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**NATIONAL JOURNAL OF PROFESSIONAL SOCIAL WORK (NJPSW)**

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Professional Social Work practice is characteristically different from other helping professions in its core approach. The person-environment approach is central to social work practice. The changing world continues to present new challenges and avenues in the field of social work. This Volume aims at highlighting some of the new approaches in social work to suit the changing world.

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## EDITORIAL

This is the 19<sup>th</sup> Volume of The National Journal of Professional Social Work. In addition to concepts such as social stress, resilience and mental health, the focus has shifted to social engineering with hygiene and its impact on family life, as well as the significance of technology in child development. An interesting and unique idea such as Equine Therapy has been introduced and it surely adds to the overall novelty quotient of this Volume.

The publication, as with the two that have preceded it, aims to bring together articles pertaining to research and practices in the field of professional social work to enable young professionals to learn from empirical sources. The articles highlight research in the area of psychosocial group intervention as well as psychoeducation in the management of mental health which will help professional social workers to contribute their services in a more efficient manner. The objective of bringing out this Volume is the dissemination of new knowledge which can be used by academicians, practitioners and students of social work. The AGBM of ISPSW, in its meeting held at Pondicherry on 23 February 2018 had authorized the editor to edit the back volume articles and publish the same in 2018. The third Volume in the series completes the requirements.

Every Volume in a series seeks to make up for deficiencies in the previous Volumes. This Volume also seeks to do the same, as suggested by the the Editorial Board. The suggestions of the specially constituted Review Committee which comprised academician, practitioners and researchers from India and abroad have been considered and implemented wherever suitable. I thank them sincerely for their efforts. I thank Dr. Jotheeswaran A Thiyagarajan, Technical Officer (Epidemiologist), Department of Ageing and Life Course, WHO, Geneva; Dr. Janki Shankar, Assoc. Professor, Faculty of Social Work, University of Calgary, Central and Northern Region, Edmonton, AB T6G0T2; Dr. Rashmi Gangamma, Assoc. Professor, 601 E. Genesee Street, Peck Hall, Dept of Marriage and Family Therapy, Syracuse, New York – 13202; Dr. N. Janardhana, Additional Professor, Department of Psychiatric Social Work, NIMHANS, Bengaluru; Dr. Lakshmana G, Assistant Professor, Dept. of Social Work, School of Social and Behavioral Sciences, Central University of Karnataka, Kalaburgi; Dr. Manisha Kiran, Head, Dept of PSW, RINPAS, Kanke, Ranchi; Prof. P. Ilango, Dean, Faculty of Arts, Bharthidasan University, Tiruchirappalli; Dr. Sonia Pereira Deuri, Prof. & Head, Dept of PSW, Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, Tezpur;

Dr. Sojan Antony, Assistant Professor of Psychiatric Social Work, National Institute of Mental Health & Neuro Sciences Bengaluru; Dr. Jahanara M Gajendragad, Assoc. Prof., IBHAS, New Delhi; Dr. Anish Cherian, Assistant Professor of Psychiatric Social Work, National Institute of Mental Health and Neuro Sciences (NIMHANS), Bengaluru deserve acknowledgement for the sincere efforts put in.

Any piece of academic writing based on field work is no doubt a challenge to edit, since the findings may or may not confirm to normally understood social constructs and many times is seen from the prism of students of Social Work. The reviewers have been gracious in their comments and observations. Their experience and technical finesse in making the observations have lifted the quality of the articles, undoubtedly. I remain grateful to them.

It is any editor's fond hope the publication will arouse interest in the concepts offered and contribute to the area of learning. Many of the observations and discoveries make a telling commentary on the ways in which technology brings about irreversible changes in attitudes and lifestyles. Mental health is in no way beyond the influence of technological developments and we ignore this fact at our peril.

I acknowledge the help rendered by the members of the present Editorial Board headed by Prof. D. Muralidhar especially their support in bringing out this issue.

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

Here's wishing all readers a fruitful time.

**Dr. Rameela Shekhar**  
Editor (2019)



## **Impact of Equine Therapy for Children with Autism and their Caregivers**

<sup>1</sup>Alen Chandy Alexander, <sup>2</sup>Sojan Antony and <sup>3</sup>Thippeswamy V.

### **Abstract**

The life of a caregiver of a child with autism is a story of hardship in different dimensions. Parents are forced to restructure the environment they live in, if they wish to take care, nurture and give a life to their children with autism. As caregivers, parents experience stress from the moment they observe that their child doesn't behave like the other children.

This study was an attempt to examine the outcomes of Equine Therapy on children with autism and also its impact on the burden of their caregivers. The study also intended to initiate discussion on whether Equine Therapy could be useful to decrease the burden level of caregivers as well as make an effective treatment for children with autism. The study was done using case study design. Five caregivers of children with autism undergoing Equine Therapy were included in the study. Themes of emotional burden, social connectivity, general family functioning as well as impact on the child were studied.

The results have shown improvement in communication, cognitive and motor skills of the child with autism as well as a reduction in the level of burden that the caregivers faced before the child began Equine Therapy.

**Keywords:** Equine Therapy, Autism, Caregiver, Burden.

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## **INTRODUCTION**

Autism is an umbrella term for a wide spectrum of disorders or developmental conditions pervasive in nature. It is a developmental disability characterized by social impairments, communication difficulties, and restricted, repetitive and stereotyped patterns of behaviors (American Psychiatric Association, 2000). A study carried out in United States of America (U.S.A.) reports 1 in 110 children (Rice, 2011) and another study from United Kingdom (Baron-Cohen et al., 2009) reveals 1 in 100 children classified as having Autism Spectrum Disorders (ASD).

Along with traditional therapies such as Applied Behaviour Analysis (Lovaas, 1987) which tend to rely on extrinsic motivation to shape behavior of children with ASD in specified ways, an increasing trend in focusing on interventions fosters a child's curiosity, interest and intrinsic motivation through reciprocal social interactions. These types of relationship-focused interventions encourage and support parents to improve their usage of responsive interactive strategies with the ASD children, and research suggests that this approach can significantly improve children's social and emotional functioning (Mahoney & Perales, 2003). Animal-assisted therapy is one such therapy that boosts intrinsic motivation and reciprocal social interactions.

The family is a major source of support for these children with ASD. Although Indian families show tremendous resilience in caring for their ill relatives, they experience a lot of physical and emotional distress.

### **Equine Therapy**

Equine Therapy, also known as Horse Riding Therapy, is a new field in animal-assisted therapy compared to other animal assisted therapies used to treat different development and other disorders in India. Animal-assisted therapy, defined as using animals within a goal-oriented setting to implement treatment, has been shown to significantly benefit cognitive, psychological and social domains (Fine, 2006). Studies also suggest that animal-assisted therapy influences physiological factors such as lowered blood pressure, heart rate and decreased anxiety levels (Morrison, 2007).

Horse riding began as a therapeutic treatment during the World War II period. Wounded soldiers were advised to undergo treatment sessions with horse riding. It started gaining

prominence with the silver medal win at the Helsinki Olympics by Liz Hartel, an Olympic medalist from Denmark. She was confined to a wheelchair due to polio. She won the silver medal for Grand Prix Dressage at the Helsinki Olympics (1952) after overcoming her disability. This repeated in 1956 and it boosted medical professionals and equine therapists to set up riding centers across Europe that offered riding as a therapy.

Therapeutic horseback riding is an animal-assisted therapy used to treat populations with physical and mental disabilities. It stimulates the multiple domains of functioning that is well suited for children with neurological disorders with a combination of motor, cognitive and social disabilities (Stickney, 2010). While horse riding is taken as a sport for most people, for disabled children mounting and riding the animal is a lesson that helps in co-ordination, concentration and confidence building. Horse riding helps in changing the behavior and emotions of disabled children (Anita, 1999). It also helps their muscles to tone up and improves blood circulation and appetite. It is possible that animal-assisted activities provide a multi-sensory environment that will prove beneficial to children with profound social and communication deficits (Ben-Sasson et al, 2009; Bass et al., 2009). It is like a platform to supplement natural therapy for children.

### **The Caregiver Burden related with Autism**

The extreme care-giving challenges faced by parents of ASD children mean that they experience greater stress and depression than parents of typically developing children (Baker-Ericzen, Brookman-Frazee & Stahmer, 2005), especially among those who have difficulty in accepting and coming to terms with their child's autism diagnosis (Milshtein, Yirmiya, Oppenheim, Koren-Daric, & Levi, 2010). Mothers of children with ASD spent more time caring for their children, spent fewer hours in leisure activities, and experienced more stress and arguments at home than did mothers of typically developing children (Smith, Hong, Seltzer, Greenberg, Almeida, & Bishop, 2009). The normally developing siblings of ASD children also tend to experience psychological problems such as stress and depression (Gold, 1993). Siblings may feel anger and frustration at the extra chores and responsibilities they have to take on (Kaminsky & Dewey, 2002). In fact, eighty percent of siblings of children with ASD have little or no involvement in childhood activities such as youth groups, hobbies and recreational classes due to their

parents' focus on treating their sibling's disorder (Barak-Levey, Goldstein & Weinstock, 2010).

Therefore, it is necessary for caregivers of children with ASD to be given targeted interventions that not only help the psychological well-being of their children but also improve their own psychological well-being by reducing and coping with the high levels of anxiety, depression, stress and social isolation that they feel. Thus, the current study was carried out to understand the impact of Equine Therapy for children with ASDs and its usefulness to decrease the burden level of caregivers.

## **METHODOLOGY**

The study was conducted at the ASC Centre and College Riding Grounds, Domlur used by Healing Horses, Bengaluru, Karnataka. It is a non-profit organization providing therapeutic services for all disabled people through Equine Therapy. The therapist had received training in Equine Therapy at the Special Equestrian Riding Therapy Centre (California, U.S.A.). The researcher conducted the interviews and focus group discussions with the aid of a therapist and trained personnel. The data was collected after obtaining informed consent. The participant could withdraw from the research study at any point in the study. The confidentiality of the participants was maintained by the researcher. The researcher provided references wherever required. The data collected was used only for research purposes.

Cases were studied by interviewing five caregivers with children with ASD and receiving Equine Therapy at Healing Horses, the NGO providing Equine Therapy for disabled persons. Participants whose children underwent the Equine Therapy at least for the last 6 months were recruited into study. The subjects were assessed on the impact of Equine Therapy on their children with ASD and stress, anxiety, social connectivity and family influence of caregivers. A semi-structured interview guide was prepared to capture the experiences of family caregivers before and after the Equine Therapy and used to enable the interviews. To counteract threats to the validity of the information obtained, discussions were conducted with the caregivers and the therapist of children with ASD on the subject of stress levels and burden. The interview revolved around examining the meaningfulness and comprehensiveness of the domains of stress that emerged during the interviewing stage.

## RESULTS

### Before Equine Therapy

**Table No. 1**

Themes	Subjective Experiences
Emotional burden	“I would take deep breaths and make sure I sounded calm, even though I didn’t feel so. I would have a hard time sleeping, thinking whether we would have to do this forever.” – Kairav’s mother
Social connectivity	“We had to hear our relatives tell us what terrible parents we were seeing our child behave and we would feel lost” – Sahil’s mother
Marital relations	“There was a time her father and I once stopped on the way to a new special school and he told me we cannot go everywhere and wasting our money while I sat quiet but mad inside thinking about my child.” – Aarohi’s mother
Anxiety Level	“We (parents) used to be very anxious while taking him outside and he (Kairav) would have to be with other people, wondering how he would respond.” – Kairav’s father
Family functioning	“Our elder daughter has compromised a lot of her roles in her friends’ circle to be with Aarti and her role as an elder sister is hard. At times, all of us seem to have a tiring day together.” – Aarti’s father

The current study results revealed that Equine Therapy was shown to provide a relaxed environment to the children with autism to communicate without invoking anxiety. The verbal communication of the child is stimulated as are interests in other physical objects. For example, in sensory issues, the child spends time lying on the horse, bareback; just hugging it and lying on it.

## After Equine Therapy

**Table No. 2**

Themes	Subjective Experiences
Emotional burden	“Seeing him (Kairav’s) improve and interact, respond to us and have less tantrums has been such a relief. Every weekend is a reason to smile for us now.” – Kairav’s mother
Social connectivity	“We have found a social connect with the caregivers here, now. We have also been able to get back to our friends after we brought them for (Sahil’s) therapy.” – Sahil’s mother
Marital relations	“After coming to the therapy, we (parents) have been able to find time to be with ourselves alone while our daughter is safe in therapy. This isn’t something rare anymore.” – Aarohi’s mother
Anxiety Level	“He (Kairav) has learnt to spend time alone and his tantrum levels have dropped significantly. We get anxious now mostly when he is outside and has chances to eat something outside his diet.” – Kairav’s father
Family functioning	“The involvement of her (Aarti’s) elder sister in the therapy has given her equal attention. I’m happy how the elder one enjoys riding and comes back gleaming. The therapy satisfies us altogether and we (family) have bonded over this strongly.” – Aarti’s father

The study results have shown development in motor skills of the children with autism; since the horse’s gait is similar to the human’s gait and gives balance to the body movements in rhythm. The complete outdoor experience in nature, social interaction and bonding with an animal improves cognition.

During the study, there has been improvement in strained marital relationships of parents after their child underwent Equine Therapy. Parenting a child with autism is very challenging which may take its toll on a marriage with the emotional and financial burden. During the therapeutic intervention, the caregivers expressed that as couples, they were able to find time and space to be together with the knowledge that their child is safe. It is possible that the parents would be able to take time for themselves in normal life just like how they were able to take time during therapy.

It was also found that there was a decrease in the levels of anxiety reported by parents after undergoing Equine Therapy. The presence of the parents while their child and therapist interacted, helped to align the child towards the interests he or she had. The therapist had advised that parents find time and space to be together with the knowledge

that their child was safe. Siblings were allowed to ride with the children with ASD at the riding grounds. This created an experience with family that was therapeutic and playful for the siblings.

## **DISCUSSION**

This study showed improvement in social interaction among children with autism.

Improvement was seen in general moods along with basic communication and motor skills. Children who had tantrums and outbursts or who seemed inexpressive were calmer and smiled more often without being prompted. As the child developed a relationship with the horse, he or she became more open towards his or her relations with people. These new and improved skills made the children confident and willing to learn new things at home and other familiar places.

The current study demonstrated that the experiences shared by the participants after undergoing Equine Therapy showed a trend in increase in social connectivity, general family functioning, social and communication skills in children with ASD and decrease in their psychological burden and hyperactivity. Many studies show that animal assisted therapies like Equine Therapy can have positive impacts on the anxiety levels of adults and children (Ewing, MacDonald, Taylor, & Bowers, 2007; Klontz, Bivens, Leinart, & Klontz, 2007; Masini, 2010; Schultz, Remick-Barlow, & Robbins, 2007; Yorke, Adams, & Coady, 2008). The caregivers expressed that the therapist's counseling, help from the support groups and the Equine Therapy program made an impact on the anxiety levels of parents, in a positive manner. There was a general improvement in family functioning after undergoing Equine Therapy. Participation of caregivers in different activities creates a bonding experience within the family unit.

## **LIMITATIONS**

The small sample size was a major limitation since there was only one centre available with Equine Therapy in India as was the limited time to spend in research. The observed trends would have been significant with a bigger sample compared to the current study. Also, the findings were based on self-reports of parents rather than objective observations.

## SUGGESTIONS

The study can be replicated with a larger sample with comparison of outcomes after participation in an Equine Therapy program with autistic children and caregivers attending another group therapy, provided with direct observation.

## CONCLUSION

The present study found improvement in communication skills, social interaction, body posture and motor skills of the children with autism spectrum disorders undergoing Equine therapy. Equine Therapy also had an impact over the stress levels of the caregivers due to the different aspects of the therapy that add to recreation, lessening of emotional burden and social connectivity. The current study results emphasize on the importance of referring children with autism spectrum disorders to Equine Therapy and its impact on reducing the stress levels of caregivers along with other effective therapeutic interventions.

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## **Transforming Tellur as an Open Defecation-Free Village: An Action Research**

<sup>1</sup>Divyashree K, <sup>2</sup>Dr. Channaveer R M, <sup>3</sup>Dr. Lakshmana G

### **Abstract**

For a large part of the Indian population, open defecation is not a problem. It is a habit, behaviour, a way of life. It is a practice that people receive from their elders, the only method of sanitation that people have ever known in many of the villages in India. Behavioural Change and Communication (BCC) and awareness generation is the only way to change something that has been accepted for generations. Starting with an open mind is the basic necessity for bringing changes in the community.

This study aimed to transform Tellur into an open defecation-free model village with an objective to assess the preparedness of the villagers for constructing and using the toilets which was to be done by changing their behaviour through BCC. This study adopted action research design. Participatory Rural Appraisal (PRA) and focus group discussion were used for collecting the data.

Out of 148 houses in the village, only six households had toilets during the initial assessment. It was found that the rest of the households were not ready to construct toilets. After 10 sessions of PRA tools and through the use of BCC and repeated efforts, about 76 families were ready to construct toilets. As a result of this intervention, 24 households constructed new Individual House Hold Latrines (IHHLs), in addition to this 6 households started effective use of their existing unused toilets. Thus the Behaviour Change and Communication brought changes among the community.

Through community mobilization, awareness and BCC, social workers can bring the desired change in the community. The present study is an example for this.

**Key Words:** Open defecation, Behaviour Change and Communication, Action research, Participatory Rural Appraisal

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## **INTRODUCTION**

Open defecation is the “practice of people defecating outside and not into a designated toilet”. The term is widely used in literature about water, sanitation, and hygiene (WASH) issues in developing countries. “The extent of open defecation in India presents a major health and safety issue. Worldwide, there are one billion people who do not have a toilet and Indians make up 60 percent of this number. Of this 60 percent, the majority comes from rural areas. Activists and the government have advocated for the building of shared community toilets as a solution to the problem, but ingrained social norms and attitudes stop people from using them” (IPFS). Even after constructing the toilets, villagers are not ready to come out of their traditional beliefs (Gods do not enter homes where toilets are constructed) and use the toilets properly. Instead of using them for sanitation purposes, they use them as just storerooms. Community participation is essential to make the people aware about healthy sanitation (Kumar, 2014; George, 2009).

## **REVIEW OF LITERATURE**

Way back in 1914, the editorial of the British Medical Journal discussed the issue of poor sanitation. In 1914, the East India Association presented an interesting paper read by a Colonel on “Position of sanitation in the administration of India” and raised the issue of scientific sanitation and strongly advocated the need for sanitation with the relevant education in the new department. The article explains that health depends on safe sanitation; education and sanitation are like mixing the cure, which prevents the diseases.

Luthi et al, (2009) conducted a study on community based approaches for addressing the urban sanitation challenges. This paper presented two approaches to solve sanitation problems. In this paper, the authors explained about the urban focused, household centered environmental sanitation and the rural focused, community led total sanitation to address the sanitation challenges. The community led total sanitation approach yielded good results in solving the sanitation problems locally. The household centered environmental sanitation yielded a good result in the urban cities of Africa, Asia and Latin America. From this review, it is understood that the appropriate model can be used to solve the sanitation problems based on the residence of population.

A study was conducted by Sharma & Bhide (2005), in Mumbai which emphasizes the collective and collaborative efforts of various stakeholders such as the government, funding agencies, civil society organizations and the affected community in solving the sanitation problems. The authors strongly believed that the participation of people is required in addressing the sanitation problem. Their participation would make them more responsible as they would enjoy the benefit of this programme. It would be more effective and efficient, if it is implemented with the support of the people. Hence, participatory approach leads to trust and transparency and therefore the facilitators can easily win the confidence of people.

Khanna & Das's (2015) study reported that poverty, gender biases, and dependency on males led the women to not demand toilet facilities. It was reported that when women or girls were going for open defecation they were facing sexual harassment, violence and thus insecurity. People mentioned that they feel 'shame' because others would see them when they were going for defecation and they were fearful of snakes and other poisonous animals.

A review of literature shows that open defecation is an issue in rural and remote areas, which needs to be addressed. Though we are in the-twenty-first century, people are still practicing traditional beliefs related to the use of toilets.

### **Statement of the problem:**

In spite of having so many programmes and schemes for eradicating open defecation, Tellur was still a village which considered constructing toilets and using them as being against their traditional beliefs. Overall in Tellur village only 6 households had built individual household latrines (IHHLs) among which only 2 were in use, the rest of the people used to go for open defecation. This was polluting the environment, along with negatively affecting the health of villagers. The lack of water access to individual households was also a challenge. An opportunity to create access to water, so as to create user-friendly IHHLs to make the village Open Defecation-Free (ODF) was the need of the hour. The ODF campaign based on a community driven approach to create a demand for IHHLs in the village was perceived as an opportunity for the internship action plan.

Community participation is an essential approach in sanitation programmes, to make the community members understand the need for eradicating open defecation and developing sanitation facilities. It gives the people a sense of community and benefits of their involvement.

### **Motivation for the study:**

The motivation behind choosing Tellur came from the rural camp in Tellur where the researcher was placed in order to fulfil academic requirements. The researcher came to know that there were only six toilets constructed by the people but only two were in working condition. Moreover during the camp, female students faced many problems regarding sanitation, which made the researcher critically analyse the actual problems faced by the resident females of that village. From there, was the origin of this action. With this background, the researcher studied the Swachh Bharat Abhiyan programme and also PRA tools for implementing that programme in Tellur village. Making a village open defecation-free is not an easy task; it takes a lot of time and efforts which can be put up only by a committed person.

### **Tellur Community Profile:**

Tellur is a small village/hamlet in Aland Taluk, situated in Gulbarga district in the northern part of Karnataka. It comes under Dannur Panchayat, a village situated 4 km away from the village with a Panchayat Development officer. It is located 42 km towards west from the district headquarters, Gulbarga; 611 km from the state capital Bengaluru. Tellur is surrounded by Omerga Taluk towards the north, Gulbarga Taluk towards the east, Afzalpur Taluk towards the south, and Akkalkot Taluk towards the west. The village falls under a drought-prone area, a majority of households depend on rain-fed agriculture and there are no allied activities; women, youth and farmers lack entrepreneurial and livelihood skills. Men earn and spend most of their earning on alcohol and gutkha (tobacco) consumption, women's labour is the main source of family support and most of the women are engaged in agricultural labour. Women experience discrimination, lack of confidence and support system to rise as entrepreneurs. Kannada is the local language here. The total population of Tellur is around 1163 which includes 648 males and 515 females living in 148 households. The total area of Tellur is 534 hectares.

## **METHODOLOGY**

### **Objectives of the Study:**

1. To create an open defecation-free society and hygienic environment in the selected village.
2. Make personal behaviour changes among the community people.
3. To make Tellur an open defecation-free model village.
4. Develop the social capital through the Swachh Bharat Abhiyan.

### **Field-based training and experience (Preparation for the field action):**

The department chose the first author to the internship programme of NCRI and supported the student for two months. The department sent the student to Kalike, an NGO in Yadgiri district, Karnataka, working towards sustainable community development in early childhood, education and WASH (Water, Sanitation and Hygiene). In Kalike, the researcher got detailed training in BCC, resource mobilisation and toilet construction for 10 days. The researcher also stayed for 2 days in a remote village, Alipur, in Yadgiri for a village study. It is an underdeveloped village with a population of around 3500 people, with 15 toilets among 548 families residing there.

The main objective of the village study was to observe the family members' behaviour, health and hygiene, and sanitation patterns. The researcher stayed with one family in the village to observe the behaviour of the people and fixed some components of the observation such as,

- Whether people use-the toilets in the village
- The amount of water the villagers use when they go for open defecation
- How they maintain the personal hygiene
- If they were washing their hands with soap or liquid upon return from open defecation
- What is their lifestyle and eating habits?
- At what time do women go for defecation and what are the difficulties faced by them?

The researcher got an overall idea about the behaviour of people in the village and their beliefs regarding open defecation in those two days. The village people believed that if they construct toilets, God would leave their homes and there would not be any prosperity afterwards. Since it was a conservative village people were very orthodox in nature, and were against the idea of having a toilet of their own. In BCC training, the researcher was taught how to change the behaviour and perspective of people through communication.

### **Process of field action at Tellur village**

After the 10-day training in Kalike, the researcher went back to Tellur to practice the PRA tools and BCC in order to bring a change in the mindset of the village people regarding safe sanitation, toilets and construction of toilets and make it an open defecation-free village. The first week was very difficult as the researcher didn't get

any kind of support from the villagers. As a part of carrying out BCC the researcher discussed with the villagers regularly and tried to understand and motivate them about the need for safe sanitation. The same was discussed among all the researchers and the strategies were changed. The researcher continued trying and gradually was successful in building a rapport with the community people. After getting a positive sign, the researcher practised the first and basic PRA tool, Transect Walk, which was very helpful in knowing the village structure in detail. Later on the researcher practised other tools too and also was able to conduct four focus group discussions with the villagers. The people were not ready initially to construct their own toilets because of poor socio-economic background and financial instability. The researcher informed them about Swachh Bharat Abhiyan, which would provide them with financial assistance to build toilets.

At last, three people came forward with the initiative of accepting the contract for construction of toilets for the villagers, which could be paid when the Swachh Bharat Abhiyan fund was released. Finally, after the hard work of 2 months, 24 toilets were constructed in the village, amongst which 4 were constructed by the household people themselves and 20 were built by the contractors. The issue of land for constructing toilets was also solved, as some of the villagers built the toilets in their own fields and thus their traditional beliefs were saved. Currently most of the villagers are using the toilets, which mainly help children, women, adolescent girls and elderly people. And now, 32 more families want to build their own toilets and that is a positive result of the researcher's hard work.

The source of data for the action research was collected from 148 households of Tellur. Action research "is either research initiated to solve an immediate problem or a reflective process of progressive problem solving led by individuals working with others in teams or as part of a community of practice to improve the way they address issues and solve problems". The researchers developed a tool to collect data from 148 households.

### **Activities undertaken**

The following activities were taken up

#### **I. Focus Group Discussion & Key Informant Interviews**

FGD guide focused on villagers' lifestyle and their daily habits on health and hygiene, problems related to health, and willingness of the people to construct IHHL. Four focus group discussions with four different types of groups namely, women, adolescents,

youth and the elderly were conducted and a discussion was held on the same research questions with the entire group. The researchers also visited the households and observed their habits in the early morning, afternoon and evening. The observation was done for about a week and the observations recorded. Based on the analysis, it was observed that changing the behaviour is an important aspect of the work

## **II. PRA TOOLS:**

### **1. Transect Walk:**

“It is a systematic walk along a defined path across the community/ project area together with the local people to explore the water and sanitation conditions by observing, asking, listening, looking and producing a transect diagram” (Chambers, 1992). The purpose of this study was to visit each and every household in the village and to understand the real situation of open defecation and hygiene and to know the number of toilets in the village. After the transect walk, the researchers came to know that there were 148 households in the village but only six toilets out of which only two were in working condition. Even institutions like schools and Anganwadis did not have toilet facilities. There was no drainage system in the village.

### **2. Services and Opportunities Map**

For practicing the services and opportunities map, the Venn diagram was conducted. Venn diagrams were developed by the logician John Venn. They represent an easy way to identify structures or relationship among organizations and how they are perceived in a community. A Venn diagram can be a useful tool in the decision making process in the interventions of many sectors. Nearly 15 people participated in the Venn diagram activity. The purpose of the Venn diagram practice was to make the people understand the available opportunities and services on health and hygiene and also the degree of relationship of the villagers with the available services. After conducting the Venn diagram, the researchers came to know that ASHA worker and ambulance services were working very well. The villagers had a strong relationship with these services. The researchers explained that there are many schemes for the development of sanitation and hygiene which are provided by the government. But people are not aware about personal as well as community hygiene schemes. The Gram Panchayat also did not have much of a relationship with Tellur village because it came under another village Panchayat.



### **3. Time Line:**

Time line is the graphical representation of a period of time, on which important events are marked. With the help of the villagers the researchers understood the history of the village. There was a discussion on the present condition and the past condition of the village. Through this activity the researchers were able to know about the village progress.

While participating in the time line activity people mentioned that the village was established in 1865-70. The school was established in 1937 but was not in good condition. In 2008 the ASHA worker facility came into the existence. The villagers suffered from serious diseases like Cholera in 1991. Many in 2012 got TB, Chikangunya and Dengue, which were the diseases which people generally suffered from in the village.

### **4. Seasonality Map:**

“A seasonal calendar is a participatory tool to explore seasonal changes (e.g. gender, specific workload, diseases, income and expenditure.)” (Chambers, 1992). Researchers conducted seasonality map to know about seasonal variations about rain, migration, income, employment, festivals and the like. It gave strategies to manage the seasonal variations based on which planning of various activities was done. It gave an idea about community work life of the people.

The seasonality map made the researchers understand that in the month of September, November and December the rate of migration is highest. June, July and August are considered as disease prone months and July receives more rain fall and generates more income than other months.

### **5. Resource Map:**

Resource maps are one of the most commonly used PRA tools. *Resource Map* “is a free, open-source tool that helps you make better decisions by giving you better insight into the location and distribution of your *resources*” (Chambers, 1992). The researchers conducted a resource map with the purpose of understanding the natural resources of this area, such as the rivers and fields. They sought to know the perception of people on available natural resources found in the community and how they were used. It gave an initiative for a discussion among the community people.

By conducting the resource map, the researchers came to know about the open defecation areas, ASHA worker and ambulance services.

## **6. Daily Activity Schedule:**

Daily activity schedules define all the different kinds of activities carried out in one day. They are particularly useful for looking at relative workloads between different groups in the community. Comparative studies show who works the longest hours, who concentrates on a few activities, who does a number of tasks in a day or who has the most of free time. The purpose of this activity was to know about the different people and how heavy their work load was. By this activity the researchers could know about the work schedules of the males and females separately and daily routine of the villagers.

By this activity researchers understood that men were working for more hours outside the home compared to women and men were spending most of their time in the fields and women shared household responsibilities completely.

## **7. Human Resource Map:**

Human resource map is an activity by which we can know about the available resources in the village. The purpose of this activity was to know about people's activities and lifestyle of the people. Through this activity, the details of human resource were obtained and presented in the background of the village.

## **8. Trend Analysis:**

A trend analysis is an aspect of technical analysis that tries to predict the future movement of a stock based on past data. Trend analysis is based on the idea that what has happened in the past will continue and this gives traders an idea of what will happen in the future. Trend analysis provides a good idea of the quantitative changes overtime in different aspects of village life, such as population, number of toilets and diseases.

This activity revealed that earlier six toilets were available: presently there are 23 toilets out of which six are being used. Before the researcher's intervention there were no drainage systems, after the intervention the condition was slightly better. In the village, there was good water facility. But the school and Anganwadi remained unchanged over the years.

## **9. Participatory Census Method:**

Participatory census method is an activity of PRA tools. It tells about the population of the village. The researchers conducted this activity and came to know about the village

population. By this activity, researchers came to know that there were 148 households in the village. Total population was 1163 which included 515 males and 648 females. In the whole village 120 children were going to school and 33 were dropouts.

### **10. Social Mapping:**

Social mapping “is a visual method of showing the relative location of households. The distribution of different types of people (such as male, female, adult, child, landed, landless, literate, illiterate) together with the social structure and institutions of an area” (Chambers, 1992). The researchers conducted this activity to know the current condition of the village and to know about their open defecation locations.

After conducting this activity, the researchers could understand the structure, resources and sources of livelihood, road facilities, schools, health centre and Anganwadi.

### **III. BEHAVIOUR CHANGE AND COMMUNICATION:**

Behaviour change communication (BCC) “is an interactive process of any intervention with individuals, communities and/or societies (as integrated with an overall program) to develop communication strategies to promote positive behaviours which are appropriate to their settings” (Family Health International, 1996).

#### **a. Preparing The Ground: Understanding and practicing activities.**

To start the work in the village, the researchers were in need of making a ground for further work. To begin with, the researchers met with the village leaders, PDO, ASHA worker as well as school and Anganwadi teachers to seek their support. To explain the main purpose of the study to the villagers, the researchers planned to conduct awareness activities. In those programmes the researchers invited all key persons and villagers to build a rapport along with spreading awareness. On the first day itself the researchers made the villagers draw a village map as it was the best activity to know about the present structure of the village.

#### **b. The Seeds of Change:**

There are some activities and events which are considered as the seeds of change. The researchers organised school events and conducted a rally to tell the people about how open defecation creates lot of problems. The researchers conducted programs in the evening and morning with both the women and men.

### **c. Nurturing Seeds of Change:**

Nurturing seeds of change activity is to address barriers which people face in the construction of toilets. The researchers discussed the toilet design and also about how to go about constructing the toilet. They also discussed the benefits of toilet construction with the villagers. So in the intervention, the researchers tried to increase the familiarity of villagers with the concept of the toilet.

### **d. Rewards (Harvesting the Fruits of Change)**

In this stage, the researchers called the people who constructed the toilet and conducted a meeting with them. In this meeting they also involved the people who were ready to construct the toilets and gave the reward of Samajhdar Star to the villagers who constructed the toilet. The objective was to motivate more villagers to come forward to construct toilets.

## **IV. MOBILIZATION ACTIVITIES**

The researchers visited the Panchayat, Taluk Panchayat, Zilla Panchayat, and Department of Rural Development for mobilizing the resources. There is a provision in Swachh Bharat Abhiyan for constructing the toilets. The researchers wrote many official letters, met the concerned authorities and brought them to the village. There were many interaction programs with the villagers by Panchayat members, officials, and leaders. The Panchayat was ready to extend the support and sanctioned Rs.15,000/- for SC/ST and Rs.12,000/- for OBC/General category villagers who were ready to construct toilets. The researchers had various sessions on the impact of open defecation on health, hygiene and already existing issues faced by women, children and the elderly.

## **V. OUTCOME ANALYSIS:**

Outcome analysis was done based on the

1. Number of people who submitted the applications
2. Number of toilets constructed
3. Number of toilets being used
4. Number of households ready to construct toilets

## **RESULTS**

Through the discussions with women and adolescent girls, the researcher came to know that they were facing many difficulties due to open defecation, especially during their menstruation and pregnancy intervals. The FGDs with the elderly and women revealed that there were many health related issues prevailing in the village such as Chikangunya, Malaria, Diarrhoea and Cholera. The elders expressed their difficulties regarding open defecation during night-time and distance was an issue. They also opined that if toilets were available in the house, it would be helpful for them. Women expressed shame about indulging in open fields for defecation, but they were helpless.

### **Number of applications and constructed**

After working six months with the villagers, the researchers got 76 Swachh Bharat applications for constructing toilets in the village, among which 24 applications were granted by the Panchayat. As a result of the intervention, 24 families constructed toilets and started to use them. The six families who already had toilets in their household, started using the toilets for sanitation. Apart from this, 32 families were ready to construct toilets. The researchers are coordinating with the officials, families, and villagers for this purpose.

## **DISCUSSION**

The study shows that the Government has introduced many programs, but people need constant support, guidance, and motivation to utilize them. The present action research shows how a Social Worker can bring change in the lives of people through sustained efforts. As studies report, lack of participation, apathy from the officials and beliefs are the major hurdles to achieve open defecation (Luthi, et.al, 2009); Kumar, 2014; George, 2009; Khanna & Das, 2015). Through the sustained efforts, networking, using PRA methods and community participation Social Workers could bring the desired changes. The present study demonstrates this. Social workers are the change agents, who can bring changes effectively by integrating theory, practice and research together. There are many social work institutions which can use this as a model to practice in their field work practice.

### **Challenges faced:**

During this action research the researcher faced a lot of challenges such as:-

- a. Lack of community participation in the beginning and suspicion that the researcher came with some vested interest rather than community welfare.
- b. The government officials had time consuming protocols for approval of files regarding Swachh Bharat Mission, its application filling, investigation and inspection (Red Tapism).
- c. There were no proper channels to get the funds for construction of toilets in the village, due to which people lost interest to continue further construction of toilets (Lack of proper channelization of funds).

### **CONCLUSION**

Currently, most of the villagers have understood the need for toilets, and 32 families have come forward to build toilets in their households and use them. The main aim is to make the village open defecation-free and be a model to the other villages. This initiative of the researchers may help the other community workers to develop an action plan for making open defecation-free villages and assist the people to develop a healthy environment in the villages and enjoy the benefits of having good sanitation facilities.

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## **Psychological Distress and Coping among the Spouses of Women with Postpartum Psychiatric Disorders**

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### **Abstract**

Childbirth is a happy moment for a couple as well as their family members. However, studies show that 1 to 2 in 1000 childbearing mothers are likely to develop postpartum psychiatric illness in 2 to 4 weeks following the delivery. It disturbs spouses and generates psychological distress. The current study aimed to understand the psychological distress and coping of spouses during the onset of PPD (Perinatal Psychiatric Disorder) in their wives.

The objective of the study is to know the level of psychological distress and coping of spouses of women with PPD. Descriptive research design has been adopted for this study. The universe of the study is spouses of women with a postpartum psychiatric illness seeking psychiatric care from NIMHANS, Bengaluru. A total of 30 spouses were selected for this study based on the convenient sampling method. Data was collected by deploying the interview method and administering the psychological distress scale of Kessler and Brief coping scale by Carver. Descriptive and inferential statistics were used for the analysis and interpretation of data.

53% of spouses of women with PPD have severe psychological distress, 20% of spouses have a low level of psychological distress during the IP Care of a wife. Nearly 40% of spouses have shown poor coping abilities to deal with psychological distress that occurred during the IP care of the wife.

Spouses of women with PPD express a significant level of psychological distress and poor coping with the same which calls for psychosocial interventions specifically for them.

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## INTRODUCTION

Pregnancy and childbirth are very precious moments for a couple. The family members including the couple have a positive image of the newborn baby and life after childbirth. The event of childbirth carries happiness and stress in equal amount for a couple. Yet, it is observed that 1 to 2 in 1000 child bearing women, are likely to develop psychiatric illness (Rai, Pathak, & Sharma, 2015). Postpartum psychiatric illness generates a significant amount of psychological distress among the spouses and influences the family atmosphere. However, post-delivery, women's health is emphasised and men's health is overlooked. Certain empirical evidence demonstrated that 11% of spouses developed clinically important psychological distress in 2 to 4 weeks followed by the delivery (Skari et al., 2002). The transition to parenthood is a major life event that affects all aspects of psychosocial functions. 38% of men developed minor psychiatric illnesses like depression and anxiety during their wives' hospitalisation for psychiatric care after childbirth (Lovestone & Kumar, 1993). The prevalence of psychiatric problems among couples with postpartum psychiatric illnesses is about 60% of spouses diagnosed with psychiatric illness in the 2 months following the onset of psychiatric illness in the wife (Zelkowitz & Milet, 2001). The above mentioned studies show that postpartum psychiatric illness generates a significant amount of psychological distress among the spouses.

Paternal depression has a negative impact on the family, including emotional and behavioural problems, which increases the conflict in marital relationships (Kim & Swain, 2007). The partners expressed a feeling of disappointment, confusion, frustration, apprehension, desperation, accusation, disturbed relationship, and many spouses opined that they are unable to help the wife to overcome the illness, which created frustration and anger (Engqvist & Nilsson, 2011). The majority of men described making many sacrifices to keep the relationship and the family together. Regaining the trust and confidence of the woman required time and was extremely difficult. It is difficult for men to cope with a situation where the wife behaves abnormally. Situations like this disturb the partner's psychological state as the partner bothers more about the prognosis of the wife's illness and caring of the new-born baby than himself (Skari et al., 2002). Most of the post-partum illnesses are acute in onset. Therefore, the partner's as well as the family members' immediate reaction is apprehension and the response to this kind of event could be seen as a crisis. Normally family members slip into a crisis, which men experience when the wife is hospitalised for psychiatric care illness (Rai, Pathak, & Sharma, 2015). In a study conducted in Australia, men in postnatal situations,

who had partners with PPD, were themselves at risk for experiencing psychological symptoms and disturbances. Differentiation of psychological syndromes is important. Higher rates of depressive disorder, non-specific psychological problems and problem fatigue were found (Roberts, Bushnell, Collings & Purdic, 2007).

Many cultural factors are associated with the treatment for mental illness and management. Perinatal mental illnesses are not considered as mental health problems in most rural parts of India as they are the most common health problems post-delivery and attributed to supernatural influences (Kulhara P, 2000). It causes significant psychosocial problems like stress, anxiety, disturbed relationships, disturbed routine activities, difficulties in managing the new-born and so on. The spouse and family seek faith healers' interventions to resolve the problem of women as well as spouses (Ramakrishna, 2017). Studies show that for partners of those affected by PPD, the period after the childbirth is a stressful one since the illness is unpredictable and occurs suddenly. Men experience frustration and confusion while facing the situation and coping with the stress.

## **METHODOLOGY**

The objective of the study is to know the level of psychological distress and coping of spouses of women with PPD. The aim of the study is to explore the psychological and emotional difficulties that spouses experience when their wives developed post-partum psychiatric illness. The Cross-sectional and Descriptive research design was adopted for the study. Convenient sampling method was chosen for selection of the sample. The universe of the study was spouses of women with a post-partum psychiatric illness who visited NIMHANS seeking psychiatric inpatient care. The sample was selected based on the inclusion criteria which were spouses who spoke Kannada, English and Telugu languages and spouses below 45 years. Spouses with a past history of psychiatric illness and spouses who had applied for legal separation were excluded from the study. Informed consent was obtained from participants. Interview method was employed for data collection. The researcher prepared a demographic data sheet to collect the demographic details. Psychological Distress Scale (Kessler et al., 2003) was administered for measuring the psychological distress. Higher the score (>30) meant high psychological distress; a moderate score (20 - 24) meant that stress is moderate and a lower score (< 20) meant lower psychological distress. The brief coping scale (Carver et al., 1997)

was administered to understand the coping patterns of spouses. It is a 4-points Likert type of 28-items scale which consists of 14 domains. The scale was described based on the responses given to each item. Ethical clearance was taken from NIMHANS Ethical Committee. SPSS version 25 has been utilized for analysis of the data.

## RESULTS

**Table:1**

Demographic Variable (Spouse)				% (N=30)	
<b>1</b>	<b>Age</b>	<b>%(n=30)</b>	<b>4</b>	<b>Occupation</b>	<b>%(n=30)</b>
	20-25	6.67		Skilled	73.33
	25-30	23.33		Semi-Skilled	10.00
	30-35	46.67		Unskilled	16.67
	35-40	23.33	<b>5</b>	<b>Economic status</b>	
<b>2</b>	<b>Education</b>			APL	40.00
	Primary	20.00		BPL	60.00
	Higher Primary	43.33	<b>6</b>	<b>Religion</b>	
	PUC	6.67		Hindu	93.33
	Graduation	23.33		Christian	0.00
	PG	6.67		Muslim	6.67
<b>3</b>	<b>Marriage Years</b>			Other	0.00
	1--3	40.00	<b>7</b>	<b>Region</b>	
	3--6	43.33		Urban	33.33
	6--9	6.67		Rural	66.67
	9--12	10.00			

In the demographic characteristic of the respondents, 46.67% were 30 to 35 years old, 23.33% were aged between 25 to 30 and 35 to 40. 43.33% had attained higher primary education and 23.33% had graduated, 6.67% were postgraduates. 43.33% were married for 3 to 6 years. 73.33% had skilled employment, 16.67% were engaged in unskilled employment. 60% were BPL holders. A majority (93.33%) were Hindus and 66.67% came from rural areas.

**Table 2**

Demographic Variable (Patient)			% (N=30)	
1. Age	2 Education		3 Occupation	
20-25	50.00	Primary	33.33	Employees 10.00
25-30	36.67	Higher Primary	20.00	Home Maker 90.00
30- 35	13.33	PUC	13.33	
35-40		Graduation	23.33	
		PG	10.00	

With regard to demographic details of the patient, 50% were aged from 20 to 25 years, 36.67% were aged between 25 and 30. 33.33% were educated till primary, 23.33% were graduates and 10% had attained postgraduate degree. A majority (90%) of the patients, were homemakers.

**Table 3**

Illness related Variable			% (N=30)		
Diagnosis	F	%(N=30)	Nature of Onset	F	%(N=30)
Postpartum psychosis	22	73.33	Acute	8	26.67
Depression	3	10.00	Insidious	22	73.33
Mania with psychotic symptoms	5	16.67	<b>The course of the illness</b>		
<b>Duration of Illness</b>			Continuous	30	100.00
Below 3 month	21	70.00	Episodic	0	0.00
3 months to 6 months	5	16.67	<b>Bonding with the baby (Objective)</b>		
6 months to 1 years	0	0.00	Adequate	7	23.33
1 years and above	4	13.33	Inadequate	23	76.67

With regard to the illness of the patients, 73.33% were diagnosed with postpartum psychosis, 16.67% had 1st episode mania with psychotic symptoms, 73.33% had illness of an insidious nature and the course of the illness was continuous for all. The illness duration of a majority, (70%), was below 3 months, that of 16.67% was between 3 to 6 months, almost 76.67% of the patients' objective bonding with the baby was inadequate and most of the time these babies were cared for by another member of the family.

**Table 4**

<b>Psychological Distress</b>		<b>% (N=30)</b>
<b>Psychological Distress Level</b>	<b>F</b>	<b>% (N=30)</b>
Likely to be well	4	13.33
Mild	7	23.33
Moderate	4	13.33
Severe	16	53.33

With regard to psychological distresses, a majority, 53.33% of the spouses, had severe level of psychological distress during the past and after their wives were hospitalised for treatment, 23.33% spouses suffered from mild psychological distress, 13.33% were in moderate psychological distress. Only 13.33% were found to be well when the wives were admitted for treatment.

**Table 5**

<b>Brief Coping (Adaptive Items)</b>				<b>% (N=30)</b>		
<b>Brief Coping Domains</b>	<b>Inadequately Doing (2 to 4)</b>	<b>% (N=30)</b>	<b>Moderately Doing 5 to 7</b>	<b>% (N=30)</b>	<b>Adequately Doing 8 to 10</b>	<b>% (N=30)</b>
Active coping	7.00	23.33	18.00	60.00	5.00	16.67
Use of emotional support	15.00	50.00	15.00	50.00	0.00	0.00
Use of instrumental support	11.00	36.67	17.00	56.67	2.00	6.67
Positive reframing	14.00	46.67	16.00	53.33	0.00	0.00
Planning	18.00	60.00	10.00	33.33	2.00	6.67
Humour	30.00	100.00	0.00	0.00	0.00	0.00
Acceptance	8.00	26.67	17.00	56.67	5.00	16.67
Religion	21.00	70.00	7.00	23.33	2.00	6.67

**Two Category model of brief coping developed by Meyer (Su XY et al 2015).**

In the above Table, 23.33% and 60% had inadequate and moderate coping difficulties in actively coping with stress and they were unable to focus on other tasks and unable to make the existing condition better. 50% of spouses had not obtained any emotional support from anyone. A majority, 56.67% of spouses, were found to have moderately received instrumental support like getting advice or help from others and 36.67% were found receiving very less of this kind of support. 53.33% of respondents did not perceive any positivity in the situation. 60% of the respondents were inadequately taking steps to come up with a strategy or plan to make the situation better and prevent the repetition of the condition. Almost all the respondents were serious about the situation and not considering it with any degree of humour. 56.67% moderately accepted the fact of the illness and expressed that they were learning to live with it and 26.67% felt inadequate in coping with the same. A majority, 70%, were not practising any religious activity to cope with current stress, 6.67% of spouses were adequately involved in performing religious activities.

**Table 6**

<b>Brief Coping (Maladaptive items)</b>						<b>% (N=30)</b>
<b>Brief Coping Domains</b>	<b>Not at all Doing 2 to 4</b>	<b>% (N=30)</b>	<b>Moderate Doing 5 to 7</b>	<b>% (N=30)</b>	<b>Severely Doing 8 to 10</b>	<b>% (N=30)</b>
Self-distraction	19.00	63.33	11.00	36.67	0.00	0.00
Denial	24.00	80.00	5.00	16.67	1.00	3.33
Substance use	25.00	83.33	5.00	16.67	0.00	0.00
Behavioural disengagement	27.00	90.00	3.00	10.00	0.00	0.00
Venting	21.00	70.00	7.00	23.33	2.00	6.67
Self-blame	28.00	93.33	2.00	6.67	0.00	0.00

With regard to maladaptive coping, 63.33% of spouses were not at all shifting their attention and concentration to divert their mind on other tasks and 36.67% were moderately able to divert their minds on other work. 80% were not at all accepting and not ready to believe what had happened; only 16.67% moderately used substances to cope with the situation, a majority, 90%, expressed that they were able to deal with the current stress. 70% of spouses were not at all sharing their negative feelings and emotions with anyone and 23.33% shared negative emotions with someone. 93.33% were not blaming themselves for what had happened.

## **DISCUSSION**

The objective of the study was to know the level of psychological distress and coping of spouses of women with postpartum psychiatric illness. The main result of the study shows that a majority, around 53%, of spouses suffered from severe psychological distress during hospitalisation of their wives for psychiatric care. Most of the spouses experienced low mood, anhedonia, sleeplessness, fearfulness and dilemma of how to handle the situation and were unable to help their partners to recover from the illness. The result shows that most of the spouses had not practised any maladaptive coping such as the use of substances or disengagement with wife and family. However, they failed in coping with the situation in terms of not attending to their routine activities, not mingling and sharing their difficulties or seeking help from others. The spouses were unable to face the stress actively, had not used any instrumental and emotional support, did not have a clear plan in terms of handling stress, and most of them had not indulged in any religious practices to manage the stressful situation.

Perinatal Psychiatric Disorder (PPD) usually appears very suddenly, and in such a situation it is normal to go into a crisis, which follows certain stages, similar to the experience of the men in this study. There are four very distinct stages, crisis phase, reaction or recoil phase, the resolution phase and reorientation phase. (Engqvist, Inger, & Nilsson, 2011). With regard to the illness, most of the women with PPD were admitted to hospital. The onset was insidious and in the initial phase the patients were taken to faith healers, which could be regarded as additional stress to the spouse and caused more sadness and anxiety. A majority of the patients were diagnosed with postpartum psychosis so that it could be assumed that psychotic symptoms like suspiciousness and referential and persecutory delusions towards the spouse and baby led to neglect of the baby and triggered a lot of trouble with the spouse. Poor knowledge of the illness in spouses led to poor coping with the situation. PPD not only affects the woman herself, but also her husband and family (Roberts et al., 2006). Parenthood causes significant changes and has an influential psychological effect on both mothers and fathers. If the mother is incapable of caring for the baby when she is on PPD, showing no interest or interaction towards the baby, it creates an obligation on the father to take responsibility of the baby. Hence, while interacting with and caring for the child, the father experiences much psychological distress most of time (Edhborg, Lundh, Seimyr & Widström, 2003). In another study it was found that the incidence of paternal depression ranged from 1-2% in community samples and from 2-4.5% among the men whose partners were experiencing the PPD (Goodman, 2004). The current study indicates that for most fathers the birth of a healthy child does not provoke a clinically important stress response either in the

acute or in the later phase. The paternal psychological distress scores showed themselves to be severe after the wife developed PPD. Clinically important psychological distress and anxiety were reported by about 53.33% of the fathers, and clinically important depression was rare (1–2%). However, an alternative explanation is that previous studies may have confounded measures of psychological distress with clinical depression. This interpretation is supported by the fact that the prevalence of psychological distress immediately after birth in the present study is in accordance with recent reports on postpartum psychiatric illness.

Many spouses found it difficult to divert their minds from the wife's illness, were poor in using emotional support, were using instrumental support (56.67%) like advice and help from others moderately. Many spouses were not seeing any positive factor in the wife's condition and did not focus on the strengths of the wife. The spouses expressed that they were thinking about some strategy and plan to make the situation better. In the aftermath of the onset of the illness, the spouse's involvement with the wife decreased as the illness progressed and her abnormal behaviour towards him prevented him from viewing it with any degree of humour. A majority refused to accept the situation and were not involved in any religious activity to cope with the stress. However, many spouses did not demonstrate any maladaptive coping behaviour such as substance use, escaping from the responsibility and self-blame. However, spouses were not active in managing the situation.

The result of this study reveals that most of the spouses developed clinically important psychological distress followed by the hospitalisation of the wife. Their mental health was ignored while treating the wife and the psychological distress and pain had gone unnoticed. Due to factors like stigma, most of the spouses had not disclosed the situation to anyone and were reluctant to obtain social and emotional support. Spouses had not practised maladaptive coping. However, it was found that they had failed in coping with the stress in a satisfactory way by utilising available resources.

The current study demonstrates that the perinatal period is a most crucial period for the spouse as he plays a vital role in taking care of the wife and new-born along with occupational and household responsibilities. Hence, it is important to consider the spouse's mental health during the perinatal period and interventions like psycho-education, group intervention, normalisation, stress management, need-based intervention, support enhancement, liaison with local health workers for further services, family and couple interventions and referral services are to be provided to spouses.



Major limitations of the study are that the sample size of the study was very small, the study does not provide any intervention package for spouses, the study focuses only on the spouse's psychological distress, stress, coping and social support during the illness. Hence it is important to assess these factors from the beginning of the pregnancy and post-delivery of women with PPD. The study also suggests that a few studies conducted in the western context found that there is a reasonable likelihood that spouse will develop various kinds of mental illnesses like depression, anxiety and PTSD. Hence, a thorough study on their psychopathology may be planned in future.

## CONCLUSION

The study shows that there is a significant level of psychological distress in spouses during the hospitalisation of their wives for psychiatric care after childbirth. Sudden onset of illness and poor knowledge among the spouses about the PPD increases the level of clinically significant psychological distress. The nature of acute onset of the illness, abnormal behaviour of the wife towards the spouse and baby and a lack of positive thoughts about the newborn baby in the wife create confusion among the spouses in terms of coping with stress.

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## **Is Technology Use a boon or bane for child development? – A Qualitative Study**

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### **Abstract**

Technology is ruling the world and we find young minds at ease with technological devices. In today's world it has become inevitable in fostering the wellbeing of children.

This study employed qualitative methodology to know about the views of parents, teachers and children between the classes IV to VI on the use and impact of technological devices. Focus Group Discussions (FGDs) were conducted separately among all the three groups in a private CBSE school. The FGDs were audiotaped and then transcribed. Framework analytical approach was used for the analysis of the transcribed data.

The findings revealed that children spent at least 30 minutes to almost the entire day in different technological devices on a daily basis. A majority of the children used their parents' devices and some even had their own gadgets. Some children have a control over the usage and most need to be prompted/scolded/beaten by the parents to refrain from over-use. Schools encourage usage of internet by giving projects. Very few parents have enabled Parental Lock and do not supervise the children. Children did not feel their usage was an issue, but both the parents and teachers did.

This study, hence, provides evidence for application of assessments on harmful technological use and supplementing interventions that would help children limit the usage of technological devices.

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## **INTRODUCTION**

Technology use has spanned all walks of life. In today's scenario we see that technological devices like television, smart phones, computers/laptops and the internet are easily accessible to children. Livingstone and colleagues (2011) reported that children have easy access to technological devices and are at ease with them. At homes, we find children spending their time on these devices and they have become virtual playgrounds that forbid real playtime activity and social interaction thus encouraging a more sedentary lifestyle. On the other hand, we see children excelling in academics, good in self-learning, teaching their peers by using technology. This brings us to the question of whether children should be encouraged to use technological devices. This paper intends to present the nature of the use of electronic devices by children and the repercussions on parents, teachers and children themselves.

## **METHODOLOGY**

This study is a part of the findings of the needs assessment carried out for the Ph. D. study entitled, '*Effectiveness of Student Enrichment Programme by teachers for rural school children*'. The needs assessment aimed at identifying the current pressing needs of rural school children and one identified need was '**Education on stipulated use of Technological Devices**'.

The study was conducted in a private school affiliated to Central Board of Secondary Education in rural Karnataka. Ethical clearance for the study was obtained from the review boards of NIMHANS and the school. The needs assessment was carried out among children studying in classes IV to VI, their teachers and parents. The parents and teachers who participated in the study provided their consent and from the children their assent was taken along with parental consent prior to participation.

A Focus Group Discussion Guide was developed and was content-validated by four experts (a Professor and an Associate Professor in Psychiatric Social Work, a Research and Development Faculty with a Ph.D. in Education and a Ph.D. Scholar in Psychiatric Social Work). The FGD guide probed the nature and duration of the use of technological devices by children, reasons for use, issues faced by parents, teachers and children with respect to the child's use, opinion about the use of technological gadgets and assistance required in regulating the child's use. Purposive sampling method was used wherein participants were requested to participate. Those teachers, parents and children who gave consent/assent participated.

Consent from parents was taken when they came for the parents-teachers' meeting. The teachers initially oriented the parents about the study. Only those parents who agreed to participate were informed about the need and relevance of the study. None of the parents referred by the teachers dissented to participate in the study. The parents also provided their consent for their children to be part of the study. Following the parents' consent, the children's assent was taken. Among six parents Key Informant Interviews (KII) were conducted as FGD was not feasible. The details of the FGD/KII conducted are given in Table 1.

**Table 1**

S. No	Participant	Number of FGDs/IIIs	Number of Participants	Total Duration
1	Teachers	3 FGDs	7+8+8 (23)	3 hours (approx. 1 hour each)
2	Children	3 FGDs	11+12+12 (35)	3 hours (approx. 1 hour each)
3	Parents	2 FGDs	5+5 (10)	1 hour (approx. half an hour each)
		6 KIIs	6	1 hour (approx. 15 mins each)

FGDs/KIIs were conducted till data saturation occurred. All the interviews were audiotaped and later transcribed. Hand coding was done to arrive at codes and then themes were generated using constant comparative method.

## RESULTS

Of the 23 teachers who participated, 4 were males and 19 were females. The age distribution was between 24 to 41 years. Most of the teachers had a PG degree and Bachelors in Education. 15 were language teachers, 6 were subject teachers and the rest 2 were dance and arts teachers. They had an average of 7.5 years of teaching experience (1 year to 20 years). As already mentioned, 35 (males 16 & females 19) children studying in IV to VI classes ranging between 8 to 10 years (mean age = 9.5) participated in three FGDs. 16 parents (males 8 & females 8) whose age ranged between 30 to 47 years (mean age = 38.66) participated. 3 of them were not formally educated and 3 had completed high school, 2 had higher secondary education, 5 parents were undergraduates and 3 were postgraduates. 7 were homemakers, 4 were agricultural labourers and 5 were

employees in the IT sector.

The themes generated as a result of the thematic analysis are listed below:

1. Availability of technological devices
2. Children's activities with gadgets
3. Time spent on electronic devices
4. The child's skill in using gadgets
5. Parental negligence
6. Measures by parents to curb use
7. Using internet for academic purposes
8. Issues with the use of gadgets
9. Expected remedies

### **1. Availability of technological devices:**

Almost all the children had television sets in their homes. Among the 35 children who participated in the study, 3 had their own personal smart phones, 6 had their personal tablets and 7 of them had desktops and 9 had laptops. Some parents had given their kids their old phones as one male child who is studying in 6th standard said, *"My father gave me his old phone. It is broken but working"*. A majority of the children used either their parents' or relative's phones/laptops. Some of the excerpts are given below:

*"My father has a phone and tablet and my uncle has his laptop. I use them"*

*"My brother and I use our parents' phones. When we ask, they give us. If we want to access computers/internet for our projects, we use dad's phone which has internet or go to the nearby browsing centre when he is not available"*.

### **2. Children's activity with gadgets**

With regards to television, children spent most of their viewing time on cartoons. Some children were interested in programmes related to wildlife, travel and science. Boys were largely interested in watching wrestling and girls were interested in watching programmes that taught arts and crafts.

With regard to mobiles, children used them predominantly to play games like Candy Crush, Temple Run, Talking Tom and Subway Surfer. Boys reported that they were interested in playing games like Shadow Fight and Stick Cricket and girls said that they play Barbie and cooking games. Some used mobiles to listen to songs. Two children said that they chat with their relatives and friends using the mobile. Many children use YouTube to view movie songs, science experiments and art and craft shows.

Some of the statements shared by the children are given below:

*“After finishing my homework, I take my mother’s phone and play Pokemon Go and try to catch them”.*

*“Whenever I finish my work, I do whatever I desire on the mobile”.*

A father working in the IT sector said, *“My son watches films on YouTube, listens to songs and plays games. He likes fighting games only. He does not spend more than half an hour on this. Only when I am free, I allow him to use it. If I have work, he cannot use it. On the mobile he uses only YouTube to view songs and movies”.*

### **3. Time spent on electronic devices**

Children and parents reported that on an average the children spend around 30 minutes to 2 to 3 hours on mobiles. One fourth-standard boy said, *“In my mother’s phone I will usually be playing till the charge drops down to 15%”.* With respect to watching television, one mother reported, *“I have to tell her multiple times to put off the TV and start studying. She will not study at all. If she starts watching, she will just forget about the time”.*

Some children have a control over the use, as one male child in 5th standard expressed, *“I myself have a fixed time for using phones/tablets. I have a schedule like how much time I should use phones, how much time I should play and how much time I should read”.*

### **4. Child’s skill in using gadgets**

It was reported by most parents that the children need not be taught the use of any technological devices and they are capable of teaching the parents. One mother reported, *“No one needs to teach them. It’s very easy for them to use. I allow my son to use it for a substantial amount of time. If I don’t monitor the usage he will probably be with it full time”.* Children reported that they mostly learn by themselves and at times observe others and learn how to use.

## 5. Parental Negligence

Children reported that when there is no one to help them in their studies, they take help from the internet by viewing YouTube especially for science projects. Only 7 parents out of 23 knew about Parental Control Mode and only 4 activated them when they used to give their devices to their children. One mother reported, *“They are interested in computers. We have a computer and a laptop too. It is their will. They use computers for long periods but we don’t sit next to them when they are using the computer. We have installed internet. We have not enabled any Parental Control”*. Almost all the teachers remarked that parents are equally responsible for their children’s over use of technological devices. Some of the reasons given by teachers were: *“There are parents who want the child not to disturb them. So they just give them all the gadgets. They want to go out so they make the child watch television and they go. Here we monitor the children. In homes parents need to monitor”*.

*“They are providing phones, tablets, laptops and internet connections to the children but not monitoring them. Some parents do but not all. I wish all the parents would. They don’t know which sites the children are browsing. Nowadays parents are rich. Not only that, we are also getting gadgets at cheaper rates. They are leading affluent lifestyles”*.

## 6. Measures by Parents to curb the use

As mentioned earlier some parents have enabled Parental Control when their children are using electronic devices. One mother stated, *“On School days he does not use the computer. On leave days also he uses it for half an hour only. If we ask him to stop, he stops. We do not supervise when he is using the computer. He is not dependent on us. He uses it by himself. We have enabled Parental Control. Initially he used to use it for a long time and we felt that he was losing his concentration. When we told him about the disadvantages, he understood and stopped”*.

Another mother reported saying, *“In my house, they do not use the mobile much. If they want something they will ask and we will provide. At such times I download and give them. They mostly don’t use the mobile. Even if they use it, they do not switch on the internet. They just play the games that are already in the mobile and when we ask, they give it back”*. Hence most parents use statements like *“You will have eye problems if you watch TV or use mobile for a long time”*, *“You will lose your concentration if you do not limit your TV viewing or mobile/computer use”*, *“You will not get good marks”* and so on to limit the use of gadgets/television but only few children oblige. Most of the parents use punitive measures like commenting on the



child's academic performance, comparing the child with other children in the locality, scolding and corporal punishments when the child is not switching off television or stopping mobile/computer use.

Some of the excerpts from the interviews are: *"I have to forcibly take the device from him. First I will yell at him... I know that he will not listen... then I have to beat him. If he receives one or two beatings only he will listen. And you know what? That too will not last long. Within a few hours he will start using them again"*, *"My son is either immersed in TV or in mobile. If I remove both, he will become restless. I feel helpless. Every day I have to beg him to study"*. *"Games are very rare. If it is videos she would watch them the entire day. I have to snatch the mobile from her"*.

## **7. Using internet for academic purposes**

The present curriculum gives space for the child's self-exploration and learning. In the name of self-learning tasks, the child has to surf the internet or use computers to complete the self-learning tasks. Some of the statements shared by children, teachers and parents where the curriculum demands internet or computer use are stated below:

*"I will use mobile phones if there is any difficulty in the Self-Learning Task. I will search in the internet and do"* (Fourth standard girl). *"We give projects and at times the child has to collect details from the internet. We insist that the parents help them"* (Sixth standard teacher). *"My child has a tablet. I have installed an application named 'learn by yourself'. I have asked him to learn maths and other subjects with this app"* (Father of a fifth standard boy).

## **8. Issues with the use of gadgets**

One of the major issues reported by children is that they forget their home assignments or do not have time to complete them when they are using these devices. One 4th standard boy stated, *"Sometimes when I play video games, I forget all my homework"*. Parents felt that technology use is at times dominating the child's activities. Some of the statements shared by the parents were:

*"Technology use is here to stay. First is the mobile, and then TV. Cartoon channels are very disturbing. Education and health wise also they dominate and nowadays some get addicted. It is like they use them till we shout at them and tell them to stop. As parents, we have to control"*.

*"Many children are getting addicted to cartoon channels. Even my daughter, when we are watching other channels, would demand to watch them"*. Most of the teachers reported that parents are helpless and complain to them regarding the child's use of electronic devices.

One teacher stated, “Mostly when we have parent-teacher meetings, parents complain that they use either computer (internet) or mobile or television. They will never spend time on completing their lessons. That is one of the major complaints from the parents”.

Another teacher mentioned that physical activity is less among children of this era saying, “Parents say that even if we push them outside saying ‘Go out and play’, they don’t go. They always watch television or use mobiles. They are not playing outdoor games nowadays”.

Issues with respect to unavoidable adult content, watching pornography, change in attitude because of wrong messages from television/other media were also reported by teachers. “We give projects and at times the child has to collect details from the internet. We insist that the parents help them. But there will be some adult stuff that would appear as advertisements. We don’t know how all these can be avoided”.

“We faced an issue where a boy who is studying in the fourth standard was using the internet for watching porn sites in the absence of parents. He used to lock the room and watch. When asked where he learnt the habit, he revealed that some big boys were talking and he had heard from them. I just typed in Google and it came on. Every day he used to watch closing the door and the parents never used to check on him. This was by a group of friends. Only after four months one boy complained that the boy was calling him and he was not interested in going. We asked him what he saw and he told us. Children can use internet or mobile but it should be monitored by the parents”.

“Even primary school children are saying ‘I love you’ to their opposite genders. When we ask the children if they don’t have parents, whom they can love, they say that this love is entirely different. This I am telling about children in first standard also. They tell me. ‘Ma’am you don’t know. It is the love that comes in television”.

## **9. Expected remedies**

This section presents the expectation of teachers from parents and the statements of parents and teachers with regards to implementation of education on the stipulated use of electronic devices. Some of them are:

*“Children need to be taught how to avoid media, what are the solutions, etc”* -(Mother of a 6th standard girl).

*We need to educate children on how to use technology, how to stay away from bad things. That needs to be included”* - (Fifth standard teacher).

*“Here we monitor the children. At home, the parents need to monitor them”*-(Fourth standard teacher).

*“My only observation is that social awareness should be included for children before seventh class only. Nowadays we hear about games like Blue Whale. The training or awareness should not induce curiosity among children to play that game but it should focus on the negative impact”*- (Father of a fifth standard boy).

## **DISCUSSION**

Downey, Hayes and O’Neill (2007) conducted a study in Ireland among 10 primary schools using mixed method among children, teachers and parents to explore the intersection between children’s play and technology. It was found that children often involve in outdoor games when they are with their friends and spend time with electronic devices when in solitude. In the present study children reported that they prefer outdoor play when they get bored with the use of gadgets. Parents reported that they could see children initially spending long hours in technological devices but they gradually reduce time when they do not find new or interesting games/applications/programmes. In an Ireland study, the researchers’ reported that teachers were more concerned with their wards’ use of electronic devices than parents. In this study also similar concern was reported by teachers than parents.

Hatch (2011) identified the merits of technology use as: children keep themselves updated, helps the child to be on par with his/her peers, enhances the child’s visual reasoning ability and helps parents to keep track of children. Some of the demerits reported were - risk to the child’s privacy, decrease in the ability to multitask, health issues (sedentary lifestyle, obesity) and changing social norms. This study also identified some concomitant findings wherein all the participants felt that technology use helps children to keep themselves updated and face the competitive world. Children and teachers reported that they are not able to concentrate or complete the assignments due to unstipulated use of technological devices. Parents also reported that such use is disturbing the children’s academic performance and they spend much time on insisting that the children regulate or stop using them.

A qualitative study conducted among children between the ages 0 to 9 across seven countries (Belgium, Czech Republic, Finland, Germany, Italy, Russia and United Kingdom) in 2015 revealed that today’s children are raised in media-rich homes and

are naïve with regard to digital devices. Children are little aware of risks and benefits from internet use whereas parents see digital technologies as positive but face difficulty when it comes to regulation of children's use and employ many restrictive strategies. The study identified that children learn by observing the elders and are accessible to incidental inappropriate content, health or social impacts of using digital technologies especially with regards to internet use. The findings concur with the present study results.

## CONCLUSION

The study findings suggest that parents need to be provided awareness on the importance of direct and indirect parental supervision when their children are using technological devices. It also unveils space for the inclusion of education on stipulated use of electronic devices in the school mental health curriculum. It also highlights the need for education of teachers on regulating the child's use of technology especially internet, as teachers serve as instruments for the child's internet use by giving projects/assignments. The study also opens avenue for assessment and detailed evaluation to prevent harmful use of electronic devices among budding minds.

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## **Psychosocial Group Intervention for Siblings of Children with Autism Spectrum Disorders(ASD)**

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### **Abstract**

Researches that focused on families of children with developmental disabilities have often looked upon parents and siblings of children (diagnosed with disabilities) as a group who might be at an increased risk of psychological problems. In particular, there are a variety of challenges that may be faced by other children in the family as a direct or indirect consequence of having a brother or sister with ASD. These challenges include feeling isolated due to lack of attention from parents, lack of understanding of ASD and related problems leading to difficulty in coping with the situation and distress or embarrassment at the behaviours of the affected siblings.

### **To objective of the study is**

To conduct psycho-social intervention module for siblings of ASD to:

- a) Improve their knowledge, coping and adjustment, sibling relationship
- b) Reduce their behavioural problems

A self-selected sample of 24 siblings, with typical development (ages 8-12 years) of children with ASD, participated in the sibling groups. Autism Knowledge Measure for Young Children, What It's like to have a brother or sister with a Developmental Disorder (Coping/Adjustment Scale), Sibling Relationship Questionnaire and Strength & Difficulty Questionnaires were administered pre- and post-intervention.

Sibling knowledge scores increased ( $p < 0.001$ ) from pre to post-intervention. Comparisons of Coping/Adjustment scales and some subscales of SRQ and SDQ pre and post-intervention scores across sibling groups showed significant difference ( $p < 0.001$ ).

The results were encouraging and contribute to the concept of interventions meeting the needs of siblings of children with ASD.

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## INTRODUCTION

Autism Spectrum Disorder (ASD) is a lifelong and pervasive developmental disability. Impairments are mainly in three key areas (triad of impairment): Social impairment, verbal and non- verbal language impairment and repetitive/stereotyped activities. Recent studies have shown an increase in the prevalence of ASD . In India, more than 10 million children suffer from autism, about 1 to 1.5 per cent autistic children between ages two and nine in India, “that means a prevalence rate of 1 in 66” (Silberberg et al., 2013). Its occurrence is generally equal across all cultures, geographic areas, and socio-economic groups (Wolfberg, 1999).

The sibling relationship is unique in that, it lasts the longest of all human relationships. Sibling relationships afford unique opportunities for child development. They offer a way for children to develop cognitively and socially. ASD represents a challenge to any family environment, particularly for typically developing children growing up with a sibling who has autism.

Siblings of children with autism have unique challenges; these include encountering negative reactions from the public due to the stereotypical, repetitive, and unpredictable behaviour of the child with autism who appears physically normal, as well as having to cope with the skill deficits and difficult behaviours of the child with autism (Morgan, 1988; Roeyers & Mycke, 1995). Moreover, several studies have reported greater emotional and/or behavioural problems in siblings of children with autism in comparison to siblings of children with any other disability or no disability (Bagenholm & Gillberg, 1991; Fisman et al., 1996; Gold, 1993; Rodrigue, Geffken, & Morgan, 1993). Consequently, sibling support groups for siblings of children with autism may be particularly needed and valuable. The current literature on ASD in India has predominantly focused on reporting symptoms and profiles of small samples of patients from specialist centers or special schools (Juneja, Sharma, & Mukherjee, 2010; Kalra, Seth, & Sapra, 2005; Thomas, 2011). While there is a growing body of literature which has explored the impact of other developmental disabilities on Indian families and the accompanying social ostracism or stigma that they face (Dhar, 2009; Edwardraj, et al., 2010; Gupta A, 2005; Kembhavi, 2009), there is comparatively little work which has explored the impact of ASD. However global research literature focused on families of children with developmental disabilities has often been designed to consider evidence that parents and siblings might be at increased risk of psychological problems as a result of the presence of a child with disabilities (Dodd, 2004).

Thus, there is a need to enable them to deal with the problems they are facing because of a child with ASD. A number of psychosocial interventions offered to family members with people of autism have been developing with increasing sophistication and cost efficacy. Family management interventions such as behaviour family therapy, family psycho education, multiple family group intervention and family consultation have shown positive outcomes both for the ASD children and their families. Research has suggested that one of the most effective ways of promoting well-being and positive adjustment in siblings of children with ASD is to involve them in a support group or program (O'Brien et al., 2009). One of the frameworks for this study was Family Systems Theory.

There are no published research studies, which discuss the development and feasibility of psycho social intervention programs on the assessed needs of siblings of the child with ASD in India. This study is thus an attempt to test the feasibility of psychosocial intervention programs tailored for siblings of children with ASD, based on their needs, to help them cope better with the siblings' condition and take care of themselves.

## **METHODOLOGY**

### **Recruitment**

The term *sibling* refers to typically developed siblings of children with ASD. All siblings of children with ASD (going to special schools meant exclusively for children with ASD) in Bengaluru formed the population. Out of the 103 children with ASD 70 had normal siblings. The researcher met the parents of those children. 47 normal siblings did not meet inclusion and exclusion criteria, 8 siblings' parents didn't want to participate in the study because of lack of time, busy work schedule and distance from schools. Some of them didn't want to disclose the diagnosis with the normal sibling. 31 normal siblings were ready to participate in the study. After the intervention, post assessment was carried out. Seven study participants were excluded because they discontinued during the intervention. Thus, after the exclusion of those participants, the number of participants for the data analysis was 24. Samples were selected through convenient sampling. Siblings of children with ASD were recruited adhering to the eligibility criteria and informed consent and assent. The study got ethical clearance from the NIMHANS Ethics Committee.

## **Evaluation Procedures**

### **Pre- and Post- assessments**

Parent evaluations were completed before, after one month and after the third month of the intervention.

### **Measures**

*Autism Knowledge Measure for Young Children (Perry, 1989)*. This is a 20-items measure intended to tap children's basic knowledge of the characteristics and causes of autism (e.g., 'Do autistic kids have something wrong in their brain that makes them act that way?'). This measure was administered orally to both pre and post-testing. The researcher checked test retest reliability. The paired t test indicated no significant difference between pre and post mean scores (pre  $M=7.80(\pm.83)$ , post  $M=8.0(\pm.70)$ ) and high positive correlation (.84) was observed between pre and post scores indicating high reliability.

*What It's Like To Have a Brother or Sister With a Developmental Disorder (Coping/Adjustment Scale; Perry, 1989)*. This questionnaire was developed as a measure of coping/adjustment, based on the clinical and empirical literature, and designed to tap issues deemed important for psychosocial adjustment specific to the situation of having a sibling with Developmental Disability. It is a 24-item questionnaire with a 4-point, verbally anchored Likert scale, as well as two open-ended items intended to measure children's adjustment. The researcher checked test retest reliability; the paired t test indicated no significant difference between pre and post means (pre  $M= 60.0 (\pm.2.73)$ , post  $M=59.8(\pm3.11)$ ) and high positive correlation (.99) was observed between pre and post scores indicating high reliability.

*Sibling Relationship Questionnaire (Furman & Buhrmester, 1985)*. The Sibling Relationship Questionnaire(SRQ) is a 5-point Likert-type format (1 = hardly at all, 2= not too much, 3 = somewhat, 4= very much, 5= extremely much). For the current study, two subscales will be used - the Warmth/Closeness measure that has 21 items and Conflict that has 9 items.

*The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997)*. This is a brief behavioural screening questionnaire for 3-16 year olds. It exists in several versions to meet the needs of researchers, clinicians and educationalists. Each version includes



between one and three of the following components: 1) emotional symptoms (5 items) 2) conduct problems (5 items) 3) hyperactivity/inattention (5 items) 4) peer relationship problems (5 items) 5) pro-social behaviour (5 items).

### Statistical analysis

The assumption of normality was tested using the Shapiro-Wilk *W* test and significant deviation was not found for most of the variables. Repeated measures ANOVAs were conducted to assess the main effects of time (before, after 1 month & 3 months after treatment).

## RESULTS

**Table 1: Participants' Details**

Variables		Frequency	Percentage
Gender	Girl	14	58
	Boy	10	42
Religion	Hindu	14	58
	Christian	7	29.5
	Muslim	3	12.5
Age in years	8	5	21
	9	5	21
	10	7	30
	11	4	16
	12	3	12
Health status	Normal	23	96
	Asthma	1	4
Birth order	Elder	9	37
	Younger	15	63

**Sibling Characteristics:** The sample consisted of 24 well siblings (10 boys, 14 girls). The siblings ranged in age from 8 to 12 years (M age = 9.8 years). The children with ASD ranged in age from 4 to 16 years (M age = 11.5 years). Most of the siblings were female children, (58%) and most of them belonged to Hindu religion (58%). Most of them were younger (63%) to the child with ASD. 96% participants appeared to have normal health status, only one child had asthma.

**Pre-Post Evaluations****Table 2: Means and Standard Deviations on the Group Evaluation over the period of 3 Months (RMANOVA)**

Variables		Base line Mean(SD)	Post 1 Assessment Mean(SD)	Post 2 Assessment Mean(SD)	RMANOVA
					P value
Autism knowledge		6.85(1.84)	14.80(1.76)	14.85(1.53)	168.3
Coping/ adjustment	Knowledge	11.75(2.24)	10.85(2.03)	10.8(2.04)	42.56
	Chores/ expectation	9.75(2.19)	8.85(2.10)	8.75(2.04)	
	School/ friends	11.05(2.7)	9(1.89)	8.85(1.92)	
	Anger/ resentment	9.85(2.51)	8.15(2.03)	7.9(1.74)	
	Mental health	8.90(1.91)	7.95(1.73)	7.7(1.65)	
	Future concern	8.20(1.93)	7.15(1.56)	6.85(1.46)	
Sibling relationship questionnaire	(warmth)	10.81(1.16)	11.68(1.28)	12.56(1.26)	66.43
	(conflict)	6.08(1.17)	7.33(1)	7.33(1)	
Strength & difficulty questionnaire	Emotional problems	1.40(1.18)	1.40(1.18)	1.35(1.18)	0.330
	Conduct problems	2.05(1.5)	2.10(1.48)	2.05(1.53)	0.506
	Hyper activity	2.55(1.23)	2.35(1.18)	2.25(1.20)	0.199
	Peer problems	3.30(1.92)	2.60(1.50)	2.50(1.39)	0.009
	Prosocial score	4.85(2.41)	5.95(2.23)	6.15(2.10)	0.001

Repeated measures analyses of variance (ANOVAs) were conducted to assess the main effects of time (pre - post intervention) on the dependent measures of sibling knowledge, coping, sibling relationship and behavioural problems. As displayed in Table II, siblings' knowledge about disability and their coping' increased from pre to post intervention and maintained that in the 3- month follow-up period.

The reports of both the siblings and parents x about the siblings' interaction and relationship with each other increased from pre to post intervention and was maintained

in the three months period. There was significant change in the domains of peer problems and prosocial score before and after the intervention. The result indicates that siblings of children with ASD had repaired their problems regarding peer behaviour and improved prosocial behaviour after the group intervention and maintained that in the 3 months' follow-up period.

## **DISCUSSION**

The existing literature suggests that siblings of children with ASD expressed their needs for better knowledge about their brother's or sister's condition. Furthermore, previous results of psychosocial interventions suggested that some siblings have difficulties related to childhood illness or disability. But many reported to be bewildered and concerned with limited knowledge of the condition or disorder as well as their own support networks being reduced (Lobato & Kao, 2002; Roeyers, & Mycke, 1995; Glasberg, 2000). The present study also considered knowledge as an important component in the siblings' psychosocial intervention program and was determined as an outcome variable.

The present study result showed significant changes in the siblings' coping/adjustment problems in six sub-domains and overall coping/adjustment scores in post assessments after attending group intervention. Therefore, it appears that the sibling support group, in the present study, may have been successful in helping the sibling to adjust with the brother's or sister's condition, and as a result, the brother's or sister's behaviours. Siblings are also perceived as a unique source of emotional support beyond parental support and peer acceptance (Seigner, 1998). This relationship is an integral component in providing an opportunity for learning and practicing social skills, emotional regulation and expression, interpersonal skills, and empathy training (Buhrmester & Furman, 1990). Siblings of children with autism have a unique perspective on their sibling relationship compared with siblings of children with other disabilities (Hastings, 2003). Siblings of children with autism experience communicative, social and behavioral challenges that are uniquely different from those of children with other disabilities (Bagenholm & Gillberg, 1991).

The result showed significant changes in sibling relationships as measured by parents on SRQ subscales. On warmth/closeness sub scale at the post-intervention interview, parents responded that the siblings' score on prosocial behaviour, affection, similarity

and admiration by the sibling got significantly increased. Knott et al. (1995) found that ASD sibling pairs had fewer prosocial initiated interactions (fewer verbal exchanges or behaviors related to sharing, cooperation and affection) than Down Syndrome sibling dyads. Similarly, the ASD siblings responded less to their siblings' prosocial initiations compared to Down Syndrome siblings. In the present study the intervention session on autism knowledge helped them to understand more about the condition which helped them to have more prosocial behaviour and affection towards the child with ASD. When the sibling started having more sharing and activities with the child with ASD, it improved her or his admiration.

The present study result showed significant changes in the siblings' peer problems and prosocial behaviour scores in post assessments after attending the group intervention. Peer problems decreased and prosocial scores increased. These scores were maintained during the three month follow-ups. These results are interesting due to the following reasons: It may be that siblings were effectively able to utilize and maintain new behavioral techniques or coping skills. The second reason may be the result of the participants' improved social and family support. Therefore, it appears that the sibling support group in the present study may have been successful in helping the sibling to adjust and cope with the brother or sister's condition. This finding was in accordance with previous results (Lobato & Kao, 2002) which have compared pre and post assessments. It showed that the parental report of global behavioral problems decreased, both internalizing and externalizing behaviors significantly decreased. However, during the 3 month follow-up only the externalizing behavior continued to decrease, while internalizing behavior stabilized.

## **CONCLUSION**

The study did not follow randomization, because participants were self-selected, a majority of the siblings were from highly motivated and possibly resourceful families which may affect the generalizability of the present results. The results also showed that autism knowledge, sibling relationship, adjustment and behavioural problems have significantly improved after three months of psychosocial intervention. It indicates that this intervention program may be useful in clinical social work interventions aiming at improving ASD-related knowledge and positive coping strategies for siblings of children with ASD.

## **Declaration of conflict of interest**

There is no conflict of interest between the authors.

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## **Effectiveness of a Brief Psychoeducation for the Husbands of Women with Postpartum Psychiatric Disorders**

<sup>1</sup>Veenashree, <sup>2</sup>N Janardhana

### **Abstract**

Whole, stretched maternity and mental health services do not provide fathers with information and support, despite the wider benefits that this would have in the treatment process.

This study made an attempt to design a 3-session based brief psychoeducation for the husbands of women with postpartum psychiatric disorders (WWPPD) and to assess its effectiveness in enhancing their knowledge about the condition of their spouses by using a quasi-experimental research design with 21 participants. Assessment was done at 3 levels i.e., Pre (baseline), Post (immediately after the intervention) and Follow-up (1 month after the intervention). The Friedman test and descriptive statistics were used to analyze the data.

Results found that the brief psychoeducation helped in enhancing the knowledge of the participants about PPD. This study has strong implications for Social Work Practice in this area at both clinical (medical and psychiatry settings) and nonclinical settings at preventive and promotive level.

**Key words:** Postpartum Psychiatric Disorders, Knowledge, Brief Psychoeducation, Husbands

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## INTRODUCTION

Pregnancy and childbirth bring strong physical, psychological, and social changes in the lives of both the partners (Matthey et al., 2000; Gawlik et al., 2014). If a woman develops perinatal psychiatric disorders (PPD) it further escalates these changes ranging from physical adjustment to emotional turmoil.

It is very essential to understand the impact of PPD on men because of the fact that the husbands' role is not limited to being a relative of a person having PPD. They themselves undergo a transition period as fathers. Both in western and Asian societies a husband typically turns to his partner for emotional support after the birth of a baby (Zelkowitz & Milet., 1997, Dennis & Ross., 2006; Gaawlik et al., 2014).

The partners/husbands of women with PPD are themselves at risk of developing mental health problems especially with high prevalence of depression, anxiety and substance abuse (Lovestone & Kumar., 1993; Zelkowitz and Milet., 1997; Condon., Boyce & Corkindale., 2004; Condon., 2006; Davey., Dziurawiec., & O'Brien., 2006) because of the role change as fathers. Having a spouse with PPD further increases this risk of developing psychiatric conditions among the husbands secondary to related concerns such as poor quality of life, poor social support, financial burden, internalization of distress, inability to work, social stigma and concern about the future.

Literature also showed that on the whole, stretched maternity and mental health services do not provide fathers with information and support, despite the wider benefits that this would have for families (O'Brien et al., 2016).

Inadequate knowledge to identify and recognize the symptoms of mental illness has a buffering effect on the prognosis and symptom maintenance of the women. Thus the husbands' positive involvement in the treatment of their spouses has a vital impact not only on the mental health of the women and the infants but also on the men (Fletcher., Garfield., Matthey., 2015).

A number of studies done focussing on the effectiveness of psychoeducational programmes for the caregivers of different types of mental illnesses found that such programmes were found to be effective in terms of enhancing the knowledge, attitude, prognosis and relapse prevention of the persons with mental illness. However few efforts have been made in the area of PPD with similar objectives that prove the efficacy of such programmes with regard to the overall wellbeing of both women with PPD and their husbands.

Developing and adopting of a father-specific and/or father-inclusive model in terms of addressing their concerns and providing information about the condition of their spouses and their roles in the management aspect serve as a satisfactory method to address their concerns and foster support networks for new fathers who may feel isolated and marginalized (Fisher, Wynter, Rowe, 2010; Alliance, 2013; Hogg, 2013; O'Brien et al., 2016).

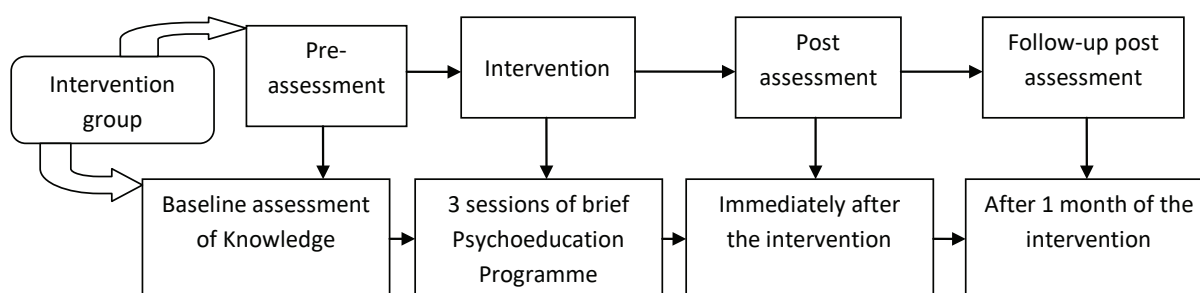
Very limited studies have been conducted to assess the knowledge about the condition of their spouses among the husbands of women with PPD in both western and Asian contexts; in India especially, there is no systematic study done in this area.

With the above background, the current research was done with the aim of assessing the effectiveness of a brief psychoeducation for the husbands of women with postpartum psychiatric disorders (PPD) in enhancing their knowledge about the condition of their spouses. The study also hypothesized that a brief psychoeducation will improve the knowledge of the husbands of WWPPD.

## METHODOLOGY

### Research Design:

Quasi-Experimental research design was used for the present study. The following chart indicates the same:



### Sample and study settings

The study sample included husbands of women with PPD admitted under inpatient care of Mother-Baby Ward (MBW) of NIMHANS, Bengaluru, India, in the time frame of 1st October 2016 to 31st March, 2017. Out of a total 30 targeted sample size, in the specified

time frame of 6 months, the researcher could complete the intervention programme including 3 levels of assessment (Pre, Post and Follow-up post) with a total of 21 samples. Participants reported to have active psychiatric disorder (reported voluntarily or by the treating team) and women below 18 years of age diagnosed with PPD were excluded from the study.

## **Measures**

A semi-structured interview schedule was developed for capturing the socio-demographic details (SDD) of the participants and their spouses. Since there is no scale available to assess the knowledge in the area of perinatal psychiatry, the researcher had developed a semi-structured interview schedule for knowledge assessment of the participants in the area of perinatal psychiatric disorders. It contained a total of 22 items with 5 point likert scale, having both positively and negatively framed items ranging from strongly agree to strongly disagree. The items focused on assessing the knowledge regarding nature, etiology, signs and symptoms, issues related to mother-baby bonding, prognosis and need for treatment in the area of PPD. Face validation of this had been done by 5 experts working in the area of Perinatal Psychiatry including Psychiatrists (1), Clinical Psychologists (1) and Psychiatric Social Workers (3).

## **Study Process**

### **Development and validation of a Brief Psychoeducation Programme (BPP):**

A literature review was done on different interventional studies which aimed at providing psychoeducation to the caregivers of persons with PPDs and other types of severe mental illnesses. Based on this, brief psychoeducation programme, for the current study, was developed. This targeted at providing 3 sessions which could be given, on a daily or weekly basis as per the convenience and availability of the participants. The duration ranged from 1 hour to 1 hour 30 minutes. The first session covered orienting the participants about BPP, dealing with misconceptions on PPDs, nature and common signs and symptoms of PPD. The second session involved educating the participants on Biopsychosocial Model of illness and the last session aimed at building an understanding of the participants regarding their role in management of PPD along with taking care of one's own health. Face validation was done by the five experts working in the area of Perinatal Psychiatry following which, appropriate modification was done.

### **Process of Intervention**

Using the semi-structured interview schedules developed by the researcher, socio-demographic details of the participants were gathered and baseline assessment of the knowledge was done. A psychoeducational intervention was then provided for the participants using the Brief Psychoeducation Programme developed by the researcher. Although group methodology was planned, the individual mode was adopted for the delivery of the intervention due to the practical difficulties. These 3 sessions were provided both on a daily and weekly basis as per the time convenience of the participants. Post assessment was done immediately after completion of all the 3 sessions and after 1 month of completion of the intervention, the follow-up post assessment was done using the same set of interview schedule.

### **Data Analysis:**

The data gathered was coded and entered in the Statistical Package for Social Sciences (SPSS) IBM 22.0 version. Shapiro – Wilk (SW) test was performed for the variables of interest at baseline and it was observed that the variables do not follow normal distribution. Thus, Friedman test which is a nonparametric test was used to analyze the data. The descriptive statistics such as frequency, percentage, mean, median and standard deviation were calculated for the socio-demographic variables. Pair-wise comparison of the interview schedule was done at all the 3 levels (Pre, post and follow-up post).

### **Ethical Considerations:**

1. The study was approved by the institute ethics committee
2. Written Informed consent was obtained from the participants before enrolling them in the study
3. Appropriate individual referrals were made as and when observed to be necessary to the adult psychiatry units for further intervention

## RESULTS

**Table 1.0: Socio-demographic Details of the Participants and their Spouse (WWPPD)**

Variables	Categories	Frequency (%)	
		Participants	WWPPD
Age (In years)	20 – 30	7(33.3)	20(95.2)
	31 – 40	14(66.7)	1(4.8)
Education	Primary – Secondary	9(42.9)	-
	High School –PUC	7(33.3)	14(66.7)
	Graduation –Post-graduation	5(23.8)	7(33.3)
Occupation	Service Sector	9(42.9)	-
	Daily Wage	12(57.1)	-
	Home Maker	-	21(100.0)
Religion	Hindu	21(100.0)	
Type of Marriage	Choice Marriage	3(14.3)	
	Arranged Marriage	18(85.7)	
Type of family	Nuclear	7(33.3)	
	Extended	8(38.1)	
	Joint	6(28.6)	
Place of Residence	Rural	8(38.1)	
	Urban	13(61.9)	
Family Annual Income (In Rupees)	1000 – 20,000	14(66.7)	
	21,000 – 40,000	7(33.3)	

Among the participants more than half (66.7%) belonged to the age group between 31 – 40 years. A vast number of the women with WWPPD (95.2%) who were the spouses of the participants belonged to the age group ranging from 20-30 years. Comparatively a good number (42.9%) of participants were educated up-to 7th standard and more than half i.e., 66.7% of WWPPD had school education ranging from 10th -12th standard. A

little more than half (57.1%) of the participants were daily wage laborers such as farmers, mason, carpentry and auto drivers. In contrast, none of the WWPPD were engaged in any sort of income-generating employment. Thus 100.0% were in the home maker category.

Apart from the variables mentioned above, all the other variables share common results for both participants and their spouse because of the cultural norms. As indicated in Table 1.0, all the participants (100%) were of the Hindu religion. A large number (85.7%) of them got married to their partners as planned and agreed by the family members, 38.1% of the sample belonged to an extended family, followed by 33.3% and 28.6% of them who belonged to nuclear and joint families respectively.

Slightly more than half (61.9%) of them resided in urban areas. A good number of respondents (66.7%) were from a below poverty line (BPL) family with the annual family income ranging from 1000-20,000/- Rupees.

**Table 2.1: Item-wise Frequency Distribution at all the 3 Phases in Yes/No Measures**

Variable No	Phase - 1 (Frequency %)		Phase - 2 (Frequency %)		Phase - 3 (Frequency %)	
	Yes	No	Yes	No	Yes	No
1. *My wife has got some kind of mental illness as a result of pregnancy and childbirth	11(52.4)	10(47.6)	21(100.0)	0.0	21(100.0)	0.0
2. I feel my wife is dramatizing her behavior	16(76.2)	5(23.8)	21(100.0)	0.0	21(100.0)	0.0
3. *Mental illnesses are multi-factorial	7(33.3)	14(66.7)	21(100.0)	0.0	21(100.0)	0.0
4. Mental illness is contagious and is passed on through breast feeding	2(9.5)	19(90.5)	21(100.0)	0.0	21(100.0)	0.0

5. *Changes in reproductive hormonal level is one of the causes for PPD	7(33.3)	14(66.7)	21(100.0)	0.0	18(85.7)	3(14.3)
6. *Poor mother-infant interaction is a sign of impaired mother-baby bonding	16(76.2)	5(23.8)	21(100.0)	0.0	21(100.0)	0.0
7. *Stress/trauma is one of the determinants of PPD	18(85.7)	3(14.3)	21(100.0)	0.0	21(100.0)	0.0
8. *Consulting a psychiatrist is essential before planning for the next pregnancy to avoid relapse	17(81.0)	4(19.0)	21(100.0)	0.0	21(100.0)	0.0
9. PPD can be controlled without seeking professional help	17(81.0)	4(19.0)	21(100.0)	0.0	21(100.0)	0.0
10.*Significant behavioral changes may be an indication of the symptoms of PPD	17(81.0)	4(19.0)	21(100.0)	0.0	21(100.0)	0.0
11.Mother-baby bonding gets impaired among all the women who develop PPD	12(57.1)	9(42.9)	21(100.0)	0.0	18(85.7)	3(14.3)
12.There is no professional help available to improve mother-baby bonding	2(9.5)	19(90.5)	21(100.0)	0.0	21(100.0)	0.0
13.PPD subsides by itself without any treatment	21(100.0)	0.0	21(100.0)	0.0	21(100.0)	0.0



14.All the women who have a history of psychiatric illness will develop PPD	5(23.8)	16(76.2)	21(100.0)	0.0	18(85.7)	3(14.3)
15.PPD will cause life time disablement in women	19(90.5)	2(9.5)	19(90.5)	2(9.5)	17(81.0)	4(19.0)
16.Jealousy of others and/or black magic have an equal role to play in determining PPD	11(52.4)	10(47.6)	21(100.0)	0.0	21(100.0)	0.0
17.Suicidal tendency is a part of revenge-seeking behavior or a sign of escaping from the new responsibilities post delivery	21(100.0)	0.0	21(100.0)	0.0	21(100.0)	0.0
18.*Postpartum blues are common in a majority of women	3(14.3)	18(85.7)	21(100.0)	0.0	17(81.0)	4(19.0)
19.If a mother develops PPD, keeping baby away from her is advisable	10(47.6)	11(52.4)	19(90.5)	2(9.5)	17(81.0)	4(19.0)
20.All the women with PPD are assaultive towards baby and others	12(57.1)	9(42.9)	21(100.0)	0.0	21(100.0)	0.0
21.Women with PPD never get better	19(90.5)	2(9.5)	21(100.0)	0.0	19(90.5)	2(9.5)
22.Personality weakness or character flaws cause PPD	7(33.3)	14(66.7)	21(100.0)	0.0	21(100.0)	0.0

**The items marked with stars are positively framed statements.**

**Note: The interview schedule is under the process of scale construction**

In view of determining the shift in responses between each of the phases from baseline to follow-up post with its quantification, the response pattern was converted from likert form to yes/no response form by merging all the positive responses to the score of 1 (i.e., for positive statements, Strongly Agree & Agree were considered as Yes (1) and Uncertain, Disagree and Strongly Disagree were considered as No (0)) and negative response to the score of 0 (vice versa with positive statements).

The results showed that at Phase-1(baseline), for item number 13 & 17 all the participants (100.0%) have given right response. For item no 2, 6\*, 7\*, 8\*, 9, 10\*, 15 and 21, more than three-fourths of the participants (ranging from 76.2% to 90.5%) have given correct response. More than half of the respondents, ranging from 52.4% - 57.1%, have marked right response for item no 1\*, 11, 12 & 16. For remaining items (3\*, 4, 5\*, 12, 14, 18\*, 19 & 22) more than half of the participants have given incorrect response (ranging from 52.4% - 90.5%).

At Phase-2 (post) all the participants (100.0%) had given appropriate response to all the variables except for item number 15 & 19 (90.5% each) with slight decrease in the score. In Phase-3 (follow-up post) except item no 5\*, 11, 14, 15, 18\*, 19 and 21, for the rest of the items the participants sustained the same level of response.

These results give further evidence to support the research hypothesis of the current study that the knowledge among the respondents about PPD enhances from Phase-1 to Phase-2 and there is sustenance of the knowledge from Phase-3 than phase 2.

Distribution of Knowledge of the Participants and its Pair-Wise Comparison at Three phases (Pre, Post and Follow-up post)

Shapiro-Wilk Test of normality was performed for the variables of interest at baseline and it was observed that the variables do not follow normal distribution. Thus, Friedman test which is a nonparametric test was used to analyze the distribution of knowledge of the participants about PPD at all the 3 phases i.e., pre, post and follow-up post.

The differences in percentile values at 50th level clearly depict that there is a difference in knowledge among the participants from pre-intervention (Phase-1), with the median score of 82.000, to immediately after the intervention (Phase-2) with an increase in the median score to 103.000. There is a slight fall in the median score to 102.000 at follow-up post (Phase-3) level. However it has not gone down to the pre-intervention level which denotes that there is sustenance of the knowledge obtained from the intervention even after 1 month of the intervention.

**Table 2.2: Distribution of Knowledge of the Participants and its Pair-Wise Comparison at 3 phases (Pre, Post and Follow-up post)**

Phases	N	Minimum	Maximum	Percentiles			p value
				25th	50th (Median)	75th	
Phase – 1	21	58.0	93.0	77.000	82.000	87.000	.000
Phase – 2	21	91.0	109.0	98.000	103.000	108.000	
Phase – 3	21	91.0	107.0	96.500	102.000	105.500	

As there was an overall difference in the knowledge of the participants from pre-intervention to post intervention, shown in Table 2.2; in order to determine the pattern of differences in view of supporting the research hypothesis, Freidman's pair-wise comparison was done at different phases.

**Table 2.3: Pair-wise Comparison of Knowledge of the Participants at 3 Phases (Pre, Post and Follow-up post)**

Phases	Test Statistics	p
Phase 1 – Phase 3	-1.143	.001**
Phase 1 – Phase 2	-1.857	.000**
Phase 2 – Phase 3	.714	.062

**The test significance level is .05 (\*\* indicates the statistical significance)**

In reference with table 2.3, the paired comparison was found to be statistically significant between pre and post intervention assessment of knowledge (.001) and pre and follow-up post assessment of knowledge after 1 month of intervention (.001). Though there is no significant difference in the knowledge of the participants about PPD from Phase -2(post) to Phase – 3 (follow-up post), in line with the study interest, it was observed that the knowledge gained from the intervention was sustained even after one month.

## **DISCUSSION**

Husbands play a very significant role in the life of women. India is majorly a patriarchal society and hence after marriage, a woman mostly shifts to her spouse's place from her family of origin. When the wife becomes pregnant both she and her husband move on to the next stage of their lives with new role expectations and responsibilities. At this crucial point of life cycle change, when the wife develops mental health issues as a result of pregnancy/childbirth it further increases the challenge of the new change in the life cycle stage. As a whole, irrespective of socio-cultural and economic background, people continue to have poor knowledge about mental illness and have a negative attitude towards persons with any mental illness because of the stigma attached to it. There are numerous rituals which are performed in India in relation to pregnancy and childbirth. When a woman unexpectedly develops PPD, unpreparedness caused due to lack of awareness about the condition and also her role in its management has its impact not only on the spouse but also on the family.

Thus in accordance with the objectives of the study, the knowledge of the participants about mental illness with the special focus on PPD was assessed using a researcher-developed interview schedule having 22 items constituting items pertaining to the nature, signs and symptoms, etiology, mother-baby bonding related issues, treatment and prognosis of PPD. Analyzing the changes in the knowledge level from phase-1 to phase-2 and sustaining of the change from phase-2 to phase-3 was the interest of the researcher as per the study hypothesis.

At the baseline assessment, the participants had scored a median score of 82.00 at Phase-1. From baseline to Phase-2 there is significant change with the increase in the

median score to 103.00, which indicates that there is increase in the knowledge of the participants from baseline assessment to post intervention level. In other words a brief psychoeducation enhanced the knowledge of the participants with the increase in median score. The paired comparison was also found to be statistically significant ( $<.05$ ) between Phase-1 and Phase-2, ( $<.001$ ) which further supported the efficacy of the psychoeducation in knowledge enhancement. Often men are not involved in the treatment process of their wives having PPD, which hinders their active role in the treatment. Through this intervention, the spouses were motivated to join the informative and educational program. Apart from this, they were also given opportunities to share their experiences and helped in managing their own mental health as a part of the brief psychoeducation programme. At the time of acute need, along with providing the information on the condition of their spouses, discussions on their queries and concerns related to it would have helped them in carrying out their roles effectively and this in turn would have also instilled hope in them. Usage of discussion method in a language familiar to them and also usage of multiple innovative modes of delivering interventions probably further added on to the scope of knowledge enhancement. In corroboration with these results, O'Brien et al's study (2016) implied that developing and adopting of father-specific and/or father-inclusive model in terms of addressing their concerns and providing information about the cognition of their spouses and their roles in the management aspect serve as the best method to address any cognitive distortion around the male identity and parenting role expectations and also can foster support networks for new fathers who may feel isolated and marginalized.

It might have also facilitated their sense of responsibility by acknowledging the need for their involvement in the treatment of their wives. It is also established by the research that husbands' involvement in the treatment of their spouses has a positive impact on the mental health of the women (Fletcher, Garfield, Matthey, 2015).

A qualitative preliminary Indian study done by Ragesh et al (2016) revealed that the participants who were the spouses of women with PPD had poor understanding about the illness of their wives. The single session based group psychoeducation was found to be effective in enhancing the knowledge of the participants regarding mental illness. At the same time, participants started showing more acceptance and a positive expression of feelings with supportive gestures as stated in the study.

In the current study, in order to assess the sustenance of the knowledge immediately after the intervention, a follow-up post assessment was done (Phase-3). It was found that there was no significant difference in the scores between Phase-2 and Phase – 3. However the score obtained by the participants at phase-3 remained close to the score of phase -2 (102.00). Though there is no significant difference in the scores between Phase -2 and Phase – 3, the pairwise comparison shows a statically significant result between Phase-1 and Phase-3 ( $<.001$ ), on par with the study hypothesis. Despite of the results which indicate no significant change in knowledge between Phase-2 and Phase-3, it remains in accordance with the hypothesis of the study, as sustenance of knowledge at phase-3 was the primary focus of the assessment.

### **Parallel results found in several other intervention-based western studies**

In a study by Davey, Dziurawiec., & O'Brien (2006), a combination of psychoeducational and cognitive-behavioral components found that the factual information provided helped in enhancing the knowledge of the participants. They also suggested that if factual information about the disorder was more widely promoted, the stigma and shame surrounding PPD might be reduced. This explains the changed attitude of the participants with the development of knowledge through psychoeducation. In another study, Fisher et al (2010) used an innovative psycho-educational program named 'What Were We Thinking!' (WWWT) where participants were given a half-day psychoeducation. One of the objectives of the package was to minimize experiences of humiliation through increasing the fathers' understanding and empathy. The study found that a universal, brief psychoeducational group program for first time parents and babies in primary care reduces the chances of postpartum mental disorders in women. Simultaneously it improved the effectiveness of the treatment outcome for women with a psychiatric history through the supportive and accepting attitude of their partners.

Brandon et al (2012) conducted a study to understand the efficacy of partner assisted psychotherapy on women with postpartum depression. Results found that involving partners in the treatment of their spouses in the perinatal period enhanced the involvement of their partners in the treatment of maternal distress. Apart from reducing depressive symptoms in the mothers, it also helped in imparting the knowledge to partners regarding the disease course of PPD, validated their own experiences of coping with the depressive experience, and also alerted them to early warning symptoms of relapse.

A majority of the available studies in the area of PPD have strong implications for involving male partners/husbands in the treatment of women with PPD especially in the form of providing information about the condition of spouses and their role in its management and also evaluating or screening men and providing required pharmacological or psychosocial interventions. In the current study an effort was made to enhance the knowledge of the husbands of women with PPD using a brief psychoeducation programme developed by the researcher and it proved to be effective. Evidence-based practices that have emerged in both clinical trials and community settings on persons with various other types of major mental illnesses and their caregivers with similar mode of intervention proved to be effective (Lukens & McFarlane, 2004).

### **Implication for Social Work Practice**

Professional Social Work being a helping profession and having its scope at preventive, promotive and curative levels has its major implication for the current study. At the training level, it should be a part of the curriculum and Social Workers need to be trained in the area of perinatal mental health . At practice level, this brief psychoeducation programme (BPP) could be adopted as an independent or adjunctive method of involving spouses in the process of nonpharmacological treatment both in the medical and psychiatry settings which facilitate holistic care delivery. This BPP could also be used in different settings such as Anganawadi Centres and various other community level centers as a promotive and preventive means. This study being one among the landmark pieces of literature, in this area, from India, not only contributes as a literature for Social Work Practitioners and for policy makers but also paves the way for future researchers.

### **LIMITATIONS**

Some of the limitations of this study include small sample size, non-availability of appropriate tools for assessment, absence of controlled group and brief follow up period.

### **CONCLUSION**

Perinatal mental health is an upcoming area in the mental health setup. The development of a psychiatric condition in women has equal impact on the women and their families,

especially their husbands. Unfortunately literature suggests that often men have not been involved in the treatment of their wives and not been provided with adequate information about the condition as well. Thus in the current study, efforts have been made to evaluate the effectiveness of a brief psychoeducation to determine the change in knowledge among the husbands of women with postpartum psychiatric disorders. The results proved that the brief psychoeducation helped in enhancing the knowledge of the spouses about PPD and developing a positive attitude towards persons with mental illness. Despite all the limitations, this study has its strong implication in Social Work Practice in this area at both clinical (medical and psychiatry settings) and nonclinical settings at preventive, promotive and curative level.

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