found to contribute to marital satisfaction such as companionship, love, emotional well-being, understanding, problem solving and supportiveness to quality of marital life (Shah, 1995). This is likely to be the protective factor for married women from adverse psychosocial effects of epilepsy.

Rationale of the study: Epilepsy produces disabling psychosocial effects on affected individuals and in families (Chaplin et al., 1999). Women are especially vulnerable to the social effects of epilepsy including stigmatization. Although, epilepsy is a neurological condition, it has a significant bearing on psychosocial, emotional and social life of
married women with epilepsy, they being 18 to 45 years of age. They face unique health issues including reproductive problems, excessive weight gain, sexual dysfunction and lower fertility rates (Agarwal, 2006). In addition, increased frequency of seizure during pregnancy, psychomotor retardation in the offspring and foetal deaths (Narasimhan et al., 2007), probable hereditary transfer of epilepsy from mother to children (Crawford, 1999) and the concerns over anti-epileptic drug use during pregnancy (Vazquez et al., 2007). Given this, it is critical to understand how marriage protects and strengthens the women with epilepsy to effectively cope with the psychosocial effects of the illness through quality marital life.

**Method**

In a single group cross sectional design, a total of 80 married women aged between 18–45 years with a diagnosis of Idiopathic Generalized Epilepsy by a certified Neurologist, were selected using probability sampling procedure. The population consisted of married women with epilepsy who are accessing services from the outpatient department of the National Institute of Mental Health and Neuro Sciences, Bangalore, India, hereafter “NIMHANS”. For the sample selection firstly, the researchers developed a sample frame based on medical reports available in the medical record section. Secondly, eighty study participants were randomly selected by using lottery technique from the sampling frame. Finally, all selected study participants were contacted at the out-patient department during follow up days while the data collection lasted for over a period of six months.

**Measurements**

A structured interview schedule was developed containing socio-demographic profile, illness and treatment profile and psychosocial issues among women with epilepsy.

Marital Quality Scale (Shah, 1995) a multidimensional scale with 50 items with male and female formats, designed to assess various aspects of marital life relevant to the Indian social and clinical contexts that includes 12 factors (understanding, rejection, satisfaction, affection, despair, decision making, discontent, dissolution potential, dominance, self disclosure, trust and role functioning) was administered. The factors such as understanding, satisfaction, decision making, trust and role functioning have only positively worded items. The responses range from “1 = Never to 4 = Usually”. The measurement has an internal consistency of 0.91 and a test-retest reliability of 0.83 over a six week interval.

Dyadic Adjustment Scale (Spanier, 1976) is a 32 item measure that gives an overall measure of dyadic adjustment. Its sub-scales may be used alone without losing confidence in the reliability and validity of the measure. The reliability, validity and utility have been reported elsewhere. Higher score denotes a better marital adjustment.
Epilepsy Psycho-Social Effects Scale (Chaplin et al., 1999) was originally developed for the investigation of psychosocial issues within the National General Practice Study of Epilepsy in the UK. It contains 42 statements derived from in-depth interviews with patients attending an epilepsy clinic in London. The statements are grouped into 14 domains. The person with epilepsy responds to each statement by indicating the level of agreement on a 5-point scale to each statement. The test-retest reliability was found to be satisfactorily high (0.64) for this instrument.

Coping Checklist (Rao, Subbakrishna and Prabhu, 1989) has 70 items describing a broad range of behavioural, emotional and cognitive responses that may be used to handle stress. Items are scored dichotomously as Yes/No, indicative of the presence or absence of a particular coping behaviour. It consists of seven subscales which covers problem focused coping, emotion-focused coping and social support seeking. The reliability and validity of the tool have been well established.

Data Analysis: Data were analyzed using descriptive statistics such as frequency, percentage, mean and standard deviation while Spearman rho was used for correlation between variables of interest.

Ethical Issues: The study protocol received the ethical clearance from the Ethics Committee of “NIMHANS”. The informed consent was obtained from each study participant while confidentiality was assured and maintained. Those participants who were in need of psychosocial support were appropriately referred to the Psychiatric Social Work team of the Neurology Department.

Results

The socio-demographic and illness profile of the study participants’ age ranged from 18 years to 45 years with a mean age of 29.17 years and a SD of 6.36 years. Spouses’ age ranged from 24 years to 55 years with a mean age of 35.63 years and a SD of 7.03 years. The women’s number of children ranged from no children to three with a mean of 1.66 and SD of 0.898. Number of children died were ranged from no death of children to two children whereas mean no. of child death was 0.21 with SD of 0.54. Frequency of abortion ranged from no abortion to five abortions with a mean of 0.58 and SD of 0.99 abortions.

About 76 out of 80 study participants were married and currently living with their husbands while remaining four participants were separated from their spouses. Duration of marriage ranged from 1–25 years in which most of the women (n = 21) were in 16 to 20 years of marriage, followed by 19 women with epilepsy were in the duration of 6 to 10 years of marriage. 44 out of 80 participants were educated up to secondary or higher secondary level, 14 out of 80 participants were educated up to primary schools whereas 16 participants had not gone to school. Most women (n = 56)
were homemakers implying that they do not earn income. Among those who are working, 15 were daily wagers, 5 were professionals, and another 5 were clerical workers. About 55% of the study participants were from middle socio-economic status while 45% were from lower socio-economic status.

Table 1: Sub-Domainwise Scores on Quality of Marital Life Women with Epilepsy and the Normal Population.

<table>
<thead>
<tr>
<th>Sub-domains</th>
<th>Women with Epilepsy</th>
<th>General Population*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Understanding</td>
<td>12.01</td>
<td>5.48</td>
</tr>
<tr>
<td>Rejection</td>
<td>22.65</td>
<td>6.16</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>9.75</td>
<td>3.00</td>
</tr>
<tr>
<td>Affection</td>
<td>11.62</td>
<td>5.28</td>
</tr>
<tr>
<td>Despair</td>
<td>5.80</td>
<td>1.66</td>
</tr>
<tr>
<td>Decision</td>
<td>10.96</td>
<td>3.75</td>
</tr>
<tr>
<td>Discontent</td>
<td>5.03</td>
<td>1.79</td>
</tr>
<tr>
<td>Dissolution</td>
<td>1.50</td>
<td>0.99</td>
</tr>
<tr>
<td>Dominance</td>
<td>6.75</td>
<td>1.66</td>
</tr>
<tr>
<td>Disclosure</td>
<td>5.48</td>
<td>2.24</td>
</tr>
<tr>
<td>Trust</td>
<td>1.61</td>
<td>0.86</td>
</tr>
<tr>
<td>Role functioning</td>
<td>6.23</td>
<td>3.01</td>
</tr>
<tr>
<td>Global marital quality</td>
<td>103.68</td>
<td>29.90</td>
</tr>
</tbody>
</table>

* These data were taken from the original work of the Shah, (1991) for comparison

Table 1 shows the mean and standard deviation on 12 sub-domains of the quality of marital life from the current study participants and scores reported by Shah (1991) on general population. The scores show that mean of all sub-domains are higher for women with epilepsy compared to general population which implies the poor quality of marital life of women with epilepsy.

Socio-demographic correlates of marital quality: Spearman’s rank correlation (rho) was used to examine the rank correlation between selected socio-demographic variables and the sub-domains of quality of marital life scale. The analysis revealed that there is a significant positive correlation between decision making and death of the children (rho = .34; p <0.01). Marital cohesion was inversely correlated with the death of children (rho = -.25; p <0.05). The result implies that death of children affected the marital cohesion. A probable explanation may be that loss of children due to death induced and maintained grief and stress which reduced the marital cohesion between couples. Discontent in marital life and number of children were inversely correlated (rho = -.25; p < 0.03) which implies that as the number of children increases, the discontent in
Does Marriage Strengthen the Life of Women with Epilepsy?

When women with epilepsy conceive and deliver (perceived) adequate number of children, it acts as a protective factor for marital happiness.

Women’s age and dissolution were significantly correlated (\( \rho = .22; p < 0.05 \)). It implies that as married women’s age increases, dissolution also increases. In line with that, husbands’ age had significant positive influence on dissolution of quality of marital life (\( \rho = .22; p < 0.05 \)). Dissolution of quality of marital life was significantly correlated with duration of marriage (\( \rho = .27; p < 0.05 \)) with an implication that as the duration of marriage increase, dissolution of the quality of marital life also increases. Finally, duration of the illness also had significantly increased the dissolution of the quality of marital life (\( \rho = .24; p < 0.05 \)). These correlations indicate that women’s age, their husbands’ age, duration of marriage and illness have a significant influence on reducing the quality of marital life.

Dominance refers to the influence of husbands on deciding the place of living, and activities of daily life such as shopping and so on outside home. Dominance and husbands’ age were significantly correlated (\( \rho = .22; p < 0.05 \)). As duration of marriage increases, dominance also increases (\( \rho = .28; p < 0.01 \)); and duration of illness was significantly correlated to dominance (\( \rho = .33; p < 0.01 \)). These correlations indicate that increase in husbands’ age, increased duration of marriage and illness significantly increase the dominance of women in marital life.

Socio-demographic correlates of coping patterns: Denial as a coping strategy and death of children were significantly correlated (\( \rho = .30; p < 0.01 \)). The result indicates that death of the children is associated with increased use of denial as coping. Similarly, use of substance as coping increased with the death of children (\( \rho = .29; p < 0.01 \)). Behavioral coping was positively correlated with abortions (\( \rho = .26; p < 0.02 \)). Further, venting as a coping strategy was positively correlated with abortions (\( \rho = .29; p < 0.01 \)). Humor as a coping strategy was positively correlated with study participants’ age (\( \rho = .24; p < 0.04 \)).

Quality of marital life and coping pattern: Correlation analysis indicates that when family members had better knowledge about the illness, study participants’ quality of marital life improved significantly (\( \rho = .33; p < 0.01 \)). The sub-domains of quality of marital life such as understanding and coping pattern were significantly correlated (\( \rho = .25; p < 0.05 \)). This positive correlation indicates that when study participant experience better understanding in marital relationships, they had better coping associated to the effects of illness. Similarly, the sub-domain of disclosure and coping pattern were correlated with a direction that better the disclosure in marital life, better would be the coping pattern (\( \rho = .41; p < 0.01 \)).

The correlation among the sub-domains of quality of marital life and psychosocial effect scales found significant positive correlation (\( \rho = .40; p < 0.01 \)). When
rejection in marital life increases, higher would be social effects of epilepsy (\(\rho = .49;\) \(p < 0.01\)). The satisfaction in marital life and social effects of epilepsy were significantly correlated (\(\rho = .46; p < 0.01\)); and so the affection in marital life and social effects of epilepsy (\(\rho = .43; p < 0.01\)). Further significant positive correlations were found in the decision making and social effects (\(\rho = .26; p < 0.05\)), dissolution and social effects (\(\rho = .32; p < 0.01\)), disclosure and social effects (\(\rho = .50; p < 0.01\)), trust and social effects (\(\rho = .47; p < 0.01\)), role functioning and social effects (\(\rho = .27; p < 0.05\)), acceptance and social effects (\(\rho = .25; p < 0.05\)), and concern and social effects (\(\rho = .39; p < 0.01\)).

Discussion

The present study revealed the significant role of socio-demographic variables such as age of the married women with epilepsy, age of their husbands, and duration of marriage, duration of illness as the critical variables that influence the quality of marital life, healthy coping pattern, and psychosocial effects of epilepsy. Though, compared to the normal population, the married women with epilepsy reported lower scores on the measurement on quality of marital life, the family members’ knowledge about the illness improved the quality of marital life. When married women with epilepsy experienced better understanding in marital relationships, they had better coping associated with the effects of illness. Disclosure is a sub-domain of quality of marital life which refers to the level of comfort and freeness to share one’s mistakes and discuss long term plan for family in trust with spouse (Shah, 1991). Women who enjoyed better comfort and freeness to disclosure in marital life were more likely to improve healthy coping. When rejection increased in marital life, higher was the social effects of epilepsy.

Social work identifies itself as a profession that focuses on client’s strength (Waller and Yellow Bird, 2002, p. 49; and Gray, 2011). It does not subscribe the notion that individual’s moral decay and failure as the core issue of human sufferings like other helping professions. Even though, it largely retained some of these elements of the basic moralistic version, especially the idea of human failure and human problems that continued to dominate in conventional therapeutic and helping process and provisions (Cohen, 1990; and Gray, 2011). Though, they are not directly visible still they are represented through complex professional jargons, diagnosis and complex theory driven taxonomies of pathological states (Gray, 2011; and Gray and Rooyen, 2002). Further, the notion of weakness, restrictions, limitations, problems, failures and disabilities are those critical concepts which guide the majority in all helping professions, therefore problem focused discourse remained central to the client-professional interactions (Cohen, 1990; Early, and Glenmayer, 2000; and Chapin, 2006). As a result, problems and pathology became pivotal to the rebuilding of strength based social work perspective (Cohen, 1990; Gray, 2011; and Gray, and Rooyen, 2002). Strength based
social workers refused to consider and label their clients as person with manic depressive symptoms, borderline personality disorder, drug addict, unmarried mother, and juvenile offenders or epilepsy patients and so on. Instead, they rebuilt the basic tenets of problem focused reasoning into viewing client as human being and using their strengths and internal and external resources to cope with adverse situations in life (Cohen, 1990; Early and GlenMaye, 2000; Pinto, 2006; and Nissen, 2000).

From this very idea of strength induced by inner and outer resources available to individuals and families within the intimate relationship contexts (Cohen, 1990), let us examine how better performance in socio-economic aspects of women with epilepsy improves and maintains quality of marital life, better marital adjustment, healthy coping with psychosocial effects of epilepsy.

The statistically significant inverse relationship between marital cohesion and death of children implied that when children’s death occurred, the marital cohesion between couples decreased. This was inferred that death induced and maintained grief and stress which in turn reduced marital cohesion between couples. Secondly, discontent in marital life was inversely correlated with number of children. It implies that women with more number of children enjoyed less marital discontent which further improved the quality of marital life. The probable inference may be that the married women with epilepsy face difficulties in the married relationships when they faced problems in conceiving and delivering healthy children due to the (side) effects of epilepsy, including anti-epileptic medicines. When women conceive and deliver (perceived) adequate number of children, it acts as a protective factor for marital happiness. Thus, the quality of married life of women with epilepsy could be strengthened by minimizing the side effects of medication and with proper guidance into conception and delivery. These results are in line with evidence base which suggest that married individuals experience better mental health and well-being than non-married individuals (Gove, Hughes, and Style, 1983; Pearlin and Johnson, 1977; Molloy et al., 2009; and Lee, et al., 2005).

The dissolution in marital life of women with epilepsy increased with increase in the age of couples, duration of marriage and illness. These may be the critical demographic contexts which warrant strength based interventions among women with epilepsy that enable them to use their inner and outer resources to sustain quality of marital life. The inner resources available to women with epilepsy that improve marital quality are understanding, affection, trust and effective marital role functioning. These are critical areas where strength based interventions may be focused to maximize these protective factors while minimizing the risk factors such as dissolution, despair, dominance and so on. On the other hand, strength based practices may also consider strengthening outer resources such as social support in terms of spousal, familial and peer supports along with consistent and timely professional assistance. Further, such efforts are
likely to improve resilience as well as healthy coping. Clinical intervention, therefore, need to consider taping both inner and outer resources available to individuals and families to reduce risk factors and maximize the protective factors in the life of women with epilepsy.

The dominance was significantly and positively associated with duration of marital life and duration of illness. The overall correlational results indicate that participants’ age, duration of illness and marriage significantly influence marital quality. Thus, these factors need to be viewed in terms of adversity inducing factors in which further research studies are required to examine how some couples are resilient to these socio-demographic risk factors. Such an approach may help to develop clinical interventions to strengthen the resources available to individuals (women with epilepsy and their spouses) and their families to successfully and sustainably manage their marital quality, improve marital adjustments as well as to cope with the psychosocial effects of epilepsy.

The socio-demographic correlates of coping patterns revealed that denial was the most frequently used coping pattern with death of children which implied that death of the children was associated with increased use of denial as coping. Substance use was also associated with the death of children but the behavioral coping was positively correlated with abortions. Further, venting as a coping strategy was positively correlated with abortions.

Family members’ knowledge about the illness had a significant positive on the marital life significantly. Further, better understanding in marital relationships was associated to better coping with the effects of illness. Besides, it was found that the better disclosure (sharing) in marital life was correlated with better coping.

The sub-domains of marital quality such as understanding and rejections were significantly correlated with psychosocial effects of the illness. Psychosocial effects of epilepsy was associated with affection, decision making, trust, role functioning, acceptance and functioning. But positive intimate relationships in terms of supportive communications, social relationships and exchanges and constructive problem solving skills co-vary with decrease in psychological and social well-being (Biglan et al., 1985; Papp, Goeke-Morey, Cummings, 2007; and Shreedevi, 2009).

**Conclusion**

In summary, this study revealed the significant role of socio-demographic variables such as age of the married women with epilepsy, duration of marriage and duration of illness as the critical variables that influence the quality of marital life, healthy coping pattern and psychosocial effects of epilepsy. Marital quality was significantly influenced by the coping pattern and social effects of epilepsy while better marital quality was associated with healthy coping of women with epilepsy (Pinto, 2006; and
Nissen, 2000). Thus, we conclude that entry of women with epilepsy into marriage significantly influence well-being (as well as distress). The implications of the results are expected to guide clinical social work interventions for persons with epilepsy, especially women from the strength perspective aiming at maximizing both inner and outer strengths and resources available to the couples as well as minimizing the negative factors with adverse consequences in marital life.

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Developing Emotional Resilience in Adolescents: School Social Work Practice in India

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ABSTRACT
Adolescence is a period of vibrant energy, crucial because of its many developmental possibilities. Emotional resilience appears to be the key to this period as it unfolds development opportunities hitherto unknown to the world of the adolescent. In this paper I would be delving at the introduction of life skill development interventions, which provide necessary triggers to increase the emotional competence and lead the adolescents towards attainment of happiness, satisfaction and scholastic success. In our work in Kerala, India, it was noticed that the overall positive mental health of the adolescents improved and traits such as their confidence, attitude, perseverance, risk taking and risk handling, achievement orientation, etc. due to introduction of life skills programme. Life skills instill the positive behaviours which enable the adolescent to cope with their daily life situations. The paper puts forward that in the context of adolescents knowing oneself, feeling good about self and others are some of the important steps to emotional resilience and finds that the school settings can best be utilised to make adolescents achieve and consolidate their strengths. This paper examines different possibilities to enhance the emotional resilience of adolescents through social work interventions in schools. Life skill development is used in this paper more in the context of making the adolescent assertive on their own strengths.

Keywords: Emotional Resilience, Life Skill Development, Positive Mental Health and School Social Work.

Introduction
Adolescence is a much discussed life period because of its importance and there are so many definitions of this age, based on different elements of it. But most of the time the definitions are kaleidoscopic between adulthood and childhood in practical life. However, everyone agrees to the fact that it is a time of energy and creativity. The use
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of energy and experience of life of the adolescent are different from place to place and these differ as per the economical, social, political and religious diversities. They are denied of the adult rights and recognition from family and society (Gullotta and Adams 2005). The expression of emotions by the adolescent is also interpreted either as childish or impertinent. The inverse relation between self concern and empathy causes emotional disturbances to the adolescents (Ruchismita, 2012). When dealing with adults the adolescent is demanded to behave like an adult but not too much like an adult. This creates a lot of insecurity in dealing with others. Adolescence, being a trying period emotionally, maintains emotional sensitivity and self centeredness. Adolescent tries to get out of some of the emotional ties with their parents to gain independence (A. P. Froese MD, 1975). This naturally demands certain skills from them to manage their emotions and day-to-day affairs. Feelings of loneliness, worthlessness, boredom and meaningless encroach to their personal selves unless they learn to deal effectively with their own self and others. It is at this juncture that the emotional resilience of the individuals counts much to the full flourished adolescent period. Theory indicates that resilient individuals “bounce back” from stressful experiences quickly and effectively (Michele M. Tugade and Barbara L. Fredrickson, 2004, p. 1). Frederikson (2001) pointed out that emotional resilience or positive helps the individuals to achieve better regulation of their emotions and behaviors. Michele M. Tugade and Barbara L. Fredrickson (2004) very interestingly explain the resilience with a suitable example. They compare non-resilience to a cast iron, which is brittle, hard and breaks very soon, whereas resilience is equal to wrought iron, which is flexible and bends to avoid breaking. Emotional resilience of the individuals are so important in their achievements and life skills play a vital role in it. Life skills enhance emotional intelligence and physical health of the individuals (Roza Olyai and Dilip Kumar Dutta 2011. p. 217). School settings are the best fields for imparting life skill education in India and social workers can best utilize the setting to help adolescents to create better emotions, which will unfold the ways to well-being.

**Emotional Resilience in Adolescents**

Emotional resilience is the strength of a person to adapt to the stressful and unfamiliar situations in day-to-day life. It must be viewed in connection with self, person, environment, relationship, etc. It is defined as the ability of a person to adapt to the stressful situations in life by Elizabeth Scott. M.S. (2012). Emotional resilience is the inner condition of an individual to be in peace with himself and with his surroundings. This ability can be bettered with training, learning and modulated behavioral intervention plans. Positive emotion is the one of the element of emotional resilience and in most of the circumstances it evidences the emotional resilience in individuals. This element is substantiated by Michele M. Tugade and Barbara L. Fredrickson (2004), with the support of many studies that resilience keeps individuals optimistic,
zestful, open to new experiences, creative, risk taking and exhibits positive emotionality. Knowing the emotions of one’s own self is the primary step to emotional resilience. Some of the major traits of emotional resilience are openness, optimism, awareness to emotions, perseverance, support, spirituality and adaptability (Elizabeth Scott, M.S. 2012). Positive emotions are necessary tools for establishing enhanced well-being (Michele M. Tugade and Barbara L. Fredrickson 2004). Positive emotions broaden the view points and reaction style of the individual and negative emotions prepare individuals to act in specific ways like attacking, showing anger, etc. (Barbara L. Fredrickson, 2004) The emotional resilience of adolescents is a matter of much significance as they are emotionally sensitive. They react to so many things and reactions are different from place to place and person to person. Emotional sensitivity is mostly depicted as the poor show of resilience. The adolescent is emotionally sensitive and prone to depression; however, he may avoid showing his true feelings (A.P. Froese, MD, 1975 p. 71). Elizabeth Scott presents emotional resilience as an ability that can be developed. Preparing individuals to build upon the emotional resilience traits, ranging from emotional awareness to happiness is the first step to enhance emotional resilience of adolescents.

Life Skills Development

Life skills development in adolescents can teach them how to act and respond to various situations rather than merely reacting to everything. Central Board of Secondary Education (CBSE), referring to World Health Organisation, emphasizes ten very important life skills to equip adolescents with. They are; 1. Self-awareness, 2. Empathy, 3. Critical thinking, 4. Creative thinking, 5. Decision making 6. Problem Solving, 7. Effective communication 8. Interpersonal relationship, 9. Coping with stress and 10. Coping with emotions. Life skills are presented by WHO as the contributing factor to positive health based on the strengths of the individuals. Life skills aim at the psychosocial strength of the individuals. Life skills enable individuals to translate knowledge, attitudes and values into actual abilities (WHO 1997, p. 8).

Source: WHO.

Effective application of life skills can influence the way one feels and understand about oneself and others. It also influences the way one is perceived by others.
Life Skill Development and Emotional Resilience

Life skills training imparted through school settings concentrate on preparing the adolescents to manage their own developmental needs by strengthening their own self. Life skills, if analyzed thoroughly, one can understand they meet our three levels of requirements, that of thought, emotions and behaviors. Quoting Health Education Authority, Kedar Nath, et al. explains mental health as emotional and spiritual resilience which allows us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own and others’ worth (P. 17). In this context the children who are mentally strong will have the abilities to develop psychologically, emotionally, creatively, intellectually and spiritually, mutually sustain interpersonal relationship, self awareness, empathy, creativity, sense of right and wrong (which is the basic prerequisite for effective decision making), take up challenges and risks in life. These factors resemble the list of life skills necessitated for a successful adolescent life and imparted through schools (2004). When we aim at strengthening the capacities and skills to handle the mental health issues of the people, it is imperative to build their resilience (Kylie G. Oliver, et al., 2006). Emotions are compared to a bucket full of water and when an additional drop of water falls in, it overflows. When adolescents are filled with so many emotions even a small emotion can make them bursting out. If they are aware of their own emotions, they would be able to reduce the intensity and number of emotions in the store (Sheri Van Dijk, MSW. 2011). Thus adolescents get better adjustment with emotions and thereby they can respond creatively to the situations. Our emotions, thoughts and behaviour are connected. In every situation people experience emotions and thoughts and behave in a certain way as to follow the thoughts and emotion. It is logical to conclude that if any one of the elements goes away from normal the other two will follow it. A strong mind will have objective sense of self acceptance, liking of one’s own self and respect for oneself. When an adolescent lacks a healthy emotional state he becomes hostile, poor in interpersonal relation and even indifferent to himself (Gerald R. Adams 2005). The core element of life skills education is to make the individual aware of himself and find out positive way out to meet the development needs. The reactions of the individuals are largely depended on the emotional state of the particular person. Overreactions are intense responses that are fueled by past experiences and raw emotions that have not been thoughtfully sorted out (Judith P. Siegel, PH.D, LCSW, 2010, p. 7).

Life Skill Development Programmes—To Identify Strengths

Ruth Conville and Tina Rae. (2012) explain well-being based on Seligman’s five measurable elements such as: positive emotions, engagement, relationships, meaning and achievements. Also an individual is expected to have some characteristics like self esteem, optimism, resilience, vitality, self-determination and interpersonal relationships.
Life skill education programmes always promote the factors listed above as the individual characteristics. Life skills help the individuals to identify their own strengths and develop those strengths to meet the day-to-day challenges. Emotional resilience is necessary to sit on top of every obstacle to control the life and even the behavior of individuals. Adversities in life, especially in the life of adolescents are not fully avoidable, so emotional resilience helps to better adapt with the changes. It is very well evident that whenever adolescents are strengthened to face the adversities effectively they gain positive energy and emotional happiness to take up the further challenges in life. Life skill programmes therefore concentrate on opportunities to take decisions and imbibe those qualities within the known self, which can recall whenever necessary. Life skills development programmes disseminate the major domains of resilience. The major domains of resilience according to Brigid Daniel and Sally Wassel (2004), are social competences, education, secure base, friendship, talents and interests and positive values. Life skills development programmes explores the individual strength in these domains to make individual strong enough to make use of the opportunities in the domains. Positive emotions are the building blocks of resilience and they are the driving factor of happiness in people (Anthony D. Ong, et al. 2010). Life skill development programmes and counseling are basically enabling the individuals to find out the hidden capacities or strengths in them to do away with negative risk factors and thereby enjoy a positive emotional state. Resilience derives from normal and ordinary human resources in the mind, brain and physique (Anthony D. Ong, et al. 2010, p. 83). It is imperative to identify those resources within the person. Life skill development activities help individuals to identify those normal resources and use them in the real practical life.

Emotional Resilience, Risk Taking and Risk Handling

‘The level of anxiety we feel is basically determined by our perception of threat and our perceived ability to manage that threat’ (Mark A. Reinecke. 2010, pp. 29–30). People who are not ready to take the risk could be lacking a positive perception to manage the threats. Assertiveness—it is essentially risk taking, being up front, and stating the facts. ‘this philosophy reflects that the underlying assumption that unassertive people lead a self-denying life that causes them to suffer in interpersonal relationships and sometimes leads to emotional and physical consequences (Fodor, 1992, p. 6). Assertiveness, one of the basic factors of positive interpersonal relationships is also explained as open and honest communication, whereas the unassertiveness is considered as passive and inhibited behavior. Referring to Eisler and Miller, Fodor explains that the ‘socially skilled are found to be more assertive and this element is crucial in life skills for an individual. Assertiveness skill can be trained and developed to a great extent. Referring to Eisler and Miller, Fodor explains that the ‘socially skilled are found to be more assertive’ (p. 6). It is also observed that some cognitive treatments are necessary for those who are unassertive in life. Assertiveness training programmes, which enable
the adolescents to handle risks effectively, are given mostly in schools and mental health facilities by clinicians. According to Fodor; “Assertiveness involves the willingness to make what is called “I” statements. That it, to be direct and honest about one’s emotional states, by owning what one is feeling” (p. 11). Emotional resilience helps the individuals to take the responsibility of his own emotions and behaviors. People who lack emotional resilience never take responsibility of their own emotions and behavior. Resilience is not a static state, rather it is a process and risks and challenges that make this process more and more result oriented. Risk taking and handling the risks successfully provides emotional resilience to the individuals (John Coleman, 2007).

Knowing Oneself and Feeling Good about Self and others

Knowing own strength is the biggest strength of a person. The mind has the strength to look back on the things which have given us happiness, joy and satisfaction. The past proud emotional experiences would further our happiness and recalling those moments would provide energy for the future accomplishments. When one person is unaware of himself especially his emotions, he loses his control over his behavior. Self awareness is crucial in dealing with emotions and gaining emotional resilience (Steven J. Stein. 2009). If a person has the capacity to understand or sense what he or she feels at present, then he has the strength to change. The insightful mind, which can be termed as inner wisdom, is an essential element in transforming negative mind to positive one (Sameet M. Kumar, Ph.D. 2009). When our minds are turned off with many reasons we would not be able to cherish the beauty of the past or the future. When an individual is not able to feel comfortable and good about his own self, he will not be able to cherish happiness from things happening around him. In Sameet M. Kumar’s own words; when we spend very little time internally criticizing our behavior toward others, that we don’t use our mind to beat yourself up. Training the mind to engage its ability to reflect with loving kindness and seek stability around joy rather than anxiety is a much more productive and beneficial way to interact with reality and a much more enjoyable way to live (2009, p. 15). Brooding over negative events, experiences and feelings yields negative results. The past happy and joyful events are the real strengths of a person to keep his mind very positive (Sameet M. Kumar 2009, p. 15). The past experience gives us the opportunity to know our strengths. Self reflection and understanding is an effective tool to make an analysis whether we would dare to live with our self and the feelings of others. Adolescents need specific training and discipline to consciously understand own feelings and the feelings of others to feel about good and others. Life skill training provides opportunity to mirror own self with the support of training tools and kits. Emotion coaching helps for strong emotional development. The emotion coaching includes understanding the emotions of the person or emotional awareness, connecting, listening, naming the emotions and finding good solutions (John Gottman, 2004).
Establishing good social relationship based on the social interactions will improve the ‘emotional muscle’ (the terminology as used by Steven J. Stein, PhD) of the individual. An adolescent, who is better able to establish good social relationship, will certainly develop a healthy emotion as it contributes to positive emotions. By maintaining good relationship and social intelligence an individual would be able to establish better interaction, encourage a person to feel good about the person, seeking help from others without alienation, giving or sharing creative ideas, calming a person down, extending helping hands and being assertive in all the matters. Empathy is one of the vital elements which can help the teenagers to develop good relationship with others, based on mutual help and interaction. Empathy gets people attached to others and enables open sharing of happiness and difficulties. Interpersonal relationship, empathy and effective communication would provide ample opportunities to the individuals to know themselves better from the objective feedbacks. Objective understanding of self is always like looking at a mirror to makeup our self. It paves real foundation for the maintenance, addition or deletion of some of the elements from our self to match with our own preferences and the expectations of others. Being creative will pay more dividends and this makes a person a good decision maker. Creative people think and act creatively and this makes things smooth and helps to handle the risks effectively. ‘How’ is always a sound question regarding risk handling and individuals with creative thinking, practice various risk taking methods and it adds value to his/her suggestions to the group or others around him.

School Social Work Setting

School setting is the most effective place to impart life skill education to adolescents due to certain factors like, a socializing agent, availability of adolescents and their accessibility to services, economic advantages as all the infrastructure is available, high level of approvals from parents, community and public and possibility of short term and long term evaluation of progress (WHO. 1997). School also has much freedom to organize formal and informal programmes for adolescent. Life skills in school settings are very effective as they develop one’s self-esteem, confidence and make things very positive and thereby bring well-being (Roza Olyai and Dilip Kumar Dutta. 2011). In many areas school Social Work professionals take up life skill education as a process to alienate some problems and to strengthen the adolescents. Programmes against drug and alcohol addiction, lack of confidence, anxiety, depression and interpersonal issues are some of them.

Conclusion

With the great significance of strength based approach and positive psychology, adolescence is considered a period opportunities, flexibility and rapid development.
Life skills education to adolescents through schools focuses on the maximum utilization of the possibilities they have in front of them in the forms of physical emotional and social behaviors. Emotional resilience of the adolescents enables them to find out their own space and identity or opportunity even in the midst of adverse situations. Life skill programmes are designed to provide a sustainable emotional strength to the individual through proper coaching and training of emotions in the schools. It also helps the individuals to be assertive on their own behavior and feelings, by understanding and accepting own feelings and behaviors.

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Early Intervention for Building Productive Roles in the Post Institutional Life of Adolescent Girls: A Case Study from Kerala, India

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ABSTRACT

This article discusses case studies of 15 institutionalized adolescent girls in Kerala, India. The studies focus on the effectiveness of the psychological well-being intervention program in their post institutional life. The intervention program was designed and implemented in 2008 to strengthen institutionalized adolescent girls' personality, help them to deal effectively with the demands and challenges of everyday life and assist them to develop the qualities in achieving a better womanhood. In 2011 a case study was conducted among 15 adolescent girls who had participated in the intervention program in 2008 that brought out evidences on sustainability of the effectiveness of the psychosocial well-being intervention program after four years of implementation amid these adolescent girls (now they are entering in early adulthood i.e. 18–23 years). The study showed that a well implemented psychosocial well-being program can bring forth positive results irrespective of environmental limitations under which it is implemented. The analysis shows that, these adolescent girls developed more active and balanced personalities, were goal oriented, more health and hygienic conscious, improved their academic performances, continued their studies, joined for vocational courses, started working at hospitals as supportive staff, and learned spoken English and computer applications. The authors argue that the quality of post institutional life can be improved by early intervention services.

Introduction

The International Federation of Social Workers (2000) defines social work as a profession that promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Social work research is mostly applied in human nature and aims at informing action, improving decision making and using knowledge for intervention. It needs to adopt different
modes of investigation often employing qualitative methods. In qualitative research, subjective nature of reality is recognized and the point of view of the researcher becomes part of the research findings. This paper utilised a case study method, one of the methods in qualitative research, as it favours intensive analysis of one or a few cases using in-depth unstructured interviews, observation, and narrative rather than depending on numerical reporting (Mark, 1996, Vijayalakshmi, 2006). Case study designs can build very detailed in-depth understanding by integrating different perspectives. They are used where no single perspective can provide a full account or explanation of the research issue and where understanding needs to be holistic, comprehensive and contextualized (Lewis, 2004). We have evaluated the effectiveness of the intervention program and its impact on the psychosocial well-being of adolescent girls in the children’s home of Thrissur District, Kerala, India after post intervention period (2008–2011).

Adolescence

Adolescence is the developmental stage that occurs from puberty to maturity lasting from ages of 12 to 18 years (Hurlock, 2002) during which the foundations of adequate growth and development occur. This maturation marks the transition of a girl to a woman capable of having children. Parents task themselves with roles to promote awareness about the growing needs of the body and mind and to an extent attempt to prevent adolescents from entering into promiscuity or other misadventures (Karalam, 2011).

Parental care giver availability serves as an indicator of guidance and structure to the adolescent child. Often lack of explicit parental control is associated with negative adolescent outcomes (Mullick, 1995) and the family provide a protective and stimulating medium for the child's physical, mental and spiritual growth and hence it is considered to be the ideal place for every child. But not all children are blessed with such continued care and protection from infancy to adulthood. Various emotional, social and economic causes such as the absence of one or both parents due to death, separation or present with marital discord can create situations where children cannot live with their parents. Under these circumstances alternative forms of state and non-government agencies care such as children’s homes and treatment for the child becomes inevitable (Siddiqui, 1997).

The Context of Care in India

According to Indian Juvenile Justice (Care and Protection of Children) Act, 2000 “Children’s home” means an institution established by a State Government or by voluntary organization and certified by that Government under section 34. (1) i.e. for the reception of child in need of care and protection during the pendency of any
inquiry and subsequently for their care, treatment, education, training, development and rehabilitation. Majority of the children are admitted to children’s home at the age of 0–5 years belong to different family backgrounds irrespective of religion. These government or non-government institutions are run on grants or sponsorship which is not adequate to meet expenses to bring up the children in the children’s home, where authorities are forced to cut short many basic facilities to the residents.

Kerala Context

Most of the non-government children’s homes are either managed by religious or private not for profit organizations in India. They have a minimum of 50 and a maximum of 175 children, unfortunately accommodated in a space meant for approximately 30–40 resident children. Typical children’s home includes dormitories for sleeping, living room cum study room, common dining room and common bathroom. In Kerala State, each institution has a director, who belongs to a religious denomination or in secular NGO operated children’s homes is the chief official who runs the institution, assisted by a small staff consisting of caretaker and office staff. In Government run children’s home, Superintendent and Deputy Superintendent are in charge of the home; a case worker, full-time caretaker and office assistants are the additional staff. Both governmental and non-governmental children’s home are administered under the District social welfare officer and Director of Social welfare Department, Government of Kerala. The major factors leading to institutionalization of children in Kerala are economic problems, broken homes and orphanhood (Jessy, 2008). According to Indian Juvenile Justice Act, 2000, these girls can live in children’s home till the age of 18 years.

Institutional Adolescents

Lack of proper environmental support will affect negatively the quality of well-being of any individual (Nayak, 2000). Physical facilities are not enough to accomplishing well developed personality in which psychological support could make the mission complete. While these children are attaining the age of adolescence, they lack a lot of necessary inputs for proper growth and development, like nutritious food, psychological support, positive environment, freedom, love, care, etc. suppose to be received by a normal child with supporting parent children leaving institutions are at a greater risk of being recruited into anti-social activities, involvement in abusive relationships, unsatisfactory job placements and poor marital relationships because of difficulties in reintegrating into society (Siddique, 1997, Nayak 2000).

The institutionalized children lack adequate opportunities to form enduring emotional relationships, which are basic to the adaptation of an individual’s personal and social needs. The deprived children were less adjusted with low mental capacity, low self
esteem, and weak super ego. The adolescent girls in Children’s Home are generally less informed on developmental changes during adolescence, life skills and access to services needed for positive outlook in life (Jose 2008, Nayak 2000).

In 2005, Government of India had launched the Adolescence Education Program and this was implemented in which Teachers impart the adolescent education to the students. Unfortunately, due to public, parent’s pressure and anxiety Adolescent education program is not yet implemented in any of the schools in Kerala. The presence of a thriving trafficking mafia that traps adolescent girls and majority of these girls lured in this manner come from impoverished backgrounds, from vulnerable family backgrounds (Menon, 2009).

**Need for Psychosocial Well-being Intervention Program**

Although social workers, students of social work and educators have been visiting Children’s Home in India for several decades, very few significant research studies have been conducted among adolescent girls in the Children’s Home, their profile and problems (Nagar 1992, Sumen 1986, Siddique 1997) including one (Jnanasaraswathi, 1994) conducted an intervention study on thirty institutional adolescents between the age group of 13–18 and on family life education. Moreover, there is very little attention given through intervention by researchers among adolescent girls in the children’s homes and most of the studies are conducted among adolescent girls from schools, and communities in India. There is a need for planning and organizing mental health services for adolescents in general and institutionalized adolescents in particular (Viswanath, 1985, Sikka, 1983).

**Psychosocial Well-being Intervention Program**

Intervention is defined as an influencing force or act that occurs in order to modify a given state of affairs. In the context of behavioural health, an intervention may be any outside process that has the effect of modifying an individual’s behaviour, cognition, or emotional state (Encyclopaedia of Mental Disorders, Intervention. n.d.). An intervention program conducted as part of the research study for the psychosocial well-being of adolescent girls in a children’s home in Kerala using experimental research design, with pre-test post-test, without control group during 2008. The pre intervention assessment done with standardised scales on the components of psychosocial well-being. The content of the Intervention package was consolidated based on the pre-intervention assessment findings, the review of published literature, discussion with children’s home authorities, and the materials already standardized and implemented by national and international organizations for adolescents. Contents of the package were Meditation, Developmental changes in adolescence and its management, Life Skill education, Legal Awareness and Gender sensitivity, Career
and Vocational Guidance, personal counselling, General Health Check up and awareness class on health, Plan for the future: Better womenhood, and peer group training. The package was delivered by a team consisting of mental health professionals, medical professionals, counsellors, advocates and professional social workers. The post intervention measurement results depicted the effectiveness of the intervention program assessed. The findings of the analysis supporting to the opinion that, the major characteristics of adolescence include physiological, psychological and emotional and social, proper guidance and help will go a long way not only in the healthy development of the adolescent to adulthood, but also in the unfolding of their inheritance talents for the good of society (Sukumaran, 2002) and it is important to identify adolescents with psychosocial problems early and target them for intervention. The results also showed that a well-implemented intervention program for the psychosocial well-being, can bring forth positive results irrespective of all environmental limitations under which it is implemented (De. Friese, Crosland, Pearson and Sullivan, 1990).

**Excerpts from the Case Studies**

Each of the fifteen case studies prepared by authors covered two broad aspects of their present life as themes after four years of post intervention/post institution life:

- Psychosocial Well-being
- Empowerment.

Among these 15 adolescent girls, three cases have been briefed in Box 1 in this paper and the names mentioned in the cases are fictions in order to hide their identity. The methodology adopted here is completely qualitative nature.

**Box 1**

*Case 1*: Reshmi, about 20 years is now working as an auxiliary staff in a hospital in Kerala, was an abandoned child when she was admitted in children’s home. She was a reserved kind of person and was constantly in a discontented mood. She had no friends in the institution and she did not like to cultivate any friendship in the future, as she has found all her friends are selfish. She used to be very emotional when she thinks of her status. She had lack of confidence in whatever she involved, had much concern about her life and had instability in thinking. She wanted to become a nurse. She worked hard to score good marks in her studies and caretaker helped her in her studies. She also showed sense of anxiety which lead to behavioral problems. During life skill training in the intervention, she was worried about her performance in each activities and she used to get upset if anyone makes comment on her like: “What she can do? Is she correct? Is she playing wrong” etc. But slowly she changed her attitude and started accepting the comments. Her change was gradual from the day first onwards. She was confused of many things in life, and was not clear on her opinion on any critical situations in life. When compared to other children in the institutions, she did not have any body to relate as hers. Unlike others, she was unaware about family, parental love, siblings and relatives. For her, everything was concentrated to functionaries of the children’s home. She was unaware about the difference in the pattern of living in children’s home as well as family life. We met her during...
2011 in a hospital where she was working as an auxiliary staff; she appreciatively spoke to me about the changes happened to her after the intervention program. She appreciated more about the life skill training of the intervention, which helped her to overcome her inferiority complex, and many other behavior problems which disturbed her, other children and institutional authorities. Being an orphan, she is continuing her stay in the institution for women. According to the present institutional authorities, she has got friends who can understand her and make her happy. Now she is comfortable to move around other friends as well as staff in her hospital. So far she is keeping her morale and values strongly and this is what authorities are expecting from all the residents.

Case 2: Jiny–18 years is studying for a Para-medical course in Kerala. She was admitted in children’s home at the age of 7 years by her mother. When her father died few months after mother find great difficulty in taking care of her children, she admitted her child to the children home. She was living in this institution happily. Her mother used to come to meet her often. She enjoyed being in the institution and her studies. In her words, her world was filled with the positives in the institution. Whenever she goes for summer holidays in her home, she wanted to come back and join soon in the institution. School teachers gave her due co-operation and help. She wanted to join a job immediately after the studies and help her mother. She had a negative attitude towards people who perform well. This was tackled during the emotional management skill training. She could identify that, convinced herself and disclosed to me during the personal counselling sessions. According to the authorities, after the psychosocial well-being program, she became more serious, started concentrating her studies seriously and had a goal to achieve. Seeing her interest, institutional authorities found a sponsor to her to continue for studies and allowed her to stay in the institution till the completion of the course. Now, along with her studies, she is learning spoken English. We met her in the institution during 2011. She appeared happier than ever. Now she is able to see the world as, without challenge there is no life.

Case 3: Amrutha, is 21 years old working as a journalist now. She was admitted in the children home at the age of 5 years and left from the institution after her final school exams, joined with her maternal aunt staying with her. She attended the psychosocial well-being intervention program when she was of 16 years in 2008. Her parents were separated when she was 5 years and her relatives admitted her in this institution. Within the limitations of institutional life, she studied but could not score good marks, had issues with other residents in inter personal relationships and had lots of adjustmental problems with other residents of the institution. She expected society should accept her and recognize her capacities with any other normal child. She used to involve very actively in all sessions of intervention. During the personal counselling sessions in the intervention, she started ventilating her issues. She wanted attention from all. She was worried about her mother who left her to relatives. She expected her mother all the time, will come and take her back. Proper assessment on her personality based on the base line scales helped to understand her strength and weakness. When we met her on 2011, she had completed journalism course and joined for an internship cum job in a reputed magazine in Kerala. In the evening she is working as evening news reader in a City cable TV channel. Now she has a well defined carrier for future. She spoke about her accomplishments from psychosocial well-being intervention program and how it could change her into a strong person with high aspirations. She seemed very confident and it reflected in her behavior. She expressed her gratitude to us for giving her insight in life and starting her career. She left the institution at the age of 16 after her final school exams. She could join with her maternal aunt and adjust with them. She started searching for vocational training courses by the government, joint in with minimal fee, successfully completed and working now.
Theme Analysis

Psychosocial Well-being

Importance of mental health and developing skills among children and adolescence are widely accepted as a contribution of psychosocial well-being. According to Psychosocial well-being working group (2003) the term “Psychosocial well-being” of individuals and communities explained with respect to three core domains:

- The Human Capacity,
- Social ecology,
- Culture and values.

From the cases, it is evident that, these girls now they are young adults could identify them as an individual with their own capacity. This is the same as realizing his or her strength and values. Ms. Reshmi commented “I could understand my strength and weakness, my issues, nature and how it affects others”. “I didn’t know anything about life, how to lead life meaningfully. Intervention program helped me to overlook my situations and assess it, design it properly.” “Earlier I did not have a plan for my life. It was all what institution provided. But after the psychosocial well-being program sessions I could understand that, there is a life which I can only make active with my own strength.” During interview, Ms. Jiny mentioned about her achievements like, “The encouraging support you provided when I was talking about the poor academic performance, the tips you gave for improving my academic program really helped me to come up in my carrier. Now I am fully confident to face the situations, the same situation once I felt helpless.” “I could design my future with my competence and aptitude.”

In the aspect of social ecology, psychosocial intervention program helped them to understand about their environment where they live, their relationships and the support system to strengthen their personality. It is obvious from Ms. Amrithas’ comment that, “I could understand more about me how to take care, difference between the infatuations and real love, importance of marriage, family, etc. Now I am feeling comfortable with my colleagues, friends and relatives and very cautious with strangers.”

The above cases reveal that, they are part of the society, socially accepted behaviour that is linked to the value system in each society. The normal social functioning encompasses their psychosocial well-being. It can be reflected in this comment that, “The guidelines we received during intervention are still relevant even now and helps me in becoming a complete woman with values and morale.” According to WHO (2000) life skills trainings empower young people to take positive action to protect them and promote health and positive social relationships. Findings of Migon (2007) supports that, the multi-dimensions include physical, mental, social, spiritual, emotional,
vocational with culture, philosophical, nutritional, educational and related parameters all these dimensions contributed to self development of these young women now.

**Empowerment**

While connecting to empowerment, educational accomplishments and economic involvement are the key elements for empowerment of women by providing access to freedom and opportunities. These young women came up to the mark and educated so that they could help for themselves and their family during the hour of crisis. Cases reveals that, how they empowered by educating themselves, grabbing every opportunity to become stronger and more powerful than before.

It is evident from their comment saying “I could take right decisions on time, started thinking and doing independently. I stopped worrying about my mother who left me. Now I reached a place where I want to be and safe. I am getting consideration from everywhere”.

It is obvious from the cases that, the problem of every girl was related to her past and its events which are affecting her achievements. Their emotions were the obstacles in their achievements. Most of the adolescent girls participated in the intervention opted for vocational training courses and professional studies. Findings are supported by study saying that, the quality of post institutional life can be improved by early intervention services (Mathew and Parthasarathy, 1988) as reported in a study on the level of reintegration into the community and adjustment of the ex-residents and destitute.

The findings of the case study are contradictory to the study findings of Quinton (1984, 1987) who conducted a study among previously institutionalized children that, institutionally-reared girl children showed a markedly increased rate of poor psychosocial functioning in adulthood. Lack of marital support was associated with poorer parenting but this effect was much stronger amongst the women who had been in children’s homes. Our case study finding emphasis that, it is important to implement the psychosocial well-being intervention program in all children’s homes in the state.

The strength based practice in social work is an effective helping strategy to build success in a personal life (Rothman, 1994). In this paper, the strengths perspective is based on the belief that all cases possess their abilities and inner resources that allow them to cope effectively with the challenges of present living. It is potentially valuable to the adolescent girls in Children’s Home in particular by helping them develop responsible attitude and behavior and establish satisfying relationships with whom they are interacting, friends, and the community and prepare them to enter in to a responsible healthier adulthood.
Conclusion

Case studies of this nature highlight important implications for future generations in Children’s Homes. The study found that, none of the cases shared any significant degree of abnormality, criminality or problem sexual behaviour. The young women had a very comprehensible understanding about the contemporary issues happening to the adolescent girls and women. These case studies incorporated data from interviews, observation, information gathered from their caretakers, friends and colleagues and revealed that, each of them had been victims of some strange sort of tragedy in their life. However, the psychosocial well-being intervention helped them to emerge from their misfortune, facilitated the building of constructive roles for better womanhood.

References


Life Skills Development in Children: A Mental Health Perspective

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ABSTRACT

The present paper is an experimental study undertaken among children in distress residing at Abhayabala (an NGO founded by poetess Prof. Sugathakumari). The author and his team of professional social workers administered Life skill Training spanning 14 sessions through the medium of social group work, for 43 girl children, in the age group 13–18, secured from difficult circumstances, sheltered and rehabilitated. The CDC (Trivandrum) Self-esteem scale was used to undertake pre- and post-assessments of the girl children and the same were validated by FGDs to assess the effectiveness of the Life Skill Training. It was found that Life Skill Training helped in affirming the innate competencies and resilience they had garnered in surviving difficult circumstances, possibilities of sharing and learning from diverse life experiences of the girl child, thereby equipping her to live a life of self-worth and dignity.

Keywords: Life Skill Training, Girl Child, Children in Distress, Social Work, Strength Based Intervention.

Introduction: The Vulnerable

India with a population of 1.2 Billion (2009) has 450 million children, constituting 38% of the total population; three quarters of the child population live in rural areas. Many of these children owing to difficult living circumstances in which they live are considered vulnerable. Vulnerability is compounded with an addition of any one or more among the following parameters—age, disabilities (physical or mental), provocative behaviours, defencelessness, passivity and ignorance.

A Case for the Vulnerable Girl Child

Owing to reasons of poverty, in India, children are forced to work early in their lives. The fact that they are forced out of school, and exposed to adults and challenging
circumstances, augments their vulnerability. The situation of the girl child is more
precarious. CRY, working in the domain of child rights had come up with some
shocking statistics that warns the world about the vulnerability of a girl child (CRY,
2010):

- 1 out of every 6 girls does not live to see her 15th birthday
- Of the 12 million girls born in India, 1 million do not see their first birthday
- Every sixth girl child’s death is accounted by gender discrimination
- 1 out of 4 girls is sexually abused before the age of 4
- Female mortality exceeds male mortality in 224 out of 402 districts in India
- Death rate among girls below the age of 4 years is higher than that of boys. If
ever she survives infanticide or foeticide, a girl child is less likely to receive
immunisation, nutrition or medical treatment compared to a male child
- 53% of girls in the age group of 5 to 9 years are illiterate.

All the above factors and vulnerabilities perpetuate scenarios that would lead to
trafficking for the purpose of forced labour, begging, or even worse, commercial sex
exploitation. A good many of them are traumatised being pimped by their relatives and
in some cases their own mothers, raped by their own biological parents or relatives,
tricked in false promises of marriage, abused and eventually abandoned, forced into
begging, and even sold for a paltry sum. Being abused in the safety of their homes or
abandoned for reasons of poverty or marital discord, they desperately escape into the
streets where they are first deceived under the guise of compassion and later victimised
by the very saviours. These children are programmed to distrust everyone, and any offer
of care and support is viewed with extreme suspicion.

Given the traumatic past, victims of trafficking and commercial sexual exploitation
require more sensitive treatment for their problems and needs. This pre-requires
better understanding about their backgrounds prior to trafficking that increase their
vulnerability, and the environs of the brothel that are harsh and exploitative. The
working team consisting of professional social workers had to be conscious and
extremely sensitive not only to the stigmata imposed by the society, but as well as the
specific behavioural experiences such as:

- overt sexual behaviours (having being habituated from a very tender age)
- short-temperedness, aggression and violence
- mood disorders
- conduct disorders
- bouts of depression
- cynicism and tunnel vision (about the future).

The frequent visits by the police and the queries by the judiciary makes their life
unbearable. Even when they are brought into the safe environment of a Home, they
are constantly haunted by the legal system for the past misdemeanours they were innocently dragged into. Leave alone this, the emotional baggage from their past come to haunt. Many of them resist the control by the caregivers, detest of being (perceived) watched and even abhor being limited in their contacts and relationship with the external world. They dream of their homes but find that these dreams are nothing more than mirages. Being taught from a very tender age to fend for themselves by earning on their own whether it be through beggary, forced labour or even prostitution, they perceive the restrictions on being kept incarceration within the safe and cozy environment as unjustified. Thus we find the children constantly finding their right to live a decent and dignified live being violated.

To top it all these children hailing from vulnerable circumstances perceive themselves as “unwanted” being habitually neglected, abused and abandoned by their own loved ones. They are haunted by negative self-talk, constantly being reminded about their inadequacies and experiences suggesting “worthlessness”; they are further stigmatised as victims of rape or ostracised being branded as “thieves” or hailing from problem families. All these obliterate their identity resulting in loss of self-confidence in their selves, ultimately affecting their self-esteem. It is in this context that a strengths based interventions becomes inevitable.

**Strength Based Interventions with the Vulnerable Girl Child**

However precarious and challenged the vulnerable girl child may appear to be, one needs to appreciate the fact that they are born survivors. In spite of all the scars of the past, these girls thrive on in circumstances perceived from the untrained unlearned eyes of the common man as ‘inhuman and ‘non-dignified’. One cannot but help appreciate the abundance of exposure to harsh realities and the quantum of resilience, grit and tact, they develop in the process of surviving continuous victimisation. If only they were CHALLENGED to realise and capitalise on these strengths, life would be much more rewarding and learning an experience. But it requires them to take a moment in the time and space to STOP!, introspect, look at themselves in terms of the directions they have travelled, assess the choices ahead, decide and move on in the direction of their choice. Strengths based practice as a social work practice theory emphasizes on people’s self-determination and strengths. Strengths based practice essentially is client-centered, more appropriately client-led, with a focus on future outcomes and strengths, that the people bring to a problem or crisis. This is where Life Skill Training as a tool of Social Work Intervention could commence.

But first, a perspective on strength based approach. The field of mental health and social services for long, has been focusing on problems, children’s deficits, problem behaviours, in short, pathologies. By 1990s researchers and practitioners within the fields of education, mental health, psychology, social work, and child welfare have begun
to question the deficit-based approach and opted to move towards a holistic model of development (Trout, Ryan, La Vigne, and Epstein, 2003). Rather than focusing on individual and family weaknesses or deficits, strength-based practitioners collaborate with families and children to discover individual and family functioning and strengths (Laursen, 2000). At the foundation of the strength-based approach is the belief that families and especially children have unique talents, skills, and life events, in addition to specific unmet needs (Olson, Whitebeck, and Robinson, 1991 as cited in Epstein, 1999). While there are a variety of programs that utilize a strength-based approach, there has been relatively little empirical research on the effects of “strength-based” programs on youth and family development (Cosden, Panteleakos, Guiterrez, and Barazani, 2004). This present attempt on Life Skill Training with Vulnerable Girl Children presented the researcher with an opportunity to capitalise on the life experience and resilience of the girl child.

Life Skill Training as Strength Based Approach

The WHO defines Life Skills as a set of those “abilities for adaptive and positive behaviour that enables individuals to deal effectively with the demands and challenges of everyday life”. The UNICEF perceives Life Skill Training as a competency developing approach that would balance Knowledge, Skill and Attitude. These are used best in the developing assertiveness, problem solving and decision making skills in areas related to drug abuse, sexual violence, premarital sex, vulnerable children, groupthink among adolescents, etc. Programs implemented in the above content areas have brought about significant change in terms of reduced violence, increased pro-social behaviour, better communication, effective interpersonal relations, better self-image and self-awareness, decision making and better emotional adjustment thereby enhancing their abilities to live life to its fullness.

Life skill training engenders self-awareness thereby enhancing the child’s self-image indirectly realising her/his self-worth and entitlement to live in dignity. Various exercises are provided to this effect. Similarly, inputs pertaining to the child’s entitlements were woven into the sessions exposing them to possible scenarios and circumstances of exploitation or abuse (e.g. sessions on technology related crimes, assertiveness (learning to say “No!”) provided foresight. There were modules that transacted activities that helped to break inhibition and foster improved communication, inculcate pro-social behaviour negotiation skills and better interpersonal relations. Exercises on decision-making and problem solving indirectly helped them to assert their right to participation. The entire module was activity based and recreational in nature. The modalities transacted were based on the principles of social group work allowing the sharing of responsibilities, participative learning and the development of a peer support system in an ambience of nurture, together realises the groups’ innate
potential for development, thereby affirming their right to Development. Life Skill training, in other words, instils self-esteem and confidence to the fullest as envisioned in Strength Based Approach.

The Life Skill Module

The Modules were transacted in 14 sessions averaging 60–90 minutes depending on the task at hand. The objectives of the Life Skill Module were:

1. Develop self awareness and build self esteem.
2. Improve interpersonal relationships and conflict management.
3. Improve skills—leadership, communication and negotiation.
4. Develop assertiveness and appropriate responses to atypical situations.
5. Develop confidence to articulate before a group.
6. Expose the group to various hazards—technological and relationships—and develop preventive strategies.
7. Exposure to various entitlements as a woman and self-protection.
8. Enhance problem solving and decision-making.

The activities transacted included:

**Session 1–3: Icebreaking and Ground Rule setting (Self-awareness)**

**Activities**

1. Preparing, cutting and colouring self introduction name tags.
2. Describing and explaining what they “loved about themselves”.
3. The group was divided into—Rainbow and Daffodils.
4. Members of each group decided on the ground rules and put it down on chart paper.
5. Groups were provided with chart paper and necessary colour and tool kit.
6. The group was asked to develop camp ‘Hand Written’ magazines to report on each day’s activities for the next day.

**Session 4: Me and Others (Interpersonal Relationship Skills)**

**Activities**

1. The participants were asked to give first introduce themselves and ask others to say a few positive things about them; the session helped the group members to realize their uniqueness and self-worth. Through this the catalysts provided an opportunity to the group members to strengthen their Inter Personal Relationships.
Session 5: Trust and Support—Need for Empathy (Empathy Skills)

1. Visiting each other’s camps and evaluating the Camp Newspapers and activities.
   The Catalysts provided the necessary suggestions.
2. Songs and action.
3. “Trust exercise”—blindfolding the individuals and asking them to walk with a partner; this helped to appreciate the value of trust, friendship, support and companionship.

Session 6: Communication: Hearing the Unheard (IPR Skills)

Activities

1. An innovated memory test; first they identified the objects which apparently turned out to be not what they had seen. They were sent back a second time and a third time over, each time they came out with more sharp and critical inferences of what they saw. Help them to appreciate the importance of observation.

Session 7–10: Communication for Personal Effectiveness (Communication and Self-Awareness Skills)

1. Roleplaying—introducing situations and asking them to respond to them—someone attempting to control, propose love, offer drugs, soliciting sex.
2. Identify appropriate responses and improve communication (Verbal and Non Verbal)—for personal effectiveness, and relevance of Mixed Messages.

Session 11: Me as a Woman: … My values! (Self Awareness Skills)

1. The catalysts introduced a comprehensive tool ‘Eternal Beauty’.
2. The participants drew the most beautiful women and were asked to mark on the figure the most valuable comments regarding the qualities.
3. The physical qualities were disregarded and the group members were asked to assess the internal inherent qualities.
4. Discussion illuminates the group regarding more important values and responsibilities concerning womanhood (e.g. beautiful hair vs. Necessity of humility); strategies to minimise vices.
5. Summing up: critical thinking, self awareness and value orientation.
Session 12: My Values: Education for the Future…..! (Self Awareness Skills)

Enactment of “naadayal school venum” a song sequence to highlight the importance of schooling and knowledge. The group whole heartedly participated in the process and came up with path breaking creativity.

Session 13: Understanding the Environment

1. “Letters to a Tree”—the group members were made to observe the environment and then reflect on it through self created sketches, songs, and letter writing to any imaginary “tree friend”.
2. Discussion about songs and poems related to protection of environment.
3. Critically evaluated the significance of environment and the eco-friendly development initiatives.

Session 14: Me and My Entitlements

1. My entitlements and responsibilities as a woman.
2. Reproductive Health for Life.

The Methodology

The study is experimental in nature undertaken in a group of 40 girls, ranging from 13 to 18 years, with varied experiences hailing from difficult social circumstance. The researchers subject the group to Social Group Work, during which the subjects were exposed to Life Skill Training modules indigenised and adopted to the special needs of the group. The agency gave the intervention team absolute freedom to design and proceed with the above intervention. The intervention aimed at inculcating within the participants the confidence to strive and live a fuller life with self-worth and dignity as envisioned by professional social work. The group was assessed for their self-esteem both prior to and after the intervention. The data was collected using interview and focus group discussion, using a checklist, interview guide and observation guide.

Operational Definition

Children/Vulnerable Children/Girl Child/Child Victims

These terms almost universally refer to children exploited for the means of begging, forced labour, trafficking or commercial sex, on account of their vulnerabilities—socioeconomic, emotional, age, gender, etc. In the context of the present study, only girl children, between the age 14–18 were considered as unit of the study.
Self-esteem is the sum total of self-confidence (a feeling of personal competence) and self-respect (a feeling of self-worth and dignity), that is implicitly generated in one’s perceived ability to understand, decide and respond effectively to social demands arising on one’s self, keeping in perspective one’s own personal values and aspirations. In the present context it broadly translates into understanding one’s own entitlements (rights as a girl child), asserting them, affirming as well as living in self-worth and dignity.

Findings
The intervention was undertaken in 14 sessions spanning a period of 21 day during May 2011. The pre-intervention assessment was done during the third session and the post-intervention measurement was undertaken approximately 60 days after the intervention. The range of Self Esteem score was 25–120. The mean score pre-intervention was 56, while mean score post-intervention 93; clearly indicating an improvement of 66% improvement of mean scores over the pre-intervention scores. This clearly affirms the fact that the intervention has helped to improve self-esteem. Improvement in self-esteem generated better self-awareness, enhancing self image, assertiveness (identifying abuse and responding appropriately), critical thinking and reflection (about oneself and legal aspects), learning to trust as well as develop interpersonal relationships, etc. In other words Life Skill Training as a strengths based approach accords the girl child an opportunity for self-reflection based on life experience, acquaint herself with her innate qualities and competencies, in the process appreciating the inherent resilience she has developed, whereupon she builds on.

Qualitative Findings
The following were the findings culled out from subjective reports obtained during personal interviews and FGDs:
1. Realisation that crises are nothing less than ‘challenges’ that provided space for learning.
2. Sharing with someone and with a guided group offered ‘universalisation’ (a principle of Social Group Work Intervention) and collective wisdom to resolve the problem.
3. Group activity helped children tide over inhibitions and progressively step forward, face and speak their mind (assertiveness).
4. The late adolescents were more clear about what they wanted to do in the future; the younger ones required sessions on “vocational orientation”.
5. The girl children began to assess themselves as unique individuals with positive qualities; realised others appreciated and valued them; in the process they could appreciate their self-worth and dignity.
6. The group activities allowed them to interact; the following were noted as residual changes:

   (a) improved initiative and role-taking.
   (b) realisation of the need to understand and respect others’ perception, (developing empathy); interpersonal relationships improved over a period of time.
   (c) teamwork improved as they had to compete keeping in mind the performance of their own group as well as the need for collaborative activities.

6. Assertiveness improved; they developed a repertoire of appropriate behaviour and confidence to deal with strangers.

7. Nature of the activities enabled them to look for alternative strategies to presenting programs generating creativity.

8. The team consisting of two ladies and gentlemen each, provided a moderation of gender, perspectives and role models in enriching and exposing the vulnerable girl children to various choices in life.

Conclusion

In conclusion, Life Skill Training as program content in social group work among the adolescent girl inmates substantially improved their self-esteem. It enhanced the child’s self-image making her realise her self-worth and allowing her to live in dignity. The development of self-awareness about entitlements and possible scenarios of exploitation or abuse, and role-playing of appropriate responses indirectly assisted them in developing assertiveness. Improved communication, pro-social behaviour, and interpersonal relations too opened up possibilities for decision-making and problem engendering effective participation. The recreational nature of the modules transacted in a group work setting allowed sharing of responsibilities, participative learning facilitated by a peer support. Life Skill Training being a competency developing approach balancing Knowledge, Attitude and Skill, may be considered as an effective, cost-effective, strength based approach to social work intervention among vulnerable young children.

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Educating Children in Urban Slums: 
A Nepal NGO Case Study

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ABSTRACT
Nepal is a transition country that has moved from the rule by a monarch to a rule by its own people representatives, which has witnessed Maoist insurgency for the last 15 years. These turbulent times also saw large scale migration of rural populations that has moved to urban areas and the capital city of Kathmandu and lives in squatter settlements or the slums. In those slums, a key need of children being education, with little supports from government and non government organizations substantial improvements are not forthcoming. Drawing from a project experience of an NGO the St. Xavier’s College of Social Work’s Partnership in Education Program (PiE programs), this paper tracks down the philosophical underpinnings of strengths approach that were central to the success of the PiE and suggest that for Nepalese society as a whole, this would be a logical way to go. In first section of the paper, a brief overview of the PiE and its inherent strength orientation is brought forward and finally reiterates through anecdotal evidence to trace the impact of such initiatives.

Keywords: Strength Approach, Social Work, Urban Slum.

Introduction
Despite the prolonged transition to peace and stability, Nepal has made impressive progress in the education sector. Despite these achievements and priority accorded to the primary sector of education, in 2011 the drop-out rate at 7.9% remains significant (UNICEF, 2012). It is equally sad to report that as per the National Labor Force Survey 2008, one third of children aged 5–14 years are economically active. Geographical disparity, gender bias, impact of food, fuel and finance, and the effects of natural and climatic hazards negatively affect the education of the most vulnerable children (UNICEF, 2012).

A survey conducted by Kathmandu Metropolitan City in slum areas of Kathmandu in 2009–2010 showed that there are 28 officially recognized slums settlement in the Kathmandu valley of which conditions are very poor. For example 40 per cent of births in these slums took place without any medical assistance, 50 per cent of pregnant women
do not go for any kind of pregnancy tests, and seven per cent of people in slums do not seek medical help for any ailment. While a full 32 per cent of children in the slum settlements are not immunized.

For children, slum experience is one of poverty and exclusion. Further this poverty has impacts on adequate access to basic amenities including education. Primary education is more accessible in urban than in rural areas but remains beyond the reach of many children growing up in poverty—especially in slums, where there is often little or no public schooling. Inequality in parental income, gender and ethnicity, are also major obstacles in pursuing education for the children in slum areas. In addition, the quality of available schooling option in poor urban areas is another issue to consider. While data tend to focus on access, enrolment and retention, these are linked to the perceived quality and benefits of available education. Overcrowding and lack of appropriate facilities such as toilets, drinking water and recreational resource are among the factors that undermine the quality of education in urban slum areas (UNCEF, 2012).

The education status of the children in urban slum areas is not productive and qualitative because there is lack of proper implementation of policies, social exclusion by non-slum communities and sometimes vested interest of non government sectors (Khanal, 2011). PiE—a project run by Social Work Department, St. Xavier’s College Kathmandu, Nepal has taken initiative to help children of urban slum areas in education. This program is successful to support children of slum areas in education to extent. This paper further share experiences of how PiE is helpful to motivate those children to pursue education along with outcome and learning of this program.

**Right to Education**

In Nepal there are several legal provisions regarding the right of education for the children. The Children Act 1991 ensures the child’s right to education. Further, the state has also rectified the convention of the rights of the child (UNCRC) which put forth the concept of primary education and free education to all.

In addition, the fundamental right of interim constitution (2007) which came into existence after seven party alliance’s consensuses also guarantees the right of each person to have access to education system and activities. Despite these promises made by government bodies, situation of education for the children in urban slum areas of Kathmandu valley witnesses slow progress. In slums of Kathmandu, there are less than 1 per cent of the total population who has completed graduate level studies. It also records that 26.4 per cent of people have completed primary education only, while an additional 14.9 per cent went on to complete some form of secondary education (Lumanti, 2009).
Lumanti an NGO working for betterment of slum and squatters in Nepal claims that there is growth in the rate of school enrollment from slum communities. Most of the children go to attend either public or government schools. So far the public and government schools are concerned, they are not able to provide qualitative education because of different reasons such as lack of proper training for the tutors, scientific methods of learning, and proper monitoring and evaluation. Lack of proper orientation regarding education in slum areas is another major challenge to educate children. Besides, there are vested interests of political parties and their leaders which also work as obstacles in educating children.

There is also caste based taboos associated with children which prevent their access in the education (Poudel, 2007). In many cases slums’ children are not accepted by other caste groups in the schools as in Nepalese societies caste and class are so deep rooted which becomes the dividing line among the people. They experience caste and class based stereotype in the school which further discourage them to pursue education (Yadav, Shrestha, Neupane and Rijal, 2009).

Based upon observation and experience, the social work department of St. Xavier’s College came to know that the urban slum’s children need immediate concerns and supports in their education. The social work department under supervision of St. Xavier’s College further started PiE program to help these children in their education. One of the major principles that this program has applied so far is enhanced capacity of children and slum communities. The strengths approach of PiE has empowered the children in slum areas to consider education as one of the most essential part of life.

Social, Cultural and Economical Status of Slums in Kathmandu Valley

It will be relevant to trace the historical background of formation of slums before understanding of social, cultural and economical aspects of these areas. Historically, slums and squatters were not considered a major urban development issue in Nepal, because the percentage of urban population living in such settlements was low. However, due to their unprecedented growth in recent years and especially since early 1980s, urban informal settlements started to become an important urban development issue. In contrary to government records, in 1988 approximately 3700 populations of squatters were located in 24 settlements which reached to 6300 (approx.) in 1992 in Kathmandu (Lunde, 1994). The numbers of settlement grew to 61 with 2031 households and 11862 squatter populations by 2000 (KMC, 2000). By the end of 2004 stakeholders recognized 70 settlements along with 15000 populations and about 3000 households (Lumanti, 2004).
At this juncture, slums have become common community for people who have been migrated from different parts of nation. As any other slums of the world, the situation is becoming worse at these areas. Further, this situation could be well understood in terms of social, cultural and economical factors. The social and cultural aspects of these urban slums need to be analyzed from two dimensions: (a) intra and inter aspects and (b) between slum and non-slum communities (Yadav et al., 2009).

There are not any majority ethnics or caste groups in these slums. Moreover, there are people from different religions, too. People have been migrated from different regions of the country. However, they have formed strong bond among themselves within and with other slum communities. The main reason behind this unity is because of fear that they would be displaced by the government if they are not united. However, there are several malpractices such as alcoholism, drugs use, child marriages, involvement in theft, criminal activities. A survey conducted by department of St. Xavier’s College in 2009 in a slum records that the most of families in urban slums are daily wage laborers who earn ₹ 4000–6000 per month. With this little earning families are not in a position to pay for the education of their children. Rather these children are put in source of income as child labor at their early age.

Partnership in Education

In 2004 St. Xavier’s College Social Work Department started PiE Program to engage its students in creative action. As part of this program social worker students started to teach the students from government school background. The major notion of the program was just to support those government school children who are not getting proper education. Later the department recognized that the slums were growing in Kathmandu valley. It also found four slums which were in terrible condition which is not far from the college. The department realized that people nearby the college were suffering with poor socio-economic condition along with poor educational support for the children. I used to work in this college and was asked by the college to conduct a survey to analyze the socio-economic situation of the slum people. The survey recorded several kinds of crisis in that area. One of the major outcomes of this survey was to identify the vulnerable situation of the education. We found that most of the children are not motivated to go to school. Among those who were attending school were not regular. We also found few families who had interest to educate their children were from poor economical condition. They were not able to afford their children education. This study further led PiE—a project that has 460 students who are taking benefit in many ways (Table 1).
Table 1: Students in Partnership in Education

<table>
<thead>
<tr>
<th>Gender Ratio</th>
<th>Distribution of Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>284</td>
<td>177</td>
</tr>
</tbody>
</table>


Objectives of Partnership in Education

- To support and guide slum children for their better quality of education.
- To explore the situation of slum children and advocate on behalf of them.
- To engage social work department’s students in creative action.

Program Description

PiE Classes

It is one of the major programs at PiE. There are two systems under this program viz. Classes on campus and on slum. Those students who can travel are asked to come to campus for the classes. Our students guide them in their homework, task and learning new lessons. In one class we have arranged at least three volunteers who take care of the children. On campus class starts at morning 6.15 am 8.15 am. During this period students and volunteers have collaborative efforts in learning process. One of the very interesting facts about this class is that none of the volunteers is allowed to use chalk or board marker to teach. They need to approach the students individually.

On slum classes have been organized for those students who are at the early age of childhood and cannot travel to campus. For them our students visit to slum and they collect the children at PiE centers. For early age children we have supplied more volunteers.

PiE Awareness Programs

This program also conducts ranges of awareness programs for both the students and communities. The social work trainees are mobilized for the awareness programs who carry out street play, discussion program, documentary and issue based puppet show. These programs cover health and sanitation, HIV and AIDS, domestic violence, fundamental and universal human rights and other social issues.

PiE Trainings

This program also provides candle making, pickle making and tailoring training to the target sections. It has ties up with the government and non-governmental organization for vocational trainings to the communities.
Application of Strengths Approach

PiE program has utilized variety of strategies and approaches to deal with students of slums areas. Among them one of the major approaches that this program identified was combination of integrated model.

As shown in the Figure 1, it was identified that it would be impossible to work with the students of slum for sustainable change unless each and every stakeholders of this program participate meaningfully. Based upon this integrated model four major parties of this program was decided as: I) Students from Slum Areas, II) Social Work Students (Trainees), III) Community and IV) Social Work Department. Later, this program confirmed that the intervention should match the capacity of the students. Here, it is important to understand what it means strength approach for the PiE. It envisions this approach as exploring and highlighting the capacity and strength of the target groups. It also believes that each and every target has potential to address his/her issues. They need to be provided with unconditional opportunities without any forms of labeling. In simpler language, PiE program put forward the idea of—Be with People and Enhance their Capacity and Strength through Integrated Model.

This section of paper would describe stakeholders’ involvement. For effective outcomes of this program all the teachers were provided by certain guideline. They were motivated to enhance strength and capacity of the students so that they would participate not only in the process but also in the decision making and in the development of plan. Teachers were instructed to show care, support, interest and dedication towards students while approaching them. In addition, a culture of coordination and cooperation were asked to demonstrate in the class so that the students can learn fast and effectively. Teachers also engaged themselves in rewarding the students for their creativity, innovation, ideas and other extra curricular activities.
Creating opportunity, believing the students and their performance along with transmitting the sense of ownership in the classes were other responsibilities of teachers in this program. However, none of the teachers was allowed to label any students.

These strategies help the social work trainees to understand that the teachers/tutors must have knowledge of strength approach to make educational goals effective. When the teachers apply the concept of strength approach in education, they are communicating warmth, genuineness, authenticity and positive regards. The teachers also believe that the student can learn and perform well if provided by good opportunities.

So far students and their respective classes are concerned, there were always focus on collaborative discussion, interaction, equal opportunity for all to learn and participate, support to explore opportunity to share incompetency and promotion of ‘we-feeling’. Apart from these, this program also felt that there must be individualization within the groups and opportunities to share their stories. The major learning of this approach is that a classroom must be students friendly where the students can share and discuss activities related to them. Moreover, students must be given chance to participate and explore the sense of community. The students should also get chances to identify their weakness in the class so that they would reflect, correct and learn by themselves.

In program like PiE, community has instrumental roles to achieve goals. Without community participation this kind of programs cannot be successful. Further community may participate if they are engaged in decision making, identification of needs along with their self determination. This program has emphasized the above mentioned components so that the community people would participate and support the program for children’s education.

There were few challenges at learning, internalization and recognition phases of strengths approach in PiE while supporting students of slums in their education. At learning phase, it was difficult for this program to develop cooperative coordination with college, social work department, trainees, students and communities. In addition, strengths approach was new aspect for this program and it was also hard to introduce and implement with the students of slum communities. Internalization of strengths approach was important in this program. However, internalization was highly affected by external factors such as lack of funding, human power, defining the frame of activities, approval by the communities’ people, coordination with other non government organizations and others. Finally, PiE had to recognize strengths approach as process to empower the slum students and communities which was not easy because of qualitative output and its evaluation.

PiE has used multiple level of social work intervention to address these challenges to make this approach more effective for the students. In order to remove confusion
about success of strengths approach among its stakeholders, this program has enhanced knowledge, skills and empowerment through socialization process. Besides, there is continuous effort for empowerment of staff, trainees, students and communities through participatory action. For recognition of strengths approach, there is ongoing monitoring and evaluation of this project and it demonstration to other social workers in Kathmandu valley.

Anecdotal Evidence

Jagdhish Prasad (name changed), a student in Social Work Department of St. Xavier’s College, worked as a volunteer teacher in Partnership in Education Program for two years. He revealed his experiences with this program and students were worthy to share. He also admitted that the children from urban slums were keen to learn when they were provided with good opportunity, care and support. Based upon personal interview, he stated following challenges and opportunities:

- Strength Based Practice in education is still not very popular in country like Nepal and it is difficult to transform into the practice because of inadequate studies about it.
- It is difficult to ensure participation of all target groups especially when they represent heterogeneous ethnic background.
- In program like PiE where there is hierarchy between students and teachers, students need continuous empowerment to participate in the learning process.
- Limited time period, research and trainings are always obstacles in exploring strength and capacity of students.
- Communities like slums do not want to practice self-determination because they feel they cannot address their problems (dependency).
- People want change, however, there are several other factors such as social, economical, legal and political which restrict them towards change process.
- Social work department provides good orientation about Strength Based Practice.
- Ideology of Partnership in Education—‘Be With People’—help them to understand the students’ capacity and strength.
- The integrated model of practice provides enough opportunity for collaborative efforts and discussion that further bring expected result.
- A good understanding of rights and justice has become basis for Strength Based Practice.
- Social work theoretical perspectives help the teachers to individualize the students and thus guarantee to explore strength and capacity.
Case Study: Impacts of Strength Approach on Student

Ashish Singh (name changed), a student from PiE was interviewed for this case study. He is originally from eastern region of Nepal who settled in this slum along with his family nine years back. His family came to Kathmandu in search of job. The poor socio-economic condition forced them to settle in slum areas.

He attended PiE classes for four years and recalls his classes as one of the productive one. He also believes that this program has positive impacts in his life. During interview, he admitted that if there were not this program for slums’ children he would not have been studying now.

He explained that PiE has helped him to be confident and pursue further study. The opportunity and access provided by this program has supported him to feel worthy and result oriented. Today he is studying in St. Xavier’s College which is one of the recognized colleges in Nepal. In his journey from slum to St. Xavier’s College this program has become trustworthy partner.

Conclusion

Urban poverty in Nepal is increasing day by day due to ignorance of concerned authorities such as government and non-government bodies. Urban poverty groups are forced to create slums for their shelter wherein the situation of social, economical and cultural aspect is in dire strait. Further, these aspects have several impacts including on educational state of children. In absence of proper provisions of support in education sector for the children of slums, PiE—a program of St. Xavier’s College started its classes to equip them with educational resources. Today, there are many students from the urban slums who are getting assistance in education. The Partnership in Education program has been implementing Strength Based Practice in intervention and has witnessed successful results. A well framed Strength Based Practice has become foundation for this program to help urban slum children in their education.

In this project with the urban slum children, it was important that community participated. Community roles are immense to sustain this kind of program because it is second major beneficiary group. Since the students belong to the community, it has right to participate in the program and decision making as well. If the community does not engage them, there would be probability of conflicts. Sometimes the community may feel being dominated, too. Hence, such a program cannot be executed without their support. When we apply strength based practice with the community, we also ensure worth, dignity and rights of the community. It also helps to enhance their capacity and the result is favorable to overall development.
Organizational staff development is another key issue of PiE. Without proper understanding of program and its objectives by staff, it would have been difficult to realize success. Therefore, this program also focused on better orientation, strength based environment, personal and professional development, and collaborative discussion for to design overall activities. One needs to understand that staffs are primary stakeholders in the organizations in delivery of such an educational project. Therefore, they must also get orientation about all sides of strength approach.

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‘Bumps’ in the Road of Life: 
A Case Study of Disability and Travel

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ABSTRACT
This case study is part of a larger project that focuses on people with a disability who travel. Research was undertaken to allow the subjective voice of the participant to relate her own narrative, through which the negotiation of her social self, cultural traditions and identity where evident. A case study approach was chosen to highlight positive areas for the client, to investigate how she set new goals, developed resilience, improved her strengths and social support networks; and how she empowered herself through travel. The participant faces issues of mobility and access, and as a result has faced numerous challenges in travelling overseas, including issues with air travel, accommodation, land transport and personal safety issues. Beginning from the client’s position, and not from the position of theory, builds on each client’s successes and lived experiences. Many clients survive even under constraints of great adversity. A strengths approach is used as the analytical framework, which shows that the research participant is empowered by the creation of a context that requires her to utilise her two most significant and distinctive human capabilities: conceptualising her own world, and making choices about how to inhabit it.

Keywords: Strengths Based Approach, Disability, Travel, Grounded Theory, Case Study.

Introduction
The research investigates aspects of travel use as a recreational pursuit of a young woman with a disability who has travelled extensively. Narratives of both inclusion and exclusion were common points of discussion during the narration of her travel experiences. Personal strengths through which the negotiation of the social self, cultural traditions and identity were embraced became evident. These highlighted positive areas for the participant, to investigate how she set new goals, developed resilience, improved her strengths and social support networks; and how she empowered herself through travel were investigated. The participant faced issues of mobility and access, and as a result faced numerous challenges in travelling both at home and overseas, including issues with air travel, accommodation, land transport and personal safety issues. The research was informed through the background
literature that was gathered in the initial phase of the research project. The literature formed the basis of the open-ended, in-depth interview questions asked of the participant (Murray and Sproats, 1990).

The research was undertaken using an inductive, theoretical approach, and through employing a grounded theoretical method that offered a number of common themes. Grounded theory as a research approach seeks to systematically generate theory from empirical material (Charmaz, 2000; Denzin and Lincoln, 2000). Open-ended, in-depth interviews were conducted with the participant. The participant was recruited through contact with a colleague from a disability support service. When a grounded theory approach is undertaken, interviews are undertaken until ‘saturation’ is reached and a constant comparative method, continually switching between newly collected data and comparing it with data that was collected earlier, is applied. This is a continual ongoing procedure, where theories are developed, enriched, substantiated, or sometimes discarded as a result of newly formed data that emerges from the research (Birks and Mills, 2011; Noerager Stern and Porr, 2011).

In this case, it was decided to represent the findings through an illustrative case study approach (Stake, 1978) with the female participant who was assigned the pseudonym of Alexis. The identified themes and categories of: setting new goals, developing resilience, improvement of strengths and social support networks; and empowerment through travel were investigated, and are used to present the findings of the case study of Alexis in this paper.

This paper therefore lends itself to a rich, robust and powerful representation through an illustrative case study approach, of how a person with a disability copes with the strains, tensions and anxieties that travel presents to her in her quest for mobility, access and success in journeys of discovery.

Background

The strengths perspective (Saleebey, 1992, 1997; Weick, Rapp, Sullivan and Kisthardt, 1989; Graybeal, 2001) presents a set of directed values that shape the lens for looking at human behavior in a very unique way. The underlying assertion is that individuals will excel in time when they are helped to understand, acknowledge and use the strengths and resources available in themselves and their surroundings. However, this straightforward concept can be seen as very intimidating by some (Graybeal, Moore and Cohen, 1995: Graybeal, 2001). Anecdotal information implies that many have seen the strengths perspective as unsophisticated and basic, or that it refutes progress in the awareness of psychopathology and a biomedical information base and practice models (Saleebey, 1996: Graybeal, 2001). This is an inappropriate response, as the recognition of strengths is not the converse of the recognition of problems. Instead, it is a sizeable part of the answer (Graybeal, 2001).
The strengths based perspective is a considerable adjustment of thinking for conventional social workers as well as students newly acquiring social work practice knowledge (Blundo, 2001). Indeed, Saleebey (1997) succinctly highlights that “everything you do as a social worker will be predicated, in some way, on helping to discover and embellish, explore and exploit client’s strengths and resources in the service of assisting them to achieve their goals” (1997, p. 3). The importance shifts from problems and shortfalls described by the worker, to opportunities and strengths recognised inequal, shared relationships with clients. Saleebey (1997) illustrates the structure of the strengths based perspective in three fundamental ideas. First, given the struggles they have, and the acknowledged reserves available to them, people are frequently doing extremely well—the best they can, given their situation. Second, people have endured up to this time—undoubtedly not without anguish and effort—through utilising their resolve, their foresight, their abilities and, as they have struggled with living, what they have discovered about themselves and their world. These capabilities are to be appreciated and inform a relationship with this information with the aim of offering help. Third, transformation can only come when you work together with client’s ambitions, sensitivities and strengths, and when you can be certain of them (Saleebey, 1997, p. 197). The strengths based practice approach adopts the perspective of the client (Saleebey, 1997, p. 197; Blundo, 2001). It is truly “starting where the client is, instead of “starting where the theory is” (Blundo, 2001, p. 302).

Insufficient research has been published investigating tourism and disability (Burnett and Bender-Baker 2001; Darcy 1998, 2002). Many researchers discussed this notion in the late 80s and early 90s (Driedger 1987; Muloin 1992; Murray and Sproats 1990; Smith 1987), but then this field of research fell silent until relatively recently (Burnett and Bender-Baker 2001; Darcy 2002; McKercher et al., 2003; Ray and Ryder 2003; Yau, Mckercher and Packer 2004).

The World Health Organisation’s International Classification of Functioning suggests that a linear, cause and outcome connection between disability and involvement, established predominantly on disability, is equally inaccurate and restrictive (WHO 2001). As an alternative, it identifies that involvement in life circumstances involves complicated relations (including social feelings, physical and artificial structures, family viewpoints, guidelines, etc.), with disability being only one of numerous causal features and perhaps not even the significant one in an individual’s capacity to partake in daily actions and life circumstances such as tourism. Consequently, the removal of physical barriers to access may only deal with a portion of the concern. Unless suitable enabling situations are initiated and the individual is allowed to take advantage of these situations, individuals may still not have the right of entry to tourism (Yau, Mckercher and Packer 2004).

While some individuals with disabilities never travel, many others benefit from an extensive, dynamic and diverse travel career. To become active nevertheless, is not a
guaranteed progression for such individuals. They confront many practical and societal impediments that can hinder their full involvement in tourism, which means more than merely buying a ticket, reserving accommodation, or purchasing for an organised tour. Individuals with disabilities have more things to contemplate and more challenges to face prior to and for the duration of a trip than those without. Undeniably, it is at times a demanding individual journey (Yau, McKercher and Packer 2004).

In addition to the extraordinary stories of those individuals and relatives that not only persevere, there are those that prosper despite great hardship (Bass and Thornton, 1983; Rothenberg, 1997; Rubin, 1994). There is also mounting importance on the strengths based approach, and the exceptional strengths, competencies and capacities of individuals who astound us by not corresponding neatly into any classification, but those who generate resolutions where none appear imaginable (Weick, Sullivan and Kisthardt, 1989; Saleebey, 1992, 1996; Graybeal, 2001).

Methods

The study is focused on people with a disability and travel. These individuals are interested in travel as recreation; and the experiences of travel for self-growth. They have a desire to examine other places and destinations as individuals in their own right. The interviews for this study were undertaken between July 2011 and December 2011. All participants had a disability. Not all disabilities were the same; some were quite profound, and others were not as visibly discernible. Two members of the research cohort were vision impaired. During the course of the interviewing process, it became evident that there were a variety of travel encounters and degrees of difficulty involved for those people with a disability who engaged in travel experiences. These individuals actively sought to extend themselves, their lives and their circumstances through the process of travel.

A set of open ended, in-depth interviewing questions were developed (Carl and Hillman, 2012) to interview the participants who had travelled extensively. A list of twenty questions was devised and contained numerous questions relevant to the travel experiences of people with a disability. The questions focused on for the illustrative case study are concerned with difficulties of travel for a person with a disability, barriers to travel for a person with a disability, preferences of travel for a person with a disability, support for travelling for a person with a disability, travel behaviour for a person with a disability, and travel experience for a person with a disability. These open ended, in-depth questions led to the discovery of the illustrative case study participant’s personal travel experiences and form the basis of the research themes and categories for this paper.

This paper will present an illustrative case study of a person with a disability who has travelled extensively. This case study also reveals important aspects of the process of travel.
as experienced by people with a disability. According to Stake (1978), the best use of the case study “… appears to … be for adding to existing experience and humanistic understanding. Its characteristics match the ‘readiness’ people have for added experience” (Stake, 1978, p. 7). The young woman referred to in this case study, and who has been assigned the pseudonym of Alexis, was selected because she was the first ‘long-haul’ traveller with a disability encountered in the data collection phase of the research project. The young woman currently resides with her two children in a house that is not really wheelchair accessible, but that has ramps placed at all the steps and entrance doors to the living accommodation. She has community support and workers that come to her house to assist her with her daily tasks.

The interview undertaken for this illustrative case study was recorded and the audio tape was transcribed and imported into NVivo. Thematic analysis was carried out on the interview (see Richards, 2009), and the resulting case study provides information pertaining to each category and theme that was developed throughout the coding phase of the research project.

Findings/Discussion

For people with a disability, being able to achieve independence for themselves in various stages of their lives are milestones in their personal worlds that give them a sense of pride and accomplishment. Indeed, when looking at Alexis as an illustrative case study, it was apparent that she had looked forward to travel and independence with great enthusiasm and anticipation. This section presents the findings and discussion from the interviews with Alexis, and discusses the four main themes that emerged from the research and her interview. These themes are: setting new goals, developing resilience, improved strengths and social support networks, and empowerment through travel.

Setting New Goals

Alexis was very adamant that after her accident she wanted to travel. Initially she just wanted to travel from her home in Central Queensland, Australia, to the Brisbane capital of her home State, Queensland. In order to do this she decided to find accommodation that catered for her as a person with a disability.

“Yes, it was a stepping stone to getting accommodation in those days nobody advertised for accessible accommodation or whatever else so, it was a stepping stone to get to Brisbane, I didn’t realise that I had to commit myself to six weeks of going into institutionalised rehab [laughs] but anyway, it was an experience.”

From realising that perhaps an institutionalised care facility may not have been the best path of escape, Alexis further recognised that there were things she had always wanted to do in her life and had never had the opportunity.
“Ah my world-wide adventure, when I was [approximately 25 years of age]. I fought for compensation for about 5 years, and I decided that regardless of whatever I was given, I was taking whatever it was to do the trip that I dreamt about when I was twelve, and that was to ride a camel to the pyramids.”

Setting the goal of seeing the pyramids and riding a camel were an ambition that Alexis had made her mind that she would undertake. Even though these goals were possible, the idea that the site would be picturesque and romantic was a great disappointment to her, as she found the location to be very westernised and com-modified. As a person with a disability she was also denied close proximity to the pyramids themselves, as wheelchair access was limited.

“…went through all that, the sphinx… And went to the pyramids… Yes yes, yes, I wanted to sort of actually get to the base rock, but yeah, physically I couldn’t have done it myself, and there was, on that particular day, there just seemed to be shoulder, I mean I’m sure it was like that every day”.

Present literature suggests that people with a disability encounter numerous obstacles to participation (McGuire, 1984; Murray and Sproats, 1990; Smith, 1987) and that, because of these obstacles, they experience less access to tourism opportunities than individuals without a disability (Turco, Stumbo and Garncarz, 1998: Yau, McKercher and Packer, 2004). This then leads to the next theme of developing resilience, where Alexis and other people with a disability develop their own strengths through fostering determination.

**Developing Strength**

Capacity building and fostering determination are important strengths for people with a disability. Empowerment is also a positive force for all people and is particularly pertinent in the case of travel and disability. Alexis explains how she has developed a sense of strength through the realisation that she can decide where she wants to live and where she wants to travel.

“…left just before I was 17 to go and live in Sydney with my older sister, came back, was here for 8 months, was going on holidays to Sydney when I had the accident.”

“…hospitalised in Sydney, but after that I went back and lived in Sydney on and off again for about the next three years. I couldn’t quite shake off the city. But ah, I soon outgrew it. But I also moved away from um Rocky and lived in Brisbane for about 2 and a half years and worked down there. Went to rehab after…”.
Travel was a catalyst to capacity and personal strength building for Alexis, as she was able to see that she was in charge of her wishes and desires and could go where she wanted to as an independent woman.

“It was interesting to travel on your own. The first time was, you know, I had people along the way I suppose, but the second time I went with two suitcases and this walking brace and a wheelchair and it was sort of like, you know, Alexis and her entourage [laughs]… it wasn’t good [laughs] you know, you had to rely on so many people to get you there…”.

Through this scenario of growth, Alexis was also able to identify her limits as well as her strengths. It has also enabled her to now, in later life, reflect upon her ability to carry out such an adventure when she was young.

“And also realising your own limitations and accepting it. Now that was another, that was, you know I swallowed a lot of disappointing pills on that trip, but thank God I did do it. You know. My body won’t allow me to do these things now, so I was young and silly, naive, and whatever, but, I saw”.

Intrinsically, people with a disability—as with all other holiday tourists—undergo a need to escape day-to-day life, although the things they wish to escape from are different from those things which people who do not have a disability want to leave behind. Abeyraíne (1995, p. 53) suggests that people with a disability “are now recognized as agents of their own destiny and not as objects of care”. Therefore, Alexis was drawn to travel, even with all its complications for a person with a disability, because she had always ‘dreamt’ of travelling since her childhood (see Blichfeldt and Nicolaisen, 2011). Other authors (see for example, Rojek, 1993) also see travel as a form of escape from the mundane trials of diurnal life.

This has led to Alexis experiencing a more enhanced and fuller approach to life and thus, has built upon her strengths. This, in turn, has had an impact upon how she perceives and interacts with her social support networks.

**Improved Strengths and Social Support Networks**

In order to improve her personal strengths, as a person with a disability, Alexis had keen experience what life had taught and shown others with a disability. Contacts and information sharing with others enabled Alexis to expand her social support networks and presented her with a new strength through an additional approach to her mobility needs. She was able to undertake this through her travel abroad.

“I’d heard about a walkabout program which was a disabled brace, and I’d heard about it in England, and anyway, I contacted the copper, that, PC Olds, that was using it, and he gave me the number of the professors in America,
and we booked to go straight from New York to..., we had so many basketball friends on the west coast in Seattle, we were gonna head straight to there and Greg [friend], anyway so I phoned up this Professor Douglas in New Orleans and he said, well if you can get here on the, in you know the date then, you know I’d be happy to see you, and that gave us sort of twelve days so we just rescheduled everything, made our way down to New Orleans, I stayed, well, got measured for the brace, that took ten days, and then Sue and I parted, she went up and got drunk for a month [laughs] I stayed at LSU, in Louisiana State University, and did the walking program with, that and the hospital next door and stuff.”

Mobility in travel is especially important for people with a disability in order for them to become more ambulatory and build their personal capacity and strengths. Alexis was able to become more active through the use of a walking brace, and this fuelled her desire to be more active and to travel and see other places. It also enabled her to utilise her support networks, but also to build new ones. This was an empowering experience for her. Retrospectively, Alexis now recalls her around-the-world travel experience with great fondness. She built many great support networks, but also came to the realisation that there are restrictions for a traveller who also has a disability.

“And also realising your own limitations and accepting it. Now that was another, that was, you know I swallowed a lot of disappointing pills on that trip, but thank God I did do it. You know. My body won’t allow me to do these things now, so I was young and silly, naive, and whatever, but I saw”.

Self-knowledge about her own abilities and capacities did not stop Alexis from undertaking her travel dreams. The barrier to her enjoyment was because of limited access and limited forward planning of those offering tourism experiences. According to Yau, McKercher and Packer (2004), in their study on travelling with a disability and access issues, “participants indicated that the nature of the journey is highly personal, with many needing to progress through each step sequentially, while others tackled them in parallel and in certain cases indicated that some stages had to be revisited” (2004, p. 950). Therefore, even though Alexis did learn about her limitations through her travel experience she was still able to build her strengths and capacity for further empowerment in both the journeys of life and travel.

**Empowerment through Travel**

Through the process of travel and independence in travel, Alexis has become empowered through a strengths based approach which has, in turn, required her to draw upon two of her greatest vital and distinctive human capacities; conceptualising her own world and making determinations about how to inhabit it (De Jong and Miller, 1995). Indeed, the travel experience for Alexis certainly pushed her to her limits on some
occasions, as we have seen. But, the thrill and exhilaration at having achieved travel in its own right and for its own sake, as a person with a disability, is not to be undervalued.

“It’s ah, the discovery, the challenge, knowing your own limitations and pushing beyond them…”

Participation in travel activities became a leveling experience for Alexis and her fellow travellers. In conjunction with her friend Sue, they sailed together on a tourist boat down the Nile from the Aswan Dam.

“But we had a great time on board the boat though, because there was the different you know. We had, you know, skits and everything else, and stage plays if you wanted to do, so we involved ourselves in our…. we created our own mummification company, you know like selling it, like ‘Sale of the Century’ that’s right, come to our place, guaranteed whatever, you know, if Pharaoh wants this or whatever, and I had to be the weakling Cleopatra [laughs]”.

Undertaking journeys enabled Alexis to adopt strengths around her curiosity regarding travel. Through travelling away from home, she was able to reconceptualise the world through her own perceptions, and was instrumental in making her own travel choices. Therefore, as argued by Blichfeldt and Nicolaisen (2011), it is apparent that tourists with a disability are required to participate in far more up-front choice making practices than able-bodied tourists. They are required to do so, so as to ensure that options of destination, transportation, accommodation, attractions and activities (Woodside and McDonald, 1994) qualify them to truly take on the persona of a tourist. This approach also empowered Alexis to inhabit, in her own way, her new found capabilities.

Conclusion

This paper has examined a young woman with a disability, Alexis, who was able to build her own strengths and capacities through independent global travel. Grounded theory was used to induce major themes and categories from the data. The research formed part of a larger research project about people with a disability and travel. An illustrative case study of Alexis was used to explicate the main themes of the research project for this paper.

Travel, and in particular global independent travel, is possible for individuals with a disability. The strengths perspective allows the people with a disability to take control of their lives. This also enables them to embrace positive change and transformation and to build capacity and resilience for themselves, in their own way, in their own lives, through travel. Issues of access, mobility, obstacles to participation and limitations imposed by others often present barriers to the ideation of ‘escape’. However, as this case study illustrates, it is possible for many people with a disability to build their strengths
and capacities and to enjoy travel, new horizons and new experiences through their own self-determination and resilience.

References


A Strengths Approach to Child and Family Wellbeing: A South Australian Case Study

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ABSTRACT
Child well-being is promoted by family well-being and the care children receive in the vital early years of life will influence their development. Families can experience disadvantage in many forms and families in regional areas are particularly vulnerable to disadvantage due to poor socioeconomic conditions, lack of services or problems accessing services. All of these risk factors have the potential to negatively impact child well-being in those families. In regional South Australia the Parenting Support Program, through an individually tailored, strengths based approach to service provision, provides a service to families which aim to help them to overcome these challenges. The program improves confidence in parenting skills, increases family resilience and well-being, links families with services and integrates them into the community. Feedback from parents is that they feel a greater sense of satisfaction in their parenting, a positive difference in the relationship with their child, a reduction in child behaviour problems and an increased confidence in the future. Participants leave the program with practical strategies for dealing with parenting problems, are utilising other services in the community to support the family and have extended their social networks to include other parents who have participated in the program.

Keywords: Parenting Program, Family Well-being, Strengths Perspective, Regional, Australia.

Introduction
There is substantial evidence in the literature on service delivery that focusing on strengths rather than deficits can bring desirable change in service user life (Rapp, 2006; Kropf and Robinson, 2004). Interventions aimed at increasing child and family well-being focus on parents developing competency in parenting and faith in their capabilities to provide holistic care to their children. Further, that they have the knowledge and skills to provide physical, psycho-social, spiritual and emotional support to their children. The Strengths perspective focuses on human beings’ inherent capacity to ‘transcend circumstances, to develop their powers, to overcome adversity, to stand up and be counted….to shape and realize their hopes and dreams’.
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(Saleebey, 2009, p. 7). Thus a strengths approach to improving parenting acknowledges the power that parents have to make a positive difference to child and family well-being.

There is ample research evidence in the literature about the effectiveness of a strength based approach; a literature review conducted by Scerra (2012) includes various studies in working with children, young people and families, that demonstrates the effectiveness of the strengths approach in ‘improving parental engagement with programs’ (Tehan and McDonald, cited in Scerra, 2012, p.45); minimising risk factors and improving ‘personal and interpersonal outcomes’ amongst the young parent (Price Robertson, cited in Scerra, 2012, p.45). However, these and several other studies (Walsh, 2002; Early and GlenMaye, 2000; Lawless, Biedrzycki and Hurley, 2008); in applying strengths principles in a family practice setting; have not outlined the approach that may assist practitioners in planning and implementing a parenting support program with a focus on strengths perspective. This paper aims to fill this gap in the literature by illuminating and examining elements of a strengths based intervention that can be used at individual and group levels to improve parenting. To illustrate the strengths based approach in promoting child and family well-being, this paper describes the Parenting Support Program being implemented in a regional centre of South Australia.

Interventions with Families—A Key Focus in Primary Health Care

The first five years of a child’s life shape their health, learning and social development (FaHCSIA, 2009). In recognition of the importance of a child’s early developmental years and the vital role that families play in that development, the Australian government has adopted the National Framework for Protecting Australia’s Children (FaHCSIA, 2009). The framework commits State and Territory governments to a number of agreed actions to promote family and child well-being with a primary health focus on early intervention. All Australian families will benefit from this initiative and this more intensive, targeted approach to service provision will provide additional support for vulnerable and disadvantaged families. Vulnerable and disadvantaged families are those experiencing unemployment, family violence, separation, mental or physical illness and social isolation. In addition, to targeted services the framework also recognises, for the first time, that grandparents, extended family and carers rather than biological parents may be caring for young children and be in need of support.

Arising out of the National Framework was the Communities for Children strategy which prioritised the funding of community based organisations to provide tailored services to meet the unique needs of families in the community. The Parenting Support Program, based at the University of South Australia Whyalla Campus is one
of those organisations. In keeping with the priorities of the Communities for Children strategy the aim of the Parenting Support Program is to ensure that children have the best start in life by focusing on targeted early intervention approaches that bring about positive family functioning, safety and child development outcomes for children 0–12 and their families. Additionally, the program aims to improve access to support services to encourage disadvantaged and vulnerable families to engage with their community, and enhance caregiver’s capacity to overcome personal and social barriers and improve caregiver parenting capacity.

**Need for Parenting Support Program in the Regional Area**

There is no doubt that the family plays a vital role in the holistic development of children. However, child rearing at all stages of life brings challenges to parents. ‘Managing behaviour’ is regarded as the biggest stress factor by parents and carers in their parenting role (Kazdin, Bass, Ayers and Rodgers cited in Flaherty and Cooper, 2010, p. 18). In turn children who have experienced abuse and/or neglect demonstrate problematic behaviour that is difficult for parents and carers to manage (Flaherty and Cooper, 2010). A recent Australian Institute of Health and Welfare (AIHW) report on children with child protection services in Australia shows high prevalence of children who were removed from their families due to neglect or abuse (AIHW, 2012). Although children of all age groups are vulnerable, younger children are at greater risk of maltreatment, hence the government focus on early intervention and service provision to reduce child maltreatment (COAG 2009). Moreover, children living in rural areas have higher prevalence rates of disruptive behavioural problems compared to their urban counterparts (Sawyer et al., 2000). These include higher rates of Conduct Disorder, Oppositional Defiant Disorder and Disruptive Behaviour Disorder characterised by behaviours such as aggression, destructiveness, disobedience, hostility, repeated trouble at school and temper tantrums and outbursts (Blomquist and Schnell, 2002; Kupersmidt, Bryant, and Willoughby, 2000). These behavioural problems not only negatively impact on children’s social and academic functioning but also place great strain on parents, families and significant others who are caring for them. In addition to this, parents living in rural areas face the challenge of limited access to services, interventions and programs that are readily available and accessible in metropolitan areas. Rural families also contend with the practical issues of distance and cost of travelling for services, and the hesitation and even stigma attached to seeking help or assistance because of privacy and confidentiality issues (Flaherty and Cooper, 2010; Swift et al., 2009). Such challenges delay early intervention and the prevention of problems experienced by families. Early and holistic intervention has been shown to bring positive change to family functioning and child well-being thereby reducing the risk of child abuse and neglect. The findings of a longitudinal Canadian
study (McMillan and Violato, 2008, p. 440) with children at three different points of time revealed that adversity such as “job loss, marital conflict or substance abuse” faced by parents impacted on the “emotional health and behavioural functioning of children”. This research highlighted ‘value of family intervention’ to improve the outcomes for children. The studies such as Swayer et al., (cited in Flaherty and Cooper 2010, p.18) emphasize having parenting training to manage complex and multiple needs of children who have faced abuse. Lundahl et al.’s. (cited in Barrett, 2010, p. 81) meta analysis of evaluation studies on parenting programs and their impact on parenting styles revealed that “parent training can make a multiple impact on parents’ lives and can have a very beneficial role in reducing the risk of child abuse”. Evidence also suggests that raising parents’ perceived level of competency is an important consideration in skill training.

Extensive research has even been conducted comparing and contrasting parental competency from other parenting variables such as parental self-efficacy and parental self-esteem (de Montigny and Lacharite, 2005). Findings have been consistent that believing oneself as able and competent in their capacity to effectively perform parenting tasks contributes to parenting quality. Furthermore, high levels of parental competency have been associated with positive parent-child relationships and interactions, increased parental warmth and responsiveness.. Therefore, the focus on parenting variables such as parental competency bolsters protective factors and fosters positive parent-child relationships. Dekovic et al. (2010) emphasised that parents need not only to acquire new parenting skills and knowledge but to also believe in their capabilities so as to build and/reaffirm their competency in raising and interacting with their children.

**Introduction of Parenting Support Program**

The Parenting Support Program is funded under the Department of Families, Housing, Community Services and Indigenous Affairs, Communities for Children stream. The aim of the program is to provide early intervention and/or intensive support to vulnerable and disadvantaged families in Whyalla, Cowell and Cleve on the Eyre Peninsular in South Australia. Whyalla has a population of approximately 27,000 people with heavy industry and mining being the largest employer and Cowell and Cleve are smaller farming communities with populations of approximately 1,200 and 1,800 respectively. The program staff are based in Whyalla and provide outreach services to Cowell and Cleve. These are supported with phone consults as requested by other practitioners or parents. To do this staff work closely with many other Human Service organisations and practitioners in the region. The service adopts a strengths based approach with the aim of building confidence and increasing skills to effect a change in parenting and improve outcomes for children and families.
The Worker

The program worker is a qualified social worker with 15 years experience working with children and families. The skills and personal qualities this person brings to the role help the worker to quickly build rapport with clients to make them feel at ease. Warmth, a genuine interest in their experience of parenting and a non-judgemental attitude of the worker help clients to relax and begin to see the possibility of bringing a positive change to their parenting style and ultimately the relationship they have with their children. Many parents attend their first session with some trepidation. Those who have self-referred can feel a sense of failure in their parenting skills and fear being seen as inadequate parents. Others may have been ordered to attend by child protection authorities or the court and can be defensive and angry at what they believe is unwanted interference in family business. Research has also found that parents stressed the need to be respected, listened to and not judged by professionals during intervention (Ward and Tarleton, 2007). Thus the skill of the worker in developing early rapport with the client is essential. As suggested by Kisthardt (in Teater, 2010, p. 48) the worker strives to build a partnership approach to working together with parents by emphasising the positive step they have taken by attending and acknowledging them as experts on their family. A strengths based approach to bringing about change in the family will involve the parent and worker combining their expertise to help the parent make choices and develop skills that will be beneficial to both the parent and the child (Kisthardt, in Teater, 2010, p. 48).

In addition to the social work knowledge that the worker brings to their role they have also received training in a number of accredited and well recognised parenting programs for example, “Triple P”®, “1.2.3. Magic”® and the “Circle of Security”®. Knowledge and skills gained from these courses equip the worker with a variety of evidence based strategies to teach parents specific skills to manage a wide range of unwanted child behaviour, with the emphasis always being on recognising and rewarding wanted behaviours. This promotes choice and provides options to parents which is also in keeping with a strengths based approach as it acknowledges that service users need to be given an opportunity to contribute to the agenda and decide upon purpose and goals of their involvement (Steinberg, 2004).

The Setting

A second feature of the Parenting Support Program is the setting. The fifth principle of strengths based practice as described by Kisthardt (in Saleebey, 2009, p. 56) suggests that “helping activities [occur] in natural community settings”. The program is located on a University Campus situated on a major road with schools and kindergartens within walking distance of the campus. The campus also hosts a community wellness centre and government funded dental clinic in addition to a café which is open to the
public and regularly hosts a baby playgroup. The location and co-location of other services makes the setting an ideal place for the Parenting Support Program because of the ease of access and anonymity it affords to those concerned about being seen and stigmatised by others who may judge them to be bad parents. Thus a visit to the campus could be seen by others as for any number of reasons and not because some is seeking help with parenting. Besides this, it also works as “an oasis of potential resources” Kisthardt (in Saleebey, 2009, p. 57) for program participants who might want to pick up or drop off children at school, undertake their own study at University or socialize with friends and relatives at cafe.

The Clients
All clients recognise that there is a problem and look for guidance asking ‘what do you want me to do’. This indicates a lack of confidence and a perceived lack of power to effect change. Instead they turn to the professional looking for the answer to the question. The second strengths principle as described by Kisthardt (in Saleebey, 2009, p. 52) points out that “The helping relationship becomes one of collaboration, mutuality and partnership. Power with another, not power over another”. A practitioner working with this perspective will challenge clients to replace feelings of discouragement and pessimism with feelings of possibility and hope (Saleebey, 2009, p. 16). This can be achieved by what Rogers calls “positive regard” to clients which is important to create a positive self image and sense of self-worth in clients (Saleebey, 2009, p. 16). The professional needs to be skilled enough to engage with parents in a conversation about what they do and how the child responds, and then draw out from them strategies that they feel comfortable using to make changes. These choices are supported rather than the professional being the expert on how the parent should manage the behaviour.

First Contact/Intake and Assessment
“The initial focus of the helping process is on the strengths, interest, abilities, knowledge, and capabilities of each person, not on their diagnoses, deficits, symptoms, and weaknesses as defined by another” (Kisthardt, in Saleebey, 2009, p. 51). This is the first principle of strengths perspective which is incorporated into intervention. At first contact with the program clients are invited to share with the worker their story of being a parent. During this conversation the worker takes note of the parent’s concerns about child behaviour that is leading to stress and unhappiness in the family. These concerns might be about children not listening, not eating, not sleeping, and throwing tantrums, to name but a few. In addition to recording what parents think is going wrong, the worker also listens for and comments on things that are going well—no matter how small or insignificant it might seem to the parent. This
could be the parent’s concern about the behaviour, their wish to make positive changes and child behaviour or routines that are working well. Allowing parents to narrate their stories of ‘reality’ as they had experienced has “transformational potential” (Witkin cited in Gray, 2011, p. 7). This is the beginning of a family strengths assessment focusing on positive strategies and attitudes the family already uses and which can be built on to address things that parents want to change.

Thus the first two principles of the strengths perspective are incorporated into intervention from the very beginning. For a more holistic assessment the worker also gathers information about other services or resources currently being utilised by the family. This means the worker draws on other social work knowledge such as an “ecological framework” (Germain, 1973); “life model” (Gitterman, 1981) and “systems model” (Pincus and Minahan (1973) which are compatible with strengths perspective (Gray, 2011, p. 6) to make an assessment of strengths at multi-sectoral level. This might be helpful in drawing resources from different sources and advocating on behalf of the clients to obtain resources and overcome disadvantage and oppression (Kondrat, in Teater, 2010). It is important to determine what other supports are in place for families experiencing problems so that gaps in service provision can be identified and where necessary parents can be linked with these resources. This ensures a primary health approach to early intervention and recognises that families can experience many different stresses and this can impact on child/parent relationships and parenting behaviours. It also recognizes the sixth principle of the strength perspective which is that “The entire community is viewed as an oasis of potential resources to enlist on behalf of service participants” (Kisthardt, in Saleebey, 2009, p. 57).

At the first meeting of worker and parent the opportunity to attend individual or group sessions is offered and parents choose what suits them best. The worker adopts a collaborative approach. It is a “two way process of mutuality and empathy [that] gives weight to the... [worker’s] ability to foster trusting relationships” (Gray, 2011, p. 7). This empowers parents to decide how they wish to learn more about positive styles of parenting. Offering the choice acknowledges that due to work and family demands not all parents are able to meet schedules set by others. According to Rapp and Goscha (cited in Saleebey, 2009, p. 11), “[t]o be empowered’ a person or group requires an environment that provides options and ascribes authority to the person to choose”. This is also keeping in with the third principle of the strength perspective that “Each person is responsible for his or her own recovery. The participant is the director of the helping efforts” (Kisthardt, in Saleebey, 2009, p. 53).

Another consideration is suitability of parents for group work. The worker needs to be alert to any conflict that might occur between group members or that some parents are not comfortable discussing family concerns in front of others. Thus, the first meeting is also a screening for suitability for group membership. The worker does this by
working collaboratively and keeping ‘open to negotiation’ to provide ‘authenticity’ to clients’ views and aspirations’ (Saleebey, 2009, p. 14).

The Group

Group sessions offered by the Parenting Program consists of six, two hour sessions, with up to ten group members. The group is led by the worker with the support of a group mentor. The mentor is a previous graduate of the group who has received extra training in group facilitation and who is able to provide parents with a source of optimism, hope and understanding that positive change is possible. In a reciprocal relationship, the client and worker share co-responsibility for the work process...the worker and client view themselves as equals...(they) co-create the practice goals, objectives and tasks” (Derezotes, cited in Kisthardt, in Saleebey, 2009, p. 53).

Social workers and mentors form collaborative partnerships with parents to assess each family’s parenting needs, identify goals for change then discuss successes and areas for further change. Parents are acknowledged as experts on their own life, are capable of making choices and bringing about wanted change. This relationship is important to facilitate sharing their experiences, failures and successes in parenting. This again demonstrates the second principle of strengths perspective as described by Kisthardt, (in Saleebey, 2009, p. 52).

The group program is designed to lead the parents through a range of topics without focusing on specific misbehaviour of children. Instead the program aims to provide parents with an understanding of why child misbehaviour occurs and then general principles and strategies that can be used in any situation with any behaviour. Thus the worker helps parents to relate the information to their specific circumstances and with the support of the worker and mentor develop their own goals for change and strategies to help them achieve those goals. This strategy realizes the fourth principle of the strengths perspective that postulates “all human beings have the inherent capacity to learn, grow and change” (Kisthardt, in Saleebey 2009, p. 54). Initially the goals are deliberately small. This is in keeping with the principles of the strengths perspective which promotes the setting and achieving of initially small goals in the belief that success will motivate people to want to set other goals and larger goals (Boyle et al., 2006; Kisthardt, in Saleebey 1992).

The first two group sessions are devoted to introducing group members to each other, outlining the program, setting group norms, sharing of experiences and introducing the concept of relationships, specifically the relationship between parent and child. The aim is to explain the importance of the child/parent relationship to promoting healthy child development and good behaviour. The strategies used to convey this information include a simple ‘watch, do, discuss’ approach to adult education. Watch, Do, Discuss—means introduce the concept, watch a video or look
at picture cards such as strength cards, practice/role play and then discuss. Discussion incorporates a lot of examples and sharing amongst group members. This also helps to normalise issues and builds relationships in the group, while simultaneously fostering confidence in individuals that they are not the only ones experiencing parenting difficulties. According to Saleebey (2009, p. 105) the process of ‘normalization’ helps participants in ‘teaching others what one has learnt in the process’. At the end of each group session members are provided with a summary sheet with reminders of what has been covered in the sessions. Feedback from clients has shown this to be very effective “video and visual examples are good; real life examples on how to complete these tasks; handouts to refer later is useful”.

By the end of the second week most group members are reporting a positive difference in the relationship with their child and an improvement in positive behaviour in the child/children. A noticeable increase in motivation to learn more and to set new goals is also evident. The relationship between group members has also strengthened and they are more encouraging and supportive of each other and their attempts at change. It is often at this stage that friendships are beginning to form and some members begin to meet outside of group sessions. This goes toward meeting the Parenting Support Program’s Funding Body Requirements that the program provide families with opportunities to connect and interact socially. Again, this also adheres to the principle of strengths perspective that ‘every environment is full of resources’ (Saleebey, 2009, p. 18). Parents can draw on each others’ knowledge, skills, support, friendship, talent, time and company.

The third week in the group program focuses on the reasons why children misbehave and describing healthy relationships and how they are fostered between parent and child and between parents. The link between wanted, positive behaviours and healthy relationships then becomes clear to parents and shows how an improvement in one brings about positive change in the other. The worker uses the same strategies of ‘introduce the concept, watch, do, discuss’ to help group members understand the concepts and work out how to incorporate the strategies into their own family. The worker ‘stimulate[s] the discourse and narratives of resilience and strength’ (Saleebey, 2009, p. 104). The process of discussing the new concepts and strategies provides an opportunity for the worker and group members to reflect on their resilient behaviour and to be an ‘affirmative mirror’ where clients could see positive behaviour, successes and accomplishments (Saleebey, 2009, p. 104). From these discussions another behaviour change goal is set for the week and progress is discussed the next week.

The fourth and fifth weeks of the program turns attention to strategies for managing unwanted behaviour and establishing wanted behaviours. Up to this point the major focus has been on understanding the importance of healthy relationships and how to develop them. Along the way parents have been using strategies to develop or improve relationships with their children. An improvement in relationships has
resulted in positive interactions between parents and children and parents report less stress at home and an increase in positive child behaviour. In the fourth week parents are introduced to a range of strategies to use when they need to manage child misbehaviour. These strategies include a step by step process for setting ground rules, giving calm, clear instructions, ignoring, consequences, quiet time and timeout. All of these strategies are modified to be age appropriate and group members are introduced to each using the same ‘introduce the concept, watch, do, discuss’ method. Discussion provides the worker with the opportunity to help group members determine what is age appropriate for their children and to decide which strategy might be best to use in which situation. Again, this aligns with principles of empowerment embedded in strengths approach to provide choice and decision making power to program participants by ‘honouring’ their decision (Lietz, 2011, p. 891). As with other weeks, goals are set, strategies are decided with progress to be discussed the following week.

Finally in week six parents come together for the final session to look back over the changes that have occurred in their family, the relationships and the behaviours. Material covered in previous weeks is briefly reviewed and discussion encouraged to identify any concerns that parents may still have about their ability to manage particular situations where child misbehaviour might be a problem. This monitoring and review of individual and collective accomplishment for parents is empowering as they can decide on future activities and suggest how they might be assisted in future (Kisthardt, in Saleebey, 1992). Finally the group is encouraged to celebrate their success with a shared lunch or something similar where certificates of successful completion are presented to each group member. This also had other benefits such as valuing other cultures and appreciating each others’ contribution (Coward and Dattani, 1993). At the last session members are also asked to complete a program evaluation sheet to determine what worked well and what could be improved about the group format, content and setting. This final evaluation contributes to a brief content evaluation which is filled out at the end of each session. These evaluations help to ensure that the content covered and strategies used to convey that information are meeting the needs of group members.

**Individual Sessions**

Clients who choose to attend individual sessions with the worker rather than a group session are able to cover the same content as the group but at a pace that is suitable to them. The same strategies are used to teach the new way of thinking about and responding to child behaviour and the worker ensures that many examples (sometimes from their own experience of parenting) are shared with the client during the discussion phase of the learning process. Without the encouragement of other group members, when working with individual clients it is important that the worker...
acknowledges and encourages the client to celebrate their successes from session to session. Once a client feels confident in their parenting the sessions will cease and as would be expected the number of sessions can vary greatly from client to client. At their last session clients are invited to contact again at any time or to participate in a playgroup.

Playgroup

The Playgroup is run in partnership with the Learning Together Program through the Department of Education and Children’s Services. The Learning Together program is a supported playgroup for families with children from birth to four years old which meets once a week for two hours in a Community Kindergarten setting. There are activities that assist parents/carers and children to engage and develop positive relationships while being encouraged and supported by workers from both the Parenting Support Program and the Learning Together Program. The playgroup is a way of transitioning families out of the Parenting Program and linking them with other appropriate services while at the same time promoting their social interaction with other parents and families in their local community. This is in tune with “graduated disengagement [process] that refers to the purposeful activities designed to increase.... [participants’] contact with other providers and naturally occurring helpers in the community” (Kisthardt, in Saleebey, 1992, p. 80).

Conclusion

This paper has illuminated how a strengths perspective has been embedded into a parenting support program to meet the needs of disadvantaged families who are caring for children exhibiting problem behaviour. Inherent in this conception is the understanding that a focus on strengths rather than deficits in family relationships has the potential to empower parents to improve those relationships. Establishing a respectful, collaborative, partnership with parents has far reaching implications for practice. It was evident in every stage and phase of the intervention process that program participants were honoured, seen as an expert, empowered and were enabled to build on their strengths to become more resilient.

The strategies used in various phases of individual and group sessions such as introducing new concepts one at a time, watch, do, discuss, goal setting, measuring success, discussion and celebrating successes depict a shared approach to learning a new way of parenting. The worker guides the process but success is not possible without the expertise and willing participation of the parents who attend the program, thus acknowledging the importance of the client-worker relationship in the helping process. Sharing between group members fosters new friendships which continue after that program has ceased. Families have also been supported to access
other resources in the community which reduces pressures on families and further promotes family well-being. This case study provides further support for the applicability of the strengths principles in conceptualizing and implementing parental training programs. A strengths based program has the potential for positive and lasting outcomes which promote family well-being and healthy child development.

References


Towards a Cultural Approach to Support Recovery in Mental Health Care

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ABSTRACT
Reducing the treatment gap for mental illness in Uganda will require collaboration between modern and traditional systems. Studies suggest that people experience and interpret their mental illness within their own cultural frameworks. Despite this modern health workers in Uganda have little appreciation of the cultural approach to supporting recovery from mental illness. This article makes both theoretical and practical endeavors to position the role of culture in supporting recovery from mental illness. In broad terms, culture can support recovery from mental illness through: supporting cognitive restructuring and promoting social integration. The cultural approach seems to promote patient autonomy and improve participation of family and community institutions in the recovery process. Enhancing cultural approach to support recovery will require a shift in the current programming of mental health programs in Uganda.

Keywords: Cultural Approach, Recovery from Mental Illness.

Mental health problems are important causes of morbidity and disability in both the developed and developing countries (Ganasen, Parker, Hugo, Sten and Seedat, 2008; Patel and Sumathipala, 2001). Uganda is currently grappling with a high burden of mental health problems (Ovuga, 2005). However, there is limited reliable statistics to help in developing a clear understanding of the magnitude of the mental health conditions in the country (Kinyanda, 2007; Mugisha et al., 2011; Ovuga, 2005).

Promoting recovery is one of the ways of lessening the burden of mental illness in the country. Thus, there is increased concern in both the high income and low income countries on how to improve recovery from mental illness (Larry and David, 2007). This however requires mental health workers to apply both theoretical and practical models in the management of mental illness (Jacob and Greenley, 2001) in a manner that is contextually appropriate to those targeted. The recovery process should be designed in a way that empowers the clients to recover their self-esteem which may be lost in the process of illness and having control over issues that surround the client’s life (e.g. engagement in education, employment, housing, social networks, community participation, etc.) (ibid).
Towards a Cultural Approach to Support Recovery in Mental Health Care

There is however a major challenge (both theoretical and practical) in improving recovery from mental illness in Uganda. Just like in many local income countries, mental health practice is dominated by the medical model (Helman, 2007). The modern practitioners have little appreciation of culture in the mental health recovery and in most cases treat some of the cultural practices (such as rituals) with suspicion. The main focus of the modern health workers is largely on hospitalization, application of drugs (to deal with biological deficiencies) and management of symptoms. They however miss out on recognizing that mental illness is a bio-psycho-social field due to the multifaceted nature of mental illness (Helman, 2007; Hjelmeland, 2010). And recovery from mental illness requires a multi-disciplinary approach including psychiatrists, psychologists and social workers. The vitality of the personal nature (the individual as a client) is always ignored in framing the design of recovery process; there is limited focus on empowering families, community institutions/groups in supporting the recovery process of the person afflicted and the family affected by mental illness. Yet the individual recovering from the mental illness should be treated as the final arbiter in the recovery arena (person-centered model/approach) (Frese, Stanley, Kress Vogel-Scibilia, 2001). Patients recovering need to play a major role in the recovery process with the help of their families, community groups while the mental health workers who may play a facilitation role. This perspective seems not be appreciated by the majority of mental health workers in Uganda due to the nature of their training as biological scientists.

However, a cultural approach to support recovery in mental health care may come along with some positive results. The contribution of culture to mental health recovery can be broadly characterized as supporting: a) cognitive restructuring and b) Social integration.

**Cognitive Restructuring**

*Dealing with Distortions*

Some mental illness comes with cognitive distortions, emotional reactions and behaviors. However, some of these distortions come from our own experiences—they reflect the life challenges one is going through. However, the experience, the manifestation and interpretation of these emotions and distortions is culturally defined (Kitayama and Cohen). It is therefore incumbent upon the mental health worker to guide the patient through the process of becoming more aware of their meaning(s). The mental health worker should also help the client to evaluate them, and when appropriate, to modify them to promote recovery from mental illness. However, this should be done as a collaborative process in which the client is assisted in taking the lead as much as possible—gaining more autonomy in due process. Within this culturally sensitive framework, the mental health worker should not assume that the client’s thoughts are “negative” distortions if they reflect the cultural experience of the patient. Instead attempts
should be made to guide the client with questions that encourage the client to make him/her to clarify his/her discoveries out of such illusions/distortions. For example, many of the patients managed from northern Uganda an area that experienced more than two decades of civil conflict still don’t believe that the trauma they are experiencing is because of the horrible scenes that some of them could have witnessed (some witnessed their very own being cooked in pots by the rebels). They instead attribute their traumatic experience to their gods that were “annoyed” because their territory (gods in Africa can occupy both a spiritual and physical territory; the physical territory is the one which is occupied by the people of that cultural group) was being occupied by government troops and/or the Lord Resistance Army rebels while the people were living in camps. Dealing with this challenge will require the mental health worker not to “throw away” such beliefs but would require him/her to help the patient label these beliefs (distortions appropriately) hence reducing the distance between the lay and the leaned cognitive structures. Emotions follow the belief systems of those involved (Kitayama and Cohen, 2007). Helping such a person will require dealing with both the client’s threats and concerns relating to the displacement of the traditional gods and later on help him/her try to relate her/his experience with the event that might have caused the trauma. The approach adopted in strengthen based social work has been not to discourage such patients to perform their traditional rituals in order to please the annoyed gods but combine this with modern therapies. By doing this, the mental health worker does not take on the process of how the client should deal with the distortions but the patient takes on the process. This seems to reduce the tension between modern and traditional lenses. The family may also have a different meaning/explanation for these distortions (it also normally takes a traditional view) and should be involved in the management process. It should play an active role since the recovery process should take place with adequate support from the family. In Uganda, community groups (such as mental health clubs) have started to play an active role in supporting patients with mental illness at community level. Such groups need to be empowered to help clients overcome these distortions within their cultural framework. Moreover people heal better within their families and communities. This approach has paid off in northern Uganda in the management of trauma patients at community level.

However, such approaches (that promote patient autonomy and empowering of families and communities) are not popular to even to those who are trained in community psychiatry. They are currently seen in Uganda as too intensive, time consuming and expensive because the mental health worker has to visit the family and community. This is quite understandable given the number of mental health workers in Uganda. For example the country has 30 psychiatrists and 10 psychologists. Butabika as a national

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1 Many people in northern Uganda were displaced by a civil conflict for over two decades. They come for specialized treatment in Butabika National Referral and Teaching Hospital. The author is a behavioral scientist in this hospital.
referral hospital with an average patient load of 400 patients has only three social workers who are supposed to undertake all the community based work in addition to hospital based activities.

**Developing Meaning in Life:** Cognitive restructuring helps patients gain strength to develop new meaning in life. Culture through both traditional and modern religion provides quite a number of possibilities: *a) explanations for their current situation b) gaining mastery of their situation.*

**Explanations for a Client's Situation**

There is no doubt that mental illness affects people’s outlook to life. Most affective disorders make patients have challenges with their current station in life. For example those with depression may have the following feelings: loss of interest or pleasure in activities one used to enjoy, feelings of guilt, hopelessness and worthlessness, suicidal thoughts or recurrent thoughts of death, sleep disturbance (sleeping more or sleeping less), loss of appetite and weight changes, difficulty concentrating, lack of energy, etc. Dealing with these challenges requires self-managed care which may include a range of strategies; including holistic remedies, spirituality, physical exercise, creativity and medication among others. Of focus to this article is how patients can in addition to other resources utilize religion/spirituality in developing new meaning in life.

Mbiti (1989) and Gyekye (1996) has expounded on the role of religion/spirituality in people’s way of life in Africa. Mbiti (1989) notes that,

> Africans are notoriously religious and each people have its own religious system with a set of beliefs and practices. Religion permeates into all departments of life so fully that it is not easy or possible to isolate it. We speak of Africa traditions in plural because there are about three thousand African peoples (tribes), and each has its own religious system (p. 1).

People can draw from their religious values to develop explanations as to why they are grappling with disease. For example they may take their suffering as normal and or a sacrifice to God (Mugisha et al., in press). This could be a springboard upon which they can work towards restoring their lost hope, self-esteem and dealing with anxiety feelings among others. The role of the mental health worker is therefore not to trivialize the religious values of patients that they may be using religion to find meaning in life. His/her role should be helping the patient to harness such cultural resources to support adjustment and recovery. In Butabika national referral and teaching hospital, having realized the role of religion/spirituality in forming people’s outlook to life, religious leaders are invited from time to time to give targeted talks during treatment sessions. It is also within the strategic plan of the hospital to invite the dominant religious groups in the country to construct churches and a mosque.
Gaining Mastery of the Event

Developing a new meaning in life involves someone having the feeling that his/her plight will change for the better (Hammell, 2004). In both traditional and modern religion, there are notions that make people develop feelings that they are in the short-term victims of illness but will become victors in the long run. There are also victory songs in both modern and traditional religion to promote this notion. They tend to regard themselves as temporary sufferers who will have better life in future. In view of this, in case of illness including mental illness, they are encouraged to perform rituals including sacrifice. Once these rituals are performed, the patients feel a sense of not only safety but also victory over the experience (Mugisha et al., 2011). This contributes to their own recovery process within their cultural frameworks.

Social Integration

Strength based social work will require recognizing the role and empowering community institutions in supporting the recovery from mental illness. The major interest here is working towards approaches/schemes that allow communities do things by themselves with little or no facilitation from the mental health worker. There are a lot of cultural resources that can be harnessed in mental health to support community recovery. These resources are community based and need to be identified. They include: a) linguistic material b) the institution of care c) the institution of sharing.

Linguistic Resources

Music can have potential in supporting recovery from mental illness. Mugisha et al. (2011) noted that songs, poems, proverbs, idioms can be useful in supporting cognitive restructuring in case a person has perceived danger. Families and community groups could use these resources that available at no cost to support the recovery of the patients, the family and the whole community (ibid). However, music and the oral culture in African are also used to further the notion of community and social integration (Mbiti, 1985); as some of the songs that promote health are sung as a family and sometimes as a community. However, since mental illness carries a lot of stigma in Uganda, it would be important that the mental health workers work closely with the traditional institutions to develop narratives within this cultural resource that don’t re-enforce stigma.

Cultural Care Institution

Mac Neils (1996) has expounded on the cultural care theory in Uganda especially its role in the management of HIV and AIDS. Caring for those that are sick is a moral obligation in all communities in Uganda. Programs on HIV and AIDS have harnessed
this resource to support the coping capacities of those afflicted and families affected by pandemic. The only challenge with mental health in Uganda is that the programming of interventions has not yet appreciated the role of such a cultural institution in Uganda yet; the health system is under resourced in terms of manpower and other resources. For example, within family and community systems there are a pull of individuals who are traditionally recognized and sanctioned to provide counseling. These are the *sengas* (aunti’s), *koja’s* and uncles. HIV and AIDS programs have blended their skills to delivery HIV and AIDS programs. Such an approach should be harnessed in mental health in Uganda. These traditional institutions should use their influence, experience and proximity to the community to undertake mental health counseling.

**The Institution of Sharing**

In Africa is a moral obligation of the old to share with the young and the rich to share with those that are poor in case of misfortune (Mugisha *et al.*, 2011). This communal morality creates some informal social insurance for those that may be facing life challenges including illness. However, as noted earlier on, mental illness is highly stigmatized in Uganda. Many family and community members abandon their own because of fear to be stigmatized and this creates a challenge to the recovery process especially in a poverty context. This puts a lot of demands on the patient who has to buy some or all the drugs in case there are drug shortages in the health facility (a common experience in Uganda) but also some of them may have lost income due to mental illness and cannot meet other obligations in social life such as payment of school fees for their children. Self-help groups are a key cultural institution in Uganda and have been useful in promoting the resilience of families during death and in orphan support activities. They could be used in supporting mental health recovery if the stigma on mental illness at community level is dealt with.

**Way Forward**

Within the domain rubric of mental health, there is need to strengthen approaches that promote self-management within the cultural context of patients and targeted communities (Frese, Stanley, Kress Vogel-Scibilia, 2001). Patients should be treated as experts of their situation. This might be difficult for some disciplines whose orientation is encored in the medical model. However, social workers and psychologists working in this area can play a leadership role in this technical enterprise. However, they will need the support of policy makers because they lack vital resources for this; they are very few in number compared to other cadres in the mental health field and many of their community activities are not funded.

1 The first author is going to undertake action research on such a methodology and the finding will be used to advocate for the re-design of the general approach to mental health in the country especially at community level.
Private organizations (such as civil society organizations) have increasingly picked interest in mental health in Uganda. They have more expertise and resources to deliver community based programs. They could take the lead in implementing culturally sensitive models in mental health. The best practices that accrue out of their interventions could be used to influence policy and planning of mental health in Uganda.

Mental health is still a young field in Uganda. Mental health has been ignored in the developing world for many decades. There is therefore need for capacity building of mental health workers at all levels in the country. One of the vital areas would be the role of cultural in recovery from mental illness.

Conclusion
Developing models that apply a cultural approach to promote recovery from mental health will require a policy move from the traditional and colonial setup of mental health services to a more patient/community driven medical model. Workers within the Western oriented systems still hold the view that modern medicine is supreme and should not be “contaminated” with cultural issues. They become the knowers (expert) and the patients become the partakers of their “wisdom” and the patient is not supposed to question. This has largely left the patients, families and community largely disempowered to play an active role in mental health recovery.

References


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