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M.Sc PSYCHOLOGY

THIRD SEMESTER

COURSE-14 COMMUNITY AND REHABILITATION PSYCHOLOGY

BLOCK - III : MANAGING THE COMMUNITY PROBLEMS

BLOCK - IV : REHABILITATION

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COURSE-14 COMMUNITY AND REHABILITATION PSYCHOLOGY

INTRODUCTION

This course Community Psychology is an upcoming branch of Psychology. It is concerned with person environment interactions and the ways the society affects individual and community functioning. It focuses upon the social, cultural, economic, political, environmental and the interactional influences of an individual to promote a positive change in health, empowerment for the individuals at the individual level as well as systematic social levels. It focuses upon the ways the society affects the individual as well as the community functioning. Community Psychology focuses on social issues, social institutions, those which influence individuals, groups and organizations.

The first block deals with an introduction towards Community Psychology, its emergence, the principles of community psychology, the major techniques, crisis, crisis intervention, the importance of mental health education in the community, community mental health and its models, the values of community psychology are being discussed here.

The second block deals with community intervention programmes, different types of intervention programmes the community psychology adapts, the community programmes for clinics, hospitals, homes etc. it deals with the community problems like suicide, violence, aggression, its causes and its prevention, it discusses about the disaster , its management, the psychological consequences of the disasters, emergency management, crime , juvenile delinquency, the psychosocial factors of criminal behaviour and prevention of juvenile delinquency.

The third block deals with managing the community problems, the major community problems like communal violence, its factors, consequences, and its prevention. Nature may pose some problems which affects the community, the natural disasters, its types, its effects, its psychological effects, the role of a psychologist in natural disaster management, managing various other problems occurring in the community, analyzing its causes, the role of a psychologists in dealing with various social problems like poverty, child labour, unemployment, gender discrimination, violence against women, crime etc are being discussed here.

The fourth block discusses about rehabilitation, its need, issues in rehabilitation, the role of a psychologist in rehabilitation, different approaches to psychosocial rehabilitation, the functions, models, principles of psychosocial rehabilitation, the various rehabilitation programmes for alcoholics, drug addicts, different types of rehabilitation, juvenile delinquency, its causes, its prevention are all being discussed in detail.

This course has provided you an understanding about community, its problems, psychological causes, psychological consequences, the importance of rehabilitation in helping those who are suffering from various psychosocial problems and the role of a psychologist in shaping a better society and a community.

Wishing you All the Best

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BLOCK: 1- INTRODUCTION TO COMMUNITY PSYCHOLOGY

UNIT: 1- EMERGENCE OF COMMUNITY PSYCHOLOGY

STRUCTURE

1.1 OBJECTIVES

After going through this unit you will be able to explain

- Meaning and definitions of Community Psychology
- Community Mental Health
- Emergence of Community Psychology
- Poverty and Mental Health
- The mental hospital

1.2 INTRODUCTION

Humans seek communities. Relationships with others are a central part of human existence. People cannot live in complete isolation from each other; individual lives and community life are intertwined.

Community psychology is different from others fields of psychology in two ways:

1. Community psychology offers a different way of thinking about human behavior. We focus on the community contexts of behavior that shift in perspective leads to the second.

2. An expansion of the definition of what are appropriate topics for psychological study and intervention. Community psychologists are interested in effective ways to prevent problems rather than treat them after they arise. The field emphasizes promoting healthy functioning for all members of a community rather than intervening when problems develops for a few of those members. And they focus their research on factors at then neighborhood, community, and societal level that support or impede healthy development rather than internal psychological process or biological factors.

1.3 MEANING AND DEFINTIONS OF COMMUNITY PSYCHOLOGY

At first, the idea of community and psychology can be seen contradictory. Community suggests the idea of persons coming together in some shared endeavor or at least geographic proximity (e.g. Groups, neighborhoods, and larger structures). Psychology has traditionally

concerned individual cognition, emotion, motivation, behavior development, and related processes. In western cultures individual and community often have been considered opposing interests. Is community psychology an oxymoron contradiction in terms?

A paradox exists when two seemingly contradictory ideas turn out, upon further analysis, to be inter related not contradictory (Rapport, 1981). That is true of individual and community, which are intertwined in a number of ways (Shinn, 1990). Community psychologists see quality of life for individuals, for communities, and for societies as inextricable.

Keeping in mind the diversity of psychologists' interests and personal views, we offer this definition of the field. Community psychology concerns the relationships of individuals with communities and societies, by integrating research with action, it seeks to understand and enhance quality of life for individuals, communities, and societies.

According to medical dictionary "Community mental health is a treatment philosophy based on the social model of psychiatric care that advocates that comprehensive range of mental health services be readily accessible to all members of the community".

According to Britain encyclopedia "Community mental health is a decentralized pattern of mental health, mental health care or other services for people with mental illness. Community based care is designed to supplement and decrease the need for more costly inpatient mental health care delivered in hospitals. Community mental health care may be more accessible and responsive to local needs because it is based in a variety of community settings rather than aggregating and isolating patients and patient care in central hospitals. Community mental health assessment, which has grown into a science called psychiatric epidemiology, is a field of research measuring rates of mental disorder upon which mental health care systems can be developed and evaluated.

Community psychology is guided by its core values of individual and family wellness, sense of community, respect for human diversity, social justice, empowerment and citizen participations, collaboration and community strengths, and empirical grounding.

Community psychology concerns the multiple relationships between individuals, communities and societies. We define community broadly. An individual lives within many

communities and at multiple levels: family networks of friends, workplace, school, voluntary association, neighborhood, and wider locality-even cultures. All these exists within larger societies and ultimately within global context. The individual must be understood in terms of these relationships, not in isolation. This means that community psychology is actually interdisciplinary, drawing on the concepts and methods of many other disciplines, including public health, community development, human development, anthropology, sociology, social work, geography, and other fields.

The principal professional society for the field in the United States is the society for community research and action, in recognition of this interdisciplinary focus. Similar organizations represent psychology in Europe, the America, Africa, Australia and Asian countries.

Community psychology's focus is not on the individual or on the community alone but on their linkages individual and communities. The field also studies the influences of social structures on each other (eg, how citizen organizations influence the wider community). But unlike sociology, community psychology places a greater emphasis on individuals and their complex of interactions with the social structures.

1.4 COMMUNITY MENTAL HEALTH

A treatment philosophy based on the social model of psychiatric care that advocate a comprehensive range of mental health services be readily accessible to all members of the Community.

According to community mental health center "A health-care facility or network of agencies that is part of a system originally authorized by the US government to provide a coordinated programme of Mental Health care to a specific population.

Community

A social group of any size whose members resides in a specific locality and have a common cultural and historical heritage.

A group associated nations sharing common interests or a common heritage system can be developed and evaluated.

1.5 EMERGENCE OF COMMUNITY PSYCHOLOGY

Community psychology emerged, in fair measure, out what Hersch (1968,69) has termed a "discontent explosion" among clinicians. Established beliefs about the nature of mental disorders and their treatment have been called into question; clinicians have found traditional roles frustrating: they question whether they can contribute significantly to the vast unmet needs of large segments of the population.

1. **Disenchantment with psychotherapy**.

Growing criticism from many quarters has shaken the faith of many clinicians in both the effectiveness and efficiency of traditional psychotherapies. Both humanistic and behavioral psychologists, from opposing vantage points have questioned fundamental premises. The psychotherapy had yet to demonstrate its effectiveness even as against no treatment whatever. This argument, launched by Eysenck in 1952, led to considerable controversy over the interpretation of the limited amount of research data available in time. It inspired more sophisticated research studies. Although the presently available evidence shows psychotherapy to be considerably more effective than Eysenck claimed. However, the same body of research has brought out some genuine issues as to the universal applicability and value of psychotherapy. The ideal patient, it has been noted repeatedly, is someone already on the way to psychological health, with fair degree of psychological competency, intelligence, personality integration, and insight. The more severely disturbed, the mentally retarded, the unmotivated and many of those facing the stresses of poverty or race are less well served.

Even if there were no question of the effectiveness of psychotherapy, it is clearly not an efficient procedure. It is costly in time, effort and money and hence most available to the most motivated and affluent. Almost seventy years ago, French predicted at the Fifth international congress of psychoanalysis in 1918 that the time had arrived for "the conscience of the community" to awaken to the fact that "the poor man has just as much right to help for his mind as he now has to the surgeon's means of saving life. The task will arise" French continued "for us to adopt our technique to the new conditions (quoted by Galdston,1971)

Despite many statements of concern and efforts at innovation, the problem of adapting psychotherapy or finding substitutes for it remains with us. Thus Eisenberg(1962) speaking out vigorously for a need to shift from a therapeutic to a preventive orientation notes: "the limitations of present therapeutic methods doom us to training caretaker at a rate that ever lags behind the growing legions of the ill, unless we strike out successfully in new directions in the search for causes and treatment, society can ill afford today's precious overspecialization in which trainees may learn one method even superbly well but remain abysmally unaware of the problems besetting the bulk of the mentally ill.

2. Changing concepts of mental health illness.

More broadly, there has been widespread dissatisfaction with traditional medical concepts, particularly as reflected in the 'custodial' but also in the 'therapeutic' approaches to mental problems. It has been argued that conceiving emotional disorders in analogy to physical diseases limits our understanding of human problems and our effectiveness in alleviating them of particular concern is the implication, in the medical model, that mental diseases reside in the individual and hence that intervention must involve treatment of the sick person to the end of removing or altering the pathological process of within him/her. In opposition to such a view, many have argued the need for a 'social' 'preventive' 'growth' and 'development' or in the general term being used here community psychology point of view which sees human problems as residing in the interplay between the distressed person and social forces.

3. Dissatisfaction with existing professional Roles.

Mental health professionals of all kinds, like their cities, have become concerned with their limited ability to effect important change in the levels of psychological distress in the larger community. Working in clinics, private offices, and hospitals, waiting rather passively for troubled people to present themselves for help many have come to realize the need for a greater area of influence and for earlier, quicker, and more effective. Clinical psychologists face the additional problems of feeling unfulfilled in medical settings where primary decisions are made by physicians. The medical environment, many feel, provides too little opportunity to exert their independence and competence; too often, they see themselves as second-class citizens in a

mental health enterprise dominated by medical men. The quest for anatomy has led many psychologists into the private practice of psychotherapy. Many others, however, see the new roles emerging in community psychology as providing a better route toward professional autonomy and of allowing greater freedom to experiment with uniquely psychological interventions.

The man power shortage

If there is one incontrovertible fact in the field of mental health today, it is at there is a serious and growing gap between manpower resources and the public needs, at least when the major mental health professions are considered their present roles and functions. The manpower shortage has been a major impetus to conceptualize professional roles, to suggest alternative ways of employing professionals' time, and to seek new workers in sub professionals roles.

The emerging community mental health centers of the 1960s have had difficulties in finding sufficient numbers of adequately trained personal. As the hospitals they sought to complement, they have had to compete with a number of attractive alternatives for already short number of trained professionals. In one projection, the recommended staffing for the new community mental health centers was one psychiatrist, one clinical psychiatrist and one clinical social worker for every 50,000 people.

In view of present needs, population growth the disproportionate growth of demand for psychological services, and the limited capacity of training institutions, it is easy to see why the manpower problem has spurred the search for new sources of manpower, more effective utilization available professional time, and new conceptual models for working with human problems.

1.6 POVERTY AND MENTAL HEALTH

Problems of the poor and minorities the need for new services comes especially into sharp focus. The life conditions of the poor are pathogenic (Shanua,1961, Hollingshead and Redlich,1958etcothers) granted, we still do not know enough about the intervening links between economy deprivation, its sociological expressions, personality development, and subsequent

pathology, the overall picture of greater in evidence and prevalence of both gross pathology and lessened psychological competence in the culture of poverty is all too well established.

Not only is there greater need but there are also great inequalities in the deliveries of services to the poor. Hollingshead and Redich (1958) showed it in their classic study that the poor tended to end up in custodial hospitals while the well to do were treated in private psychotherapy, summing up M.B Smith and Hobbs(1966,P,14) noted that "the more advanced mental health services have tended to be a middle class-luxury; chronic mental hospital custody, a lower-class horror. The relationship between the mental health helper and helped has been governed by an affinity of the clean for the clean, the educated the affluent for the affluent". This is not to suggest that mental health workers have maliciously decided to ignore the needs of masses of the population; indeed, most in their personal attitudes would sincerely wish to see the state of the poor improved.

But the conditions of the clinical work, the settings in which it takes place, the nature of the contract between helper and helped all lead to the likelihood that disproportionately more service will be given to the middle class and disproportionately less to the poor. The psychological mindedness, introspectiveness, striving for personal growth, and motivation for therapy important to psychotherapy are part of the middle class values shared by the therapist and his middle class patient. The lower-class person may distrust the mental health effort. Its institutions, hospitals and clinics are part of the white, affluent establishment as are most of its practitioners.

As Reiff, Riessmna, and others have pointed out the poor person often sees his problems differently than does the middle-class client. Psychological distress, he feels, is less due to his personal inadequacies than to the harsh conditions imposed on him. His problems do not reside within, but arise from without. He is oriented to action, expects to see things done, and has little patience for talk. The middle-class patient, like his therapist, see him-self handicapped by neurotic symptoms which cause pain and limit effectiveness, self-understanding and increased personal freedom are the proper goals of therapy. By contrast the lower class person suffers more from helplessness in the face of debilitating social stresses and his lack of competence to deal with them.

1.7 THE MENTAL HOSPITAL

Another major impetus to the emergence of community psychology was the poor condition of the larger state mental hospitals by the end of World War-II. Socially oriented clinic and clinicians have tried,

1. To improve the conditions of life within the hospital in order to make it more-therapeutic and less custodial.
2. To develop alternate forms of community based care to avert the need for hospitalization entirely.
3. At least to so alter hospital practices-for example, by providing facilities for partial hospitalization- so as to facilitate reintegration into community life after briefer and more limited hospitalization.

When William Juke founded the Retreat in York, England, in 1792 he wanted it to be "a quiet haven in which the sheltered bark might find the means of reparation and safety". In the early days of the American republic, such notions guided the thinking of human men who established asylums in which people could escape the stress of life and emerge ready again for productive social life. They believed that the mentally ill treated humanely and urged to greater responsibility and self-control were capable of resuming normal lives in society: a point of view which has been called "moral treatment" (Bockoven,1963).

By the mid-nineteenth century, however, American society changed radically, and with it faith in moral treatment declined. Waves of new immigrants were swelling urban populations and straining the resources of psychiatric hospitals. Early in the present century, overall there was lessened belief in what Albert Deutsch (1949) has called the "cult of curability" small asylums grew into vast, overcrowded and understaffed state hospitals, often located for from population centers, and so poorly supported that basic necessities of food, clothing, and shelter were often lacking. In some private hospitals and the best of the state institutions more humane and therapeutic care was of course available. But for the bulk of the American population, the state hospitals were the only available resource. These, by the time of World war-II, had become "the shame of the state" (Dentsch,1948).

The goal of the community mental health movement is at its most ambitious to keep people with disabling psychological problems entirely out of hospitals. Ultimately, this is to be achieved through prevention but more immediately and realistically by the development of alternate means of dealing with crisis and by providing alternate institutions (e.g., day and night hospitals, halfway houses) more closely tied to community life. Implicit is the assumption that the hospital, certainly the large, isolated public institutions, is inherently bad and that psychiatric care should be shifted from the hospital to community settings. Despite the most fervent hopes, it seems unlikely that a time will ever come when some portion of the patient population will not need the special resources of a hospital. Hence, there is continued need for improving inpatient care while seeking alternatives to hospitalization.

Recent history has shown that the admirable goal of "emptying the hospitals" can too readily be perverted by state administration more concerned with budgets than with human welfare. State hospitals have been closed, or their services sharply reduced, and their problems shifted to communities without sufficient resources. The closing of the Agnews state hospital in California, for example, led to a sharp increase in the flophouse population of San Jose, with attendant increase in crime and other social problems. As a long-term aim, however, doing away with custodial hospitalization, which has been a major impetus of the community psychology movement, remains a necessary goal.

1.8 SUMMARY

This unit has given a clear understanding about the meaning, definition of community psychology, various concepts which are important to understand community psychology is being explained here. Community Mental Health, the emergence of community Psychology dating back to its origin is discussed. The factors like poverty and its impact on mental health, the mental hospitals and its role in community mental health is discussed.

1.9 KEYWORDS

Community Psychology

Community mental health

Poverty

Mental hospital

1.10 CHECK YOUR PROGRESS

1. Define Community Psychology.
2. Explain Community Mental Health.
3. Write a note on the emergence of Community Psychology.
4. Explain the role of Mental Hospitals in a community.

1.11 ANSWERS TO CHECK YOUR PROGRESS

1. 1.3
2. 1.4
3. 1.5
4. 1.7

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UNIT: 2 - PRINCIPLES AND MAJOR TECHNIQUES OF COMMUNITY PSYCHOLOGY

STRUCTURE

2.1 OBJECTIVES

After going through this unit you will be able to explain

- Principles of Community Psychology
- Major Techniques of Community Psychology
- Crisis Intervention
- Consultation
- The role of non-professional helpers
- Mental Health education

2.2 INTRODUCTION

The present unit focuses upon the principles of Community Psychology, the major techniques of the community interventions, crisis is the common situation in a community, individuals as well as a community should always be prepared to handle crisis and also overcome them. Crisis intervention its conditions, techniques are discussed here. Consultation, its types, characteristics of consultation and the importance of mental health education is given here.

2.3 PRINCIPLES OF COMMUNITY PSYCHOLOGY

Community Psychology involves certain major principles which are being explained as follows:

1. Social-environmental factors are critically important in determining and changing behavior.
2. Social and Community interventions (system-oriented interventions as against person-oriented interventions) can be effective for making Social institutions (e.g. family, school) more health-enhancing as well as for reducing individual suffering.
3. Such interventions should be aimed at prevention rather than treatment or rehabilitations of emotional disorders. Not only the individual-in-need but the population-at-risk is the proper concern of community psychology.

4. Interventions should have as its goal the enhancement of Social competence rather than simply the reduction of psychological distress. Community-oriented programs should stress the adaptive rather than the pathological in social life.
5. Help is most effective when available close to the settings in which problems arise. Therefore, Community clinicians should work in familiar settings close to the person in need rather than in socially and geographically aliens settings.
6. The Community clinician should reach out to clients rather than waiting passively for them to seek his services. Such services should be flexible, readily available at the place and the time of need, and offered in an atmosphere which reduces rather than accentuates the social distance between helper and helped. Help should be available to those who need it most, not only to these who seek it.
7. To use available resources and to extend its potential impact, the professional should collaborate with Community resource people (caretakers) and use non-professional Co-workers. His work may involve consultations more than direct services.
8. Traditional role requirements and professional's customs have to be relaxed. Community services require imaginative programming and new conceptual models; innovations are to be encouraged.
9. The Community should participate in, if not control, the development and operations of programs which are to serve its needs. Program priorities should reflect the needs and concerns of Community members.
10. Mental health problems should be broadly rather than narrowly viewed for they interlock with many other facets of social well-being, such as jobs, housing and education. To be maximally effective, community mental health programs should deal with as wide a range of social problems as possible.
11. Educating the public to understand the nature and causes of psychosocial problems and the resources available for dealing with them is a valued task.
12. Since many mental health problems relate to broad-scale social stresses such as poverty, racism, urban density and alienations, which are beyond the reach of professional interventions', the community psychologist should be oriented toward, and possible facilitate, social reform.

13. To develop the knowledge necessary for informed interventions, Community psychology requires naturalistic and ecological research approaches.

2.4 MAJOR TECHNIQUES OF COMMUNITY INTERVENTIONS

We will consider four major techniques of Community interventions:

1. Crisis interventions.
2. Consultations.
3. The use of non professional workers.
4. Mental health education.

2.5 CRISIS INTERVENTIONS

Concept: Life proceeds through a successions of human crisis, some developmental and some accidental. Movement from one maturational phase to another necessarily involves transitional stage where established behavior patterns are no longer adequate to new demands and challenges. The skilled crawler is the stumbling toddler before he can become the successful walker. Psychosocial growth, as Erikson (1951, 1959) has described it, confronts the growing person with a sequence of developmental tasks. The successful resolution of each establishes necessary character traits of the mature person, including trust, autonomy, and identity among others. Successful resolution of developmental crises (as well as accidental crises) also has the non specific effect of increasing the personality's resources for crisis-management itself. Defensive and coping mechanisms grow out of previous crisis experiences and make the individual more adept in future ones.

Crisis Interventions

Caplan sees crisis interventions as one of the principal techniques of primary preventions. In and of itself, a crisis is not a mental illness'; but it may be critical premorbid event within which there are the seeds of subsequent pathology. Early intervention in the crisis state itself may thus avert later, more damaging consequences of equal importance is the parallel proportions that working with people in crisis may also provide opportunity for positive growth as well as simply restoring a former equilibrium.

In crisis, there is heightened confusion and painful affects but also, Caplan proposed, ater susceptibility to suggestions and desire for help. The suggestibility and openness to change, if only to relieve the intolerable anxiety and uncertainly, may induce people to seek psychological help, even though they may earlier have denied persistent problems to which the present crisis is related. Crises thus bring to light enduring psychological problems and they can be the point of entry for subsequent therapeutic interventions. The challenge of crisis intervention lies in the fact that it occurs in a time when people are maximally open to change for better or for worse.

Some other general qualities of crisis should be noted (Caplon, 1964: L .Rapport, 1962).

1. The crisis state tends to be temporally self-limiting.
2. There tend to be parallel changes in the individual's feeling and Cognitive states.
3. If partially or wholly unresolved, crises tend to return.

Necessary conditions for crisis interventions programs

Providing for people in psychological crisis is a major theme in Community mental health. Since crisis interventions tend to be brief, more people can be served by a limited staff. Moreover, crisis services reach sections of the populations who neither know, value, nor seek conventional psychotherapy. In the crisis state people both seek relief from immediate distress and ways of dealing with intolerable situation although they may not be psychologically minded nor motivated toward personality change. By the standards of psychotherapy, the goals of crisis interventions are limited, but their potential extended impact is great.

Effective crisis intervention programs require important change in clinical practice. These have been slow to develop. Thus, McGee (1968) notes: "Despite a broadened outlook towards crisis interventions, our overall orientation in this area is related to a fairly traditional model having to do with intake and psychotherapy, among other things. The typical stance of a mental health agency is to wait until the individual in crisis appears for help. Once this occurs his problem is evaluated, and he is offered some form of psychotherapy. As yet, approaches to crisis interventions do not sufficiently emphasize the concepts of outreach and consultation (Mc Gec, 1968, P.323). He proposes that clinics make greater efforts to reach out to people in need, partly through consultation and education in the Community. Organizing a good crisis unit-indeed, any

Community-oriented services-requires special attention to matters of location, availability, setting, staff mobility and functions among others, that are of less importance in traditional clinics. A number of these matters will now be considered.

The technique of crisis interventions

At the present time, crisis intervention is possible in various ways, for no single model has emerged. Current practice involves adaptations of short term psycho-therapeutic and social casework techniques particularly of the short characterized as ego-supportive, here and now oriented, problem-centered, or reality oriented. Protagonists of crisis methods argue that they are not just less (or one phase of) psychotherapy, and that the goal does not involve gaining understanding of conflicts-particularly those which are unconsciously rooted-nor are historical exploration, corrective emotional experiences, transference, and character reconstruction important to the process. What is involved can be inferred from various accounts although the particular process would obviously vary with the nature of the crisis, the social circumstances within which it occurs, the severity of the evoked reactions, and the particular personality involved. In addition to direct work with the patient, crisis intervention commonly involves consultation with relevant others and direct effort to alter the social environment.

Some general properties of the clinical process in crisis intervention can be sketched. The immediate goals are;

1. To relieve present distress, notably anxiety, confusion, and hopelessness.
2. To restore the patients previous functioning
3. To help him, his/her family and significant other learn what personal actions are possible and what community resources exist, secondary, and more extended, goals would include.
4. Understanding the relations of the present crisis to past experience and present psychological problems.
5. Developing new attitudes, behavior and coping techniques that might be more effective future crisis.

Initially, the clinical transactions focus on the crisis itself and immediately precipitating events. By reconsidering the stressful events, new contexts and understandings can emerge. The

accompanying painful affects can be reduced, in part by venting feelings and in part by coming to see them as understandable stress reactions. In later phases, the emphasis shifts to problem-solving efforts. Previous life events, particularly those which were successfully managed, are explored to bring out the patients coping resources which might again be utilized or adapted in the present instance. Necessary information and advice is given, but hopefully in an effort to serve rather than undercut the patient's own efforts at self-determinations. Alternate solutions are visualized new behaviors rehearsed and future consequences considered. Along with the dominant focus on the present dilemma, there is a strong future orientation in this form of therapy.

The relation between clinician and patient, central to any therapeutic process cannot evolve slowly over time as in conventional psychotherapy. It must be built rapidly on the basis of the patients helplessness and confusion and his readiness to invest trust and hope in the clinician. Such attitudes are encouraged by the therapist, who rapidly communicates his confidence, competence, and authority. The clinician is necessarily more active and directive than he might be in larger term psychotherapy. Under such conditions, there is the realistic possibility of inducing a complementary regressive role in the patient, in which he gains relief but loses independence by turning his problems and fate over to the therapist. There is a paradox and danger here, for the relation is based on the patient's helplessness and the therapist authority, though its purpose is to encourage self-respect and self-determination. If possible, such danger is averted by continued focus on the problem to be solved, the limited time available, and the patient's own competence and capacity for autonomy. There is little discussion of the relation itself and transference elements are minimized. Unlike conventional psychotherapy, the end is constantly in new view. Termination is explicitly expected and dealt with. Under these conditions, the more forceful and active role of the therapist is less likely to influentilize the patient.

2.6 CONSULTATION

Consultation is emerging as one of the major techniques is Community Psychology. In one or another form, consultation is as old as clinical practice itself; it is an inevitable byproduct of specialization in any area. In essence, the consultative process involves one person (the consultee) who has a problem but lacks the knowledge or skill or it solutions, turning to another

(the consultant), who has the requisite ability to aid in its solution. One common meaning of consultation refers to the arrangements in which a problem is turned over to consultant who then takes responsibility for its solution. We are not concerned with this meaning here. We will be dealing with the case in which a consultant aids the consultee who however, retains responsibility for subsequent actions, whether in the care of particular clients or in the management of a program or organization. For this reason, the consultant is said to provide an indirect service to the person or organization in need, for he works through someone who continues to provide direct services.

The importance of consultation derives from the fact that the potential contribution of skilled professionals is multiplied. A greater number of clients can be helped through counsel given to mental health professionals, administrator Community caretakers or nonprofessional aides than could possibly be done by the same professional giving direct services to each of the same clients. At the same time, the quality of services is improved, as the consultee develops new skills and knowledge in his work with the consultant.

In the early development of Community mental health services in Massachusetts during the 1950s, consultation was accorded a prominent position (Hallock and Vaughas, 1956), it has become one of the central functions expected of Community mental health centers under federal legislation. From the perspective of clinical services, consultations not only extend the reach of working clinicians but it can as well serve an educative function. The consultee can work more effectively with future clients, applying the principles learned in consultation with the earlier clients.

In addition to extending and improvising clinical services consultation figure is importantly in program development and planning mental health research, and effecting changes in community organization and institutions. Mental health consultants in schools or factories may help create settings more productive of psychological help; consultations with community leaders or government officials may result in far-reaching social changes. In each of these cases, distinctive skills and experience are required of the consultant, but they have in common sharing of his knowledge with a much larger population than he could serve directly. As consultation has become more valued, particularly as an instrument of preventive intervention is community psychology, there has been increased concern which is both similar to, yet importantly different

from, such activities as psychotherapy, clinical supervision, education or administration (Altrocchi,1972, Caplan, 1970, Mannino and Shore, 1972).

Types of Consultations

Caplan (1963, 1964,1970) has distinguished four classes of mental health consultations.

1. Client-centered case consultation

This is the familiar case referred to a specialist who provides direct services to the client. A clinician with particular expertise may be asked by the consultee or the client himself, to examine the patient, make recommendations for further treatment or himself take over responsibility for subsequent clinical care. The important relation is between the consultant and the patient the interactions between consultant and the referring clinician, although important, is secondary.

2. Consultee-centered case consultation

Here the focus is on the consultee's difficulties is working with a particular patient or patients. The focus may be as narrow as the treatment of a particular case, or as broad as the consultee's understanding or management of many patients of similar kind, but in either case, the focus is upon the work of the consultee, to which the particular clinical issues are secondary. The consultee is often a fellow mental health professional, but he could as well be a community care taker, non professional or in some other fashion involved with the client. Although he may see the patient on a particular occasion, the consultant remains essential outside of the clinical relation.

3. Program-centered administrative consultation.

Here, like in client-centered case consultation the focus of concern is with the program itself, rather than the consultee's problem in it. At the extreme, a consultant may be called in to provide specific technical help, such as advising on the construction of new building suggesting alternate designs or analysis in research, reviewing staff organizations, providing information on

community resources or in any of numerous other ways, giving specific help to the program. His role is instrumental to the work of the consultee and his organization.

4. Consultec- centerred administrative Consultation

Here, like in conslutee-centered case consultations, the focus is on the work of the consultee in regard to his program. The consultee's understanding of the situations, prevention efforts, knowledge and attitudes that would facilitate or block the solution of problems, the center of concern, the particularities of the program are secondary.

In actually, it may be difficult to maintain the distinction between a consultee- centred mode and a client or program-centered mode of consultations. Often, it is a matter of relative emphasis and frequently the relation moves from form one mode to the other. The distinction is important, however, because there are different contracts expectations, and consequently, behaviors appropriate to the different consultation models. Consultation of the consultee-centered kind is more likely to fulfill the dual purposes of consultation. On the one hand to contribute to the solution of the patient's (or program's) problems, while at the same time developing the capacity of the consultee to solve future problems.

General characteristics of consultation

1. The relationship is voluntary.
2. The consultant is an outsider.
3. The relationship is time-limited.
4. Consultation is problem-focused.

Functions of Consultants

Altrocchi (1972) reviews the various functions which the consultant can serve. First among these is his role in the teaching and training consultee in which he/she functions as both a technical expert and resource person. He brings to the attention of consultee results of appropriate research, the literature of the field, experience with comparable problems in other

settings. Knowledge about the functioning of other agencies, techniques that have been developed elsewhere, and other material of relevance to the work of the consultee.

Secondly, he serves as a communication facilitator, either among consultees within an agency or between agencies or between the consultee, the agency and the larger community. By virtue of his more extended view of work in the field and of other resources a consultant is often in a position to bring together previously isolated workers or agencies. Related is the third role, that of human relations mediator barriers to effective communications among agencies, reduced competition and mutual fear and encouraged collaboration.

Phases is the consultation process

The process of consultation moves through a sequence of stages, each of which posed particular problems. Gibb (1959) has distinguished entry, diagnosis, data collection, relation boundary definitions, resource development, decision making, and finally termination.

2.7 THE ROLE OF NON-PROFESSIONAL HELPERS

The use of people without formal training or credentials as helpers in mental health programs has become an increasingly important trend is community psychology. In this section we will discuss kinds of people involved, the functions served and discuss some issues of selections, training and supervision and some of the problems in this emerging field.

Four somewhat related arguments have been used to justify the training and use of non-professionals.

Increase of Helpers

It increases the sheer number of available helpers. Added to the body of professional workers. Non professionals can relieve professional time, provide additional services, allow more patients to be seen and so on. If there were sufficient professionals, non professionals, might not be necessary, according to this argument. But there are not, and hence they are

necessary. The emphasis is on more. This position responds to the chronic shortage of trained manpower.

Unusual qualities of workers

Non professionals can add different and unique qualities to manpower pool, and their training could be justified even if there were no manpower shortage. Particularly in serving lower class and minority communities, there are cultural barriers between the professionals. "Indigenous on professionals" drawn from the community and sharing it culture, have helped bridge these barriers in community mental health programs (Reiff and Riessman, 1965). Similarly, former delinquents, criminals, drug addicts, alcoholics and mental patients have all contributed to work with patients who have similar problems. Parents have been trained to work with their disturbed children, either as behavior therapists (Wahler, Winkel, Peterson and Morrison, 1965) or in a form of client-centered play therapy called 'filial therapy". **N**on professionals work in mental health, their unique attribute which recommended them whether derived from class or race, personal problems or family status.

Psychological growth and competence of the helper

A third argument shifts the emphasis from the client to the helper himself and justifies on professional straining in the terms of its potentials for facilitating psychological growth and social competence of the worker himself. This is a major theme in the 'new careers' programs in poverty communities. As the worker develops skills and responsibility for the welfare of others, he becomes a more effective, satisfied, and valuable citizen himself. The underlying psychological principle is of course, an old and familiar one. Being a helper helps the helper; the teacher learns when teaching. Participants in Alcoholic Anonymous, synanon Recovery inc. and similar group run by deviants for fellow sufferers support positive growth in themselves. Riesman (1965) has termed this the 'helper therapy' principle.

Recruitment into professional career

Non professional service can be an effective basis for recruitment is to professional careers. In the past, particularly in volunteer programs for college students the opportunity to learn directly about problems of mental health and to test their fitness for and interest in a

clinical career. Indeed, many clinicians date their career decisions from a summer's work in a mental hospital.

Broadly speaking non professionals includes many kinds of people, working in different roles, in different settings with differing degrees of involvement, and with different career ends. Most generally what they have in common is that they are not professional; they do not have the training, degrees, titles or social recognitions. They may be students, high school or college or school dropouts. They may be adolescents, mature women, or elderly people. They may be socially like or unlike professionals; socially like or unlike clients served. Work is done in hospitals or clinics, community mental health programs or action programs, in their jobs, they may be paid or unpaid, full of part-time.

2.8 MENTAL HEALTH EDUCATION

Mental health education is intended to serve two broad though related purposes;

1. to educate the public and its leaders about the nature of mental disorders and methods of treatment to convey the magnitude of the problem and to mobilize actions toward improving the care and treatment of the mentally disturbed. The plea is for interest and comparison rather than stigmatization and rejection.
2. To improve the mental health of community by encouraging preventive activities professional associations, citizens groups and governmental agencies engage is educational activities towards these ends. The effort to inform and change public attitudes is an important theme of community psychology. It may be conveyed by lectures or films, newspaper or magazine articles comic strips T.V programs or spot advertisements. The best talents and techniques of communication experts are used. They are apparently quite successful in informing and changing attitudes as well as encouraging particular health related activities.

The practice of mental health education

Practice in this realm can be considered in terms of three components: Technique, target, group and content.

1. Technique

A major thrust is mental health education in recent years is the greater utilization of group processes for developing understanding of mental health issues. From the work on group dynamics and the related efforts in the dynamics of planned change. In the Lewinian tradition, there is increasing recognition of potential of voluntary group interaction as a vehicle for problem solving and attitude change in the mental health realm as well as other aspects of social life. Where people participate themselves in the educational process, rather than being "educated at" change is likely to be quicker and more permanent. Hence, a major effort of mental health educators involves group discussions in which the educator is more a resource person than a lecturer. In this regard, it can be noted that consultations, though considered as a separate topic, can be conceived in much the same framework and is actually a major technique for providing mental health education.

The mass media, however, remains the primary route for reaching the public at large. Television, newspapers, and magazines carry reports on mental health program and developments. Problems of neurosis and psychotherapy have become familiar on many TV dramatic programs, as have concerned with drug abuse delinquency, alcoholism, and other social problems. Various kinds of mental health programs are pictured, such as crisis clinics, suicide preventions and community mental health centers. All of this reduces the strangeness and fearsomeness of the work of mental health.

Lectures to organized groups (weather to the Lions Club or an eight -grade class), demonstrations and the films are important ways of communicating mental health information. Movies have been produced for many special audiences and are often shown along with discussion led by a professional. Mental health associations and professional groups have speakers' bureaus which provide speakers on request.

2. Content

What is taught relates both to the technique used and to the needs of the target group, as well as the goals of the mental health educator. Thus, if the propose is to strengthen support for mental health facilities in the community, and the audience is composed of community leaders, then presentations may include mental health statistics, cost-benefit accounting or limitations of

present resources, much of which might be presented in printed form or in a lecture with discussion. With a parents group the focus is more likely to be on matters of child development and their importance for later mental health, a more participatory format would likely be required if any substantial change in attitudes and later action is to be expected. In order to be effective, an educator must not only have a broad knowledge of psychotherapy and psychopathology, development, interventions method social problems and understanding of the organization and facilities of mental health but also have the knowledge and skills of communications and group processes required of a fine teacher or consultant.

3. Target group

In any community there are numerous potential target groups. Adels on and Lurie (1972) suggest three major groups who should be given the highest priorities in mental health education.

1. Those vulnerable to emotional disorder. This include children and their families, groups going through any developmental crisis. Such as starting in a new school or career, those facing special stresses such as illness or loss of job and those under long-term stress, such as inadequate housing, chronic unemployment, and the like. In these cases the primary purpose of education is to help these groups to deal with their own problems.
2. Those holding power in the community, whether local, statewide or national those belonging to the power structure are important targets since the fate of the mental health enterprise, whether a local community clinic or a national research programme depends on their understanding and good will. For other reasons, however, the powerless and deprived are also of concern, for increased understanding on their part can lead to their taking a more vital part in the development of services best suited to their needs.
3. Those with Care-taking Functions. Teachers, ministers, physicians, and the police, need mental health information because they are involved in more or less direct ways with the problems of vulnerable people.

In lengthy review, Adelson and Lurie (1972) details the particular forms of education which are provided for those in the educational system, health system religious organizations, industry and government at all levels. Within each of these systems, the pattern of educator-participants-topic-technique that might be used differs importantly. The kind of program set up for pediatricians concerned to understanding the behavior problems of children might involve lecturers by a child psychiatrist; by contrast, a meeting for industrial executives to encourage them to hire former patients would probably require both factual presentations by someone who understands the problems of industrial productions and sensitivity-group sessions to work through emotional resistances.

In the community approach, educational efforts are the concern of all mental health professionals but they require in addition the special talents and training of 'mental health educators' (E.E. Goldston-1968). Like colleagues in the older field of health education mental health educators have particular expertise in educational methods, communications, and media. By sharing their knowledge with psychiatrists and psychologists, they can sharpen their educational efforts; at the same time, they can take primary responsibility for public information programs and presentations to particular target groups. To discharge these functions well, they should not only be broadly informed in the general field of mental health, and have special training in communications, public relations and social psychology, but should also be well versed in problems of community organization and planned change. Specially training for mental health education is now being carried on in a number of schools of public health.

2.9 SUMMARY

To sum up with, this unit has given an overview about the principles of community psychology, the major techniques of community psychology, crisis intervention, consultation, its types, the role of non-professionals helpers, the importance of mental health education are dealt in this unit.

2.10 KEYWORDS

Community interventions

Crisis intervention

Consultation

Non-professional helpers

Mental health education

2.11 CHECK YOUR PROGRESS

1. Explain the principles of Community Psychology.
2. Explain major techniques of Community Interventions.
3. Define crisis intervention.
4. Discuss the role of non-professional helpers.
5. Explain the purposes of mental health education.

2.12 ANSWERS TO CHECK YOUR PROGRESS

1. 2.3
2. 2.4
3. 2.5
4. 2.7
5. 2.8

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UNIT-3 COMMUNITY MENTAL HEALTH AND MODELS

STRUCTURE

3.1. OBJECTIVES

After going through this unit you will be able to explain

- Concept of Community Mental Health
- Community Mental Health and Medical Models
- Clinical Models
- Custodial Model
- Therapeutic Model
- Community Models
- Clinical Model
- Public Health Model
- Social Action Model
- The Medical Model

3.2 INTRODUCTION

The term 'Community Psychology' overlaps with the older concepts of community psychology, preventive psychiatry, community mental health and social psychiatry, all of which emphasize the importance of the social environment in determining and changing human behaviour. Each of these terms has been defined in more conservative or more radical ways, as either being chiefly concerned with the development of new methods for the care of the mentally ill or being oriented to broad scaled social change of importance to the normal as well as deviant members of society.

3.3 CONCEPT OF COMMUNITY MENTAL HEALTH

The term 'Community Psychology' covers the concepts of community psychology, preventive psychiatry, community mental health and social psychiatry, all of which emphasize the importance of the social environment in determining and changing human behaviour. Some have distinguished a practice field (community psychology) from a field of research and theory (social psychiatry). The term social psychiatry it is very interesting to note, dates at least from 1917 when Southard first coined it in analogy to the then new field of Social Psychology (N.W.

Bell & Spiegel, 1966). Just as Social Psychology comes from the conjunction of Social and Psychological concepts, Southard believed that Social Psychiatry" should join Social and Psychiatric concerns. Terminological complexity is added by the fact that Sociologists have had long standing interests in the study of the action of social factors on emotional disease. Thus Dunham (1947) reviewing this field for the American Sociological Society described an already well developed area of theory and research. A field of social psychiatry has emerged, he notes, from the attempt to study certain problems considered as psychiatric from the point of view and with the techniques of the sociologists.

However, he is troubled by the "semantic difficulties" in the term since other social and behavioural scientists are much involved in the same area. This fact, he notes further 'questions the proposition that a field of social psychiatry should be regarded as exclusively the product of the sociologists" (Dunham,1947). Indeed, then social psychiatry is widely used by psychiatrists, by some to characterize a focus of practice as well as research (M.Jones, 1968). Thus, to avert confusion, Weinberg (1967) urges other sociologists to use Arnold Rose's term psychiatric sociology" to identify their unique concerns. The same general area has been called the "social psychology of mental health" by psychologists such as Wechsler, Solomon and Kramer (1970). Clearly, there are no distinct or consistent meanings implied in the various combinations of 'social' 'community' and 'sociological with psychiatry' psychology and "mental health". In addition, the terms favoured often reflect the disciplinary allegiance of the user.

In this regard, the term "community mental health" which has gained wide usuage in recent years, may be the most neutral and inclusive. It can properly include the work of all of the helping professions", such as clinical psychologists, psychiatrists, psychiatric social workers, group and youth workers, school and counseling psychologists. Welfare workers and criminologists and probation officers. The same term can encompass theory and research as well as practice techniques and programmes. Although "community" does not imply as broad a focus as 'social' in the present usage the two terms have become essentially synonymous. Community mental health can be narrowly conceived to mean primarily the application of socially oriented treatment techniques to mental patients but it can as much be broadly conceived to include prevention and efforts to foster psychosocial competence and positive mental health. Thus, the

staff of Langley porter Neuropsychiatric Institute of the University of California in San Francisco defined community mental health as follows:

The broad, multidiscipline field concerned with the wide variety of forces and structures in a community which affect the emotional stability of a significant group of its members. It is contrasted with the traditional clinical approach which focuses on the particular individual in emotional distress. The attention is directed at social institutions including those concerned with welfare, health, legislation, minority groups, employment, education, which can in their functioning either enhance or hinder the emotional growth of a large segment of population.(S.E.Goldstein,1965).

In this statement, "community mental health" is essentially synonymous with community psychology. However, community mental health has come to mean provision of psychiatric services in community mental health centers. To preserve the sense of the broader field which concerns here, the term "community psychology" will be used, although as noted the distinctions between these terms are difficult to maintain.

3.4 COMMUNITY MENTAL HEALTH AND MEDICAL MODELS

For analytic purposes, mental health orientations can be described in terms of five distinct models, which in turn, fall into three major groups. Like any analytic scheme,these categories are somewhat arbitrary and admittedly gross, but they can be helpful to comprehend contrasting views. The five models are:

I. Clinical models
    A. Custodial model
    B. Therapeutic model
II. Community models
    A. Clinical model
    B. Public health model
III. Social action model.

The clinical models span the entire field of mental health as it existed, with relative minor exceptions, until, the mid-1950s. Emphasis is on the individual in distress. At the custodial pole,

thinking is anchored firmly in a medical concept of psychiatric illness; in the therapeutic position, psychological understanding and psychotherapy are emphasized. The therapeutic pole encompasses a wide variety of conceptions of personality, psychopathology and psychological interventions. What they have in common is a concern with the wellbeing of the individual patient.

The community models, by contrast, shift emphasis from the individual towards the social setting. There is a growing trend, in the community mental health movement, to provide early and immediately available care to all parts of the population, hopefully in ways that might prevent as well as treat psychological disturbance, in setting as integrated as possible with community life. These concepts and methods are still very much in development phase. Interventions at the clinical pole, like those of the therapeutic model to which it is closely related, still focus largely on the individual in need, although there is more explicit concern with the social context of intervention. By contrast, the public health pole of the community orientation concerns more directly on the social influences which affect individuals lives. The analogy, and hence the term, is to the public health physician's efforts to discover and eradicate the sources of disease to which a 'population at risk' is exposed. A clinical approach is concerned with the diseased individual, a public health approach is aimed at prevention through the elimination of disease causing conditions.

Finally, the social action model which contrasts public health model, that ultimately human problems are reflections of the strains in society. Hence, broad scaled reorganization of social institutions is absolutely essential in order to achieve full and lasting relief of human problems.

3.5 CLINICAL MODELS

Clinical Models can be broadly classified into two categories. They are as follows:

3.5.1 CUSTODIAL MODEL: This orientation is the view that the patient is the victim of psychiatric condition, that he has limited if any capacity to manage his own life, and that therefore, professional care must be imposed by society, for his sake and welfare of others. It is in this sense that the model is described as custodial. It is best

exemplified in traditional psychiatric hospitals. Patients are often committed involuntarily, but even if admitted at their own request, the hospital takes over the major responsibilities for their lives. The patient's conditions are usually viewed as a disease likely of biological origin. Patients are given drugs, electroshock and other somatic therapies. Psychological and social interventions are either not available or believed to be of minor importance. Psychiatric diagnosis is valued, though more often used for administrative and record keeping purposes than to guide treatment. Authority and responsibility are vested in physicians, with other professionals viewed as "paramedical" and ancillary. The medical model dominates work in the traditional hospital.

3.5.2 **THERAPEUTIC MODEL:** This is the largest, most evolved and internally differentiated category, for it encompasses most of the activities of clinicians from positions as diverse as psychoanalysis, existentialism and behaviourism. What is common to all the approaches within a "therapeutic" model is faith in the efficacy of psychological intervention, of one or another sort, for bringing about desirable changes in patients. Patients are viewed as disturbed individuals, whose conditions have psychological roots and who can voluntarily contact for professional services. In this model, the clinicians works directly with the patient, and only secondarily or not at all with relevant others in his/her social environment. Thus, the hallmarks of this orientation are primary concern with a person in distress, respect for his needs and desires, personally contracted interventions, which usually occur in a professional setting(hospital, clinic or private practice) and are offered by a professionally trained mental health worker.

3.6 COMMUNITY MODELS

The Community Models can be divided into two categories. They are as follows:

3.6.1 CLINICAL MODEL

The community orientation emphasizes the role of social factors as determinants of human problems. Patient care is brought into the context of community values and institutions, as far as possible, in innovative settings which are more flexible than traditional mental health

institutions. A major aim is to make clinical services immediately and easily accessible to all portions of the population. Particularly the poor and disadvantaged who had previously been denied adequate services.

At the clinical pole, intervention methods are generally of the same type as in the therapeutic model, though adapted to the special needs and life styles, of particular communities. Services are offered in settings that are less professional (eg, storefront clinics) frequently in collaboration with family members and community 'caretakers'. Sometimes with the help of specially trained community members (indigenous nonprofessionals). The immediate goal is to carry patients through life crisis and to foster social competencies. There is relatively less concern with attempting to bring about major personality changes of the sort sought by psychotherapists. Therapy is briefer and more focused. In community oriented practice, the clinicians are necessarily more involved with the daily life and social problems of his client, particularly in work with poor and minority populations and his/her role is less distinguishable from those of other helping professionals (eg, social welfare workers, employment counselors, etc). The present problems of the client and his immediate social behaviour are more the focus concern than his life history, personality organization and functioning, values and attitudes. In order to serve as large a population as possible as effectively as possible, shorter and less costly modes of psychological intervention are sought and valued. Because the well-being of the patient is intimately connected with the behaviour of the family members and relevant others in the community, the clinician works with them. In other ways he/she also becomes directly involved in efforts to alter the patient's environment in order to alleviate psychosocial stress. Extensive personality evaluation, through interviews or psychological testing, are a luxury in community clinical service.

3.6.2 PUBLIC HEALTH MODEL

Here the shift is from direct involvement with the human problems of particular people toward efforts to alter some of the social conditions which affect whole communities. In principle, prevention is the major goal. Toward this end, there is a shift from person-centered to population centered or social- system -centered interventions. The family, school, workplace and social ecology in which the person lives are more an issue than the thinking, feeling or actions of that person. To reduce stressful qualities in those systems, if it is argued, would have the ultimate

effect of advancing the well-being of large groups of people as well as helping the particular individual in distress.

Any social institution can, in principle be the target of community psychological intervention, but most typically community psychologists focus on those which are most immediately involved with the lives of community members and which may be most accessible to change. This is perhaps best illustrated in interventions in schools. Through consultation with teachers, community psychologists attempt to sharpen teachers' sensitivities to the learning and emotional needs of children, particularly if they are from differing social backgrounds. At the same time they may work with school administrators, teachers, and community people in the effort to alter the educational system itself, curriculum, teaching methods, communication method, communication patterns within the system, and the way it relates to other portions of the community all to the end of increasing the likelihood that the school experience will be more growth enhancing. Relevant research for understanding social and community processes and for developing programs of community intervention is more in the model of social-science research than that of psychological investigation.

3.7 SOCIAL ACTION MODEL

This model represents the extreme social oriented position. It rests on the fundamental assumption that society, not the patient, is disturbed and need change. Activities of mental health professionals, even if community oriented, are seen as palliative at best (Leifer,1969). At its most literal, this position not only denies the value of clinical intervention but sees it as a positive barrier to effecting radical change. Human problems lie in the fabric of society itself and change in its fundamental structures is needed if human well-being is truly to be achieved.

Within this model are located the most vigorous critics of "medical-model" thinking, some arguing that the medical conception of psychiatry disguises its role as an instrument of social control in as repressive society and thereby limits its potential for contributing to social change. Commenting on the present state of psychiatry, Leifer(1970) notes that "psychiatry is social action disguised as medical treatment" and again community psychiatry is a quasi-political movement supported by state sanctioned power and money. Within this view, therapeutic and community approaches are both used to influence and control the individual in accordance with

the dominant ideology of the state, industry, and other centers of power in our society. In varying form, radical social critics have restated the same theme.

A less radical version of a social action position argues that the goal of mental health might be best achieved by influencing major social programmes, and that the target of intervention should be less the individual or community institutions than the political and social policy makers in the highest possible positions of authority. The premise is the same, that changes must proceed from the largest and most basic social institutions on down to the smaller, but the role of social action agent is conceived more as consultant to and friendly critic of, those in power rather than being their revolutionary antagonist.

3.8 THE MEDICAL MODEL

Along with the new conceptualization of human problems and modes of mental health care, there is considerable controversy around the medical or disease model. Continuing to think of psychologically disturbed behaviour in disease terms limits attention essential to ethical and social questions and keeps intervention within the institutions of medicine. Psychiatrists, psychologists, sociologists, and social critics have argued that the use of medical metaphors block proper understanding and treatment of psychosocial problems and should be abandoned. Often these attacks occur from different vantage points, themselves contradictory and on different issues loosely united within a notion of the "medical model" different aspects of which have been emphasized in each polemic. Here are some of the elements ascribed to a medical conception of psychological dysfunction which have been attacked from one or another viewpoint;

1. There are disease entities, which have etiology course and outcome.
2. These diseases are of organic origin.
3. Even if conceived as psychological diseases, they are viewed in analogy with physical ailments.

There is an underlying state which is manifested in surface symptoms. Disease is to be inferred from symptoms; changing symptoms will not cure the disease.

4. People get these diseases through no fault of their own.

5. Cure depends on professional intervention, preferably by people with medical training.
6. The diseases are in the person and although they may have culturally distinct manifestations. The essential disease process is universal and not culturally specific.

An early and vigorous attack on the "myth of mental illness" was launched by the psychiatrist Thomas Szasz (1960;1961). By now, he asserted the concept of mental illness is nothing but a convenient myth, most mental symptoms cannot be related to lesions of the nervous system. Rather, they are communications the patient offers which characterize his beliefs about himself and the world. They are necessarily parts of his social and ethical context, and should be treated accordingly. The patient should have the right to determine how and why his behaviour should change, and he should also be responsible for his acts. Under the guise of medical care deviants are punished and incarcerated. Medicine cannot and should not judge ethical and social issues. And so Szasz argues that psychological disturbances should be regarded as the expression of how he should live. And again, mental illness is a myth whose function is to disguise and thus render more palatable the bitter pill of moral conflicts in human relations.

From a quite different vantage point behaviouristic clinicians center their attack on the issue of disease and symptom (Krasner & Ullman,1965). They argue that the visible symptom is the disease and that there is neither need nor justification for assuming underlying disease states. Their approach to therapy, consists of attempts to remove symptoms or to substitute new behaviours through the application of learning principles. They have less quarrel with other aspects of the medical model. By contrasts, existentialistic and humanistic clinicians, at complete variance with the behaviouristic group, oppose the deterministic theme in the disease model, and the emphasis on historical and unconscious factors. Far more important, they believe the patients phenomenal experience, his quest for meaning and his striving to realize his potential. From yet another perspective socially oriented clinicians are unhappy at the focus on the individual patient and on interpersonal factors, whether organic or psychological, which divert attention from the social systems within which people live and function, well or poorly. Keeping human problems within the scope of medical concepts and institutions, they further argue, limits the innovations (eg, use of nonprofessionals, new settings, etc.) necessary for comprehensive community care. A more extreme view is represented by those sociological theorists who would see mental illness as

another form of social deviance, like criminal behaviour, sexual aberrations, immorality or drug use, which is defined by social values. What is most critical, they contend (eg, Scheff,1966) is the valuation society places on the behaviour, whether it defines it as sick, dangerous, sinful or acceptable. In this view, the patient is given a role (crazyman), which he can accept and act accordingly.

Finally, there are psychologists who contend with the medical model out of status rather than conceptual concerns. Within the medical model, the physician is necessarily in the dominant role while other professions are viewed as ancillary, a term which derives from the Latin for 'handmaiden'.

The understanding of psychological functioning has been greatly facilitated by the study of principles of broad generally, such as stress and defense, which figure in biological as well as psychological adaptation. Still, overdependence on medical metaphors for the conceptualization and treatment of psychological problems presents distinct dangers, such as;

1. Both implicitly and explicitly, biological rather than psychological or social factors are stressed. This is true of the patient's conception of his problem, as well as the professionals. If I have a disease then there must be something wrong with my body, cut it out or dose it, and I will be well again. Or If I am sick, what good is it to sit here talking?
2. The view of the patient as passive recipient of expert care is fostered. It is true of course that in many medical conditions the cooperation of the patient is of critical importance, but in psychotherapy the patient is, in a significant sense, a coequal partner without whose collaboration therapy is impossible.
3. Medical role models are perpetuated. Too often, these have an authoritarian cast. The doctor knows best, follow his prescriptions and you will be well. Needless, to say, the "authoritarian doctor and passive patient" relationship can exist if the doctor is a Ph.D as well as M.D. Indeed, psychologically, minded psychiatrists, notably psychoanalysts, often go to lengths to disassociate the psychotherapists role from the physician role.
4. Emphasis on disease directs attention to a search for specific etiologies, therapies and prognoses. It can lead to an overemphasis on the diagnostic phase of the clinical

process. Good clinical practice requires clearly describing and understanding a patient's condition (though some clinicians might argue the proposition). But overemphasis on diagnosis can divert concern from the ultimate purpose of fostering change.

5. With diagnosis, there are the dangers of labeling and stigmatizing. But in the present scheme of things a label such as 'schizophrenic' may have the effect of casting out the sufferer and consisting him to banishment in a mental hospital. While the label does not create the condition, as some role theoretical views hold, it does matter greatly. It has social import for the patient contribute to his self-concept and the actions of people toward him.
6. The disease model emphasizes the pathological themes in life and neglects the sources of competence and strength in personality development. Professional activity is too often directed toward discovering personality weaknesses rather than strengths. If a person comes to a clinic, he and we view him as ill and being ill needing to be restored to health. The disease model encourages, though by no means does it enquire, emphasis on pathology.

There is need for vocabulary and ways of thinking which conceives psychological problems in terms those traditional in medicine. To argue this point, critics have too often simplified modern medical thinking, though probably not much of line with common usage. To sophiscated medical thinkers, health is not simply the absence of disease. Thus, the charter of the World health organization defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Similarly, issues like discrete disease entities, patient passivity dangers of labeling, doctor authoritarianism, and other matters just discussed have been given thoughtful attention in medicine and need not be intrinsic to a 'medical model'. However, they do represent the kinds of attitudes and distortions which are commonly held and which from the vantage point of psychological health, limit our and the public's understanding of the problem. The words and concepts of medicine, at least as understood by the average man, can block progress. Not likely they will remain with us for a good long time but the literal application of medical metaphors should be resisted.

3.9 SUMMARY

To sum up with, this unit has dealt with the various models of community mental health. Mental Health Models of Community like the clinical models which are further divided into custodial and therapeutic model. The community models like clinical model, public health model, and social action model are being discussed in detail in this unit.

3.10 KEYWORDS

Community Mental Health
Medical Models
Clinical Models
Custodial Model
Therapeutic Model
Community Models
Public Health Model
Social Action Model

3.11 CHECK YOUR PROGRESS

1. Define the Concept of Community Mental Health.
2. Explain Community Mental Health and Medical Models.
3. Explain the types of Clinical Models.
4. Discuss Community Models and its types.
5. Describe Social Action Model.
6. Explain Medical Model.

3.12 ANSWERS TO CHECK YOUR PROGRESS

1) 3.3
2) 3.4

3) 3.5
4) 3.6
5) 3.7
6) 3.8

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UNIT: 4 - VALUES OF COMMUNITY PSYCHOLOGY

STRUCTURE

4.1 OBJECTIVES

After going through this unit you will be able to explain

- Values of Community Psychology
- Core values of Community Psychology
- Individual and family wellness
- Sense of Community
- Respect for human diversity
- Social Justice
- Empowerment and citizen participation
- Collaboration and community strengths
- Empirical grounding

4.2 INTRODUCTION

Awareness of values is crucial for community psychology. Values are deeply held ideals about what is moral, right or good. They have emotional intensity; they are honored, not lightly held. In this unit we are going to discuss about the importance of values in community psychology .The individual, family ,the sense of being in a community, individuals are different still each individual need to be respected for what they are ,the respect for human diversity, social justice empowerment and citizen participation, collaboration and community strengths, emphirical grounding all these are discussed in detail.

4.3 VALUES OF COMMUNITY PSYCHOLOGY

Awareness of values is crucial for community psychology. But what exactly do we mean by values? Values are deeply held ideals about what is moral, right or good. They have emotional intensity; they are honored, not lightly held. Values may concern ends (goals) or means (how to attains goals), or both. They are social; we develop values through experiences with others. Individuals hold values but so do families, communities, and cultures. Values may be rooted in spiritual beliefs or practices but can also be secular. Many values conflicts involve choices about which of two worthy values is more important in a given situations (Nelson et.al, 2010).

In Community psychology, discussion of values is useful for several purposes.

1. Values help clarify choices for research and actions. Even defining a problem is a value-laden choice, strongly influencing subsequent action. Public definition of community and social problems reflect the worldviews of the help the powerful and help to maintain the status quo. Attending to values can lead to questioning those dominant views. For community psychologists, deciding whether to work with a particular organization or community requires attention to values. Sometimes, the community psychologist may conclude that his or her values do not match those of a setting and choose not to work in that setting (Isenberg. et.al., 2004).

2. The discussion of values helps to identify when actions and espoused values do not match. Consider a community leader who helps to find a neighborhood social center to empower teens who are gay, lesbian, bisexual or questioning their sexuality. The leader decides how to renovate the space and plans programs, allowing the youth themselves little say, despite the leader's intent, this actually disem powers the youth (Stanley, 2003).

   Or consider an alternative high school that seeks to empower student's, their families, and teachers (Gruber & Tyrickett, 1987). But when decisions are to be made, the teachers have sources of day-to-day information and influence those students and parents lack; teachers thus dominate the discussion. Despite the exposed values of all involved, the organizational practice does not empower students and families. The problem is not individual hypocrisy but an organizational discrepancy between ideas and actual outcomes.
3. Understanding a culture or community involves understanding its distinctive values. For instance, Potts (2003) discussed the importance of values of family and community unity, and interdependence of the land, water and human communities.
4. Community psychology has a distinctive spirit (Kelly, 2002), a shared sense of purpose and meaning. That spirit the basis of our commitment and that, what keeps us going when obstacles arise (Kelly, 2010). It is thoughtful but also passionate and pragmatic, embodied in research and action

4.4 CORE VALUES OF COMMUNITY PSYCHOLOGY

The spirit of community psychology is based on seven core values;

1. Individual and family wellness.
2. Sense of community
3. Respect for human diversity
4. Social Justice
5. Empowerment and citizen participations
6. Collaborations and Community strengths
7. Empirical grounding

We begin with the value most closely linked to the individual level of analysis. Proceeding to those more closely linked to community and macro system levels. This order is not a ranking of these values importance. Our discussion of these seven values is influenced by, yet different from, the discussion of values of Isac Prilleltensky and Geoffrey Nelson (2002). These seven values based on our experiences, are just one way of summarizing the field's Values. Each individual and working group within the field must decide what values will be central to their work. Our discussion here is intended to promote the discussion of these values and the issues they raise for community life. As Bond (1989) and Riger (1989) will be guided by some set of values and serve someone interests, whether we realize it or not. Better to discuss and choose our values and how to put them into actions.

Debi Stames, a community psychologist, provided examples of how she has applied each value in her leadership on the Atlanta, Georgia, City Council. These examples illustrate how one committed person can make a difference by speaking out and working co-operatively with others.

4.5 INDIVIDUAL AND FAMILY WELLNESS

Wellness refers to physical and psychological health, including personal wellbeing and attainment of personal goals (Cown, 1994). Indicators of wellness include Symptoms of psychological distress and such measures of positive qualities as resilience, social-emotional

skills, personal wellbeing, and life satisfaction. These and similar indicators are often outcome criteria for community psychology interventions.

Strengthening families can promote individual wellness. Community prevention programs that focus on child development often address parent and family functioning. However, individual and family wellness is not synonymous.

Individual/family wellness is also the focus of clinical psychology and related fields. Community psychology goes beyond, yet complements, clinical methods by placing individual wellness in the context of ecological levels of analysis.

To promote individual/family wellness, community psychologists have studied and developed community interventions focused on the prevention of maladaptive behavior, Personal and family problems, and illness; promotion of social-emotional competence and of health; social support networks and mutual help groups; intervention programs in such non clinical settings as schools and workplaces; and advocacy for changes in social services, laws, policies and programs to promote physical and mental health. In her work on Atlanta city council starner promoted the value of individual and family wellness by heading an action group that produced policies and programs for homeless persons and families. This led to developing services along a continuum of care: emergency shelter care, transitional housing, self-sufficient housing for living independently, Job training, supportive housing for homeless persons with serious mental illness and a resources opportunity center and management information systems that coordinated services among 70 agencies serving the homeless.

Starner's efforts benefits homeless persons and families and the community at large. Prilletnesky (2001) proposed the concept of collective wellness to refer to the health of communities and societies. Cowen's (1994) descriptions of wellness include concepts of empowerment and social justice. Certainly, individual and community wellbeing are interwoven and collective wellness is an attractive general principle. It is involved with the next five values that we discuss.

4.6 SENSE OF COMMUNITY

Sense of Community is the center of some definitions of Community psychology (Sarson1974). It refers to a perception of belongingness, interdependence, and mutual commitment that links individuals in a collective unity (McMillan 1986). For example, community psychologists have studied sense of community in neighborhoods, schools and classrooms, mutual help groups, faith communities, work places, and Internet virtual environments. Sense of community is a basis for community and social action as well as resource for support and clinical work.

The value of sense of Community balances the value of individual/family wellness. The emphasis in western cultures and in their fields of psychology is on the individual, which in its worst forms can foster selfishness or indifferences to others. Building a sense of Community goes beyond individualization to a focus on interdependence and relationships, form a community psychology perspective quality of life for individual and community ultimately depend on each other.

Yet sense of Community is not always positive. It can involve distancing 'insides 'from 'outsides'. It can be bolstered by ignoring or attacking diversity within a community. Creating injustice or deadening conformity. It is not a cure-all. In especially risky neighborhoods, withdrawal from the community may be adaptive for adults or children (Brodskey, 1996). Thus, this value must be balanced with other values, especially social justice and respect for diversity.

In her work in Atlanta, Starner (2004) promoted this value through several initiatives. Atlanta has become a leader in replacing large, concentrated public housing units with attractive, well-built, mixed income communities. Starner was considered naive for championizing the mixing of middle-income and lower income residents. These have increased feelings of Community across social class lines.

In addition, starner helped initiate community and redevelopment plans for seven Atlanta neighborhoods affected by the 1996 Olympics development. Finally, she helped initiate new quality of life zoning and building ordinances requiring street planning and housing features that encourage neighboring. For instance, those ordinances promote having services within walking distance and having front porches and sidewalks so that people can see each other and chat more.

4.7 RESPECTS FOR HUMAN DIVERSITY

This value recognizes and honors the variety of communities and social identities based on gender, ethnic or racial identity, nationality. Ability or disability, socio-economic status and income, age or other characteristics, understanding individuals-in-communities requires understanding human diversity (Trickett 1996). Persons and communities are diverse, defying easy generalizations and demanding that they be understood in their own terms.

This is a not a vague respect for diversity as a politically correct attitude. To be affective is community work, community psychologists must understand the traditions and folkways of any culture or distinctive community with whom they work. That includes appreciating how the culture provides distinctive strengths and resources for living. Researchers also need to adapt research methods and questions to be appropriate to a culture. This is more than simply translating questionnaires; it involves thorough the examinations of the aims, methods, and expected products of research in terms of the culture to be studied (Hughes and Seidman-2002).

Respect for diversity does not mean moral relativism; one can hold strong values while also seeking to understand different values. For example cultural traditions differ in the power they grant to women; religious traditions vary in their teaching about sexuality. Respect for diversity also must be balanced with the values of social justice and sense of community-understanding diverse groups and persons while promoting fairness, seeking common ground, and avoiding social fragmentations. To do that, the first step is usually to study diversities in order to understand them. A related step is to respect others as fellow persons, even when you disagree.

4.8. SOCIAL JUSTICE

Social justice can be defined as the fair, equitable allocation of resources, opportunities, obligations, and power in society as a whole. Social justice has two meanings especially important here. Distributive justices concern the allocation of resources (e.g, money, access to good quality health services or education) among members of a population. The community mental health movement that arose in the United States in the 1960's was a distributive effort to provide mental health services to more citizens. Who determine how such resources are distributed? That is the question of procedural justice, which concerns whether process of

collective decision making include fair representations of citizens. Thus, distributive justice concerns the outcomes of a program or social policy, while procedural justice concerns how it is planned and implemented.

A social justice perspective is often most concerned with advocacy: for social policies (e.g. laws, court decisions, government practices, regulations) and for changes in public attitudes, especially through mass media. But it can also guide clinical work with members of oppressed populations and research on psychological effects of social justice injustice or changes in social policy.

Social justice involves concerns for wellness of all persons and an inclusive vision of community and recognition of human diversity. Procedural justice is especially related to value we present next; citizen participation in making decisions and genuine collaboration between psychologists and community members.

In practice, the pursuit of social justice must be balanced with other values and with inequalities in power that are difficult to change (Prilleltensky 2001).

4.9 EMPOWERMENT AND CITIZEN PARTICIPATION

Fundamental to a Community psychology perspective is the consideration of power dynamics in individual relationships, organizations, and communities. Empowerment is aimed toward enhancing the possibilities for people to control their own lives. Empowerment is a process that works across multiple levels and contexts; it involves gaining access to resources and exercising power in collective decision making. Citizen participation is a strategy for exercising this power. It emphasizes democratic process of making decisions that allow all members of a community to have meaningful involvement in the decision especially those who are directly affected. Grassroots citizen groups, neighborhood organization and community-wide prevention coalitions promote citizen participations. Citizen participation also refers to the ability of community to participate in decisions by larger bodies (e.g., macro systems) that affect its future. Empowerment and citizen participation are related to the concept procedural justice.

Citizen participation does not automatically lead to better decisions. Sometimes, citizens do not consider the rights and needs of all individuals or groups, and empowerment has been

used to justify the strengthening of one group at the expense of another. Thus, this value must be balanced with values of sense of community. Social justice, and respect for diversity. This can lead to conflict among competing views and interests. However, simply avoiding conflict by limiting opportunities for meaningful citizen participation is often worse for those values than promoting free debate.

4.10 COLLABORATION AND COMMUNITY STRENGTHS

Perhaps the most distinctive value of community psychology, long emphasized in the field, involve relationships between community psychologists and citizens and the process of their work.

Psychologists usually relate to community members as experts; researchers, clinical or educational professionals and organizational consultants. That creates hierarchical, unequal relationships of expert and client-useful in some contexts but often inappropriate for community work. Psychologists also traditionally address deficits in individuals (e.g diagnosing mental disorder), while community psychologists search for personal and community strengths that promote change. Community psychologists do have expertise to share with communities. However, they also need to honor the life experience, wisdom passionate zeal, social networks, organizations, cultural traditions, and other resources (in short, the community strengths) that already exist in a community Building on these strengths is often the best pathology to overcoming problems.

Furthermore, community psychologists seek to create a collaborative relationship with citizens. So community strengths are available for use. In that relationship, both psychologist and citizens contribute knowledge and resources and both participate in making decisions. For example, community researchers may design a study to meet the needs of citizen, share research findings with citizens in a form that they can use, and help use the findings to advocate for changes by decision-makers. Developers of a community program would fully involve citizens in planning and implementing it.

Collaboration is best pursued where psychologist and community share common values. Thus, it is crucial for community psychologists to know their own values priorities and to make

careful choices about with whom to ally in the community. It also means that differences in views that emerge must be discussed and resolved fairly.

4.11 EMPIRICAL GROUNDING

This value refers to the integrating research with community actions, basing (grounding) action in empirical research findings whenever possible. This uses research to make community action more effective and makes research more valid for understanding communities. Community psychologists are impatient with theory or action that lacks empirical evidence and with research that ignores the context and interests of the community in which it occurred.

Community psychologist's use quantitative and qualitative research methods. Community psychologists prize generating knowledge from a diversity of sources, with innovative methods. Community psychologists believe no research is value free; it is always influenced by researcher's values and preconceptions and by the contexts in which the research is conducted. Drawing conclusions from research thus requires attention to values and context, not simply to the data. This does not mean that researchers abandon rigorous research but that values and community issues that affect the research are discussed openly to promote better understanding of findings.

4.12 SUMMARY

This unit has dealt completely about the values, its importance, and the core values of community, the individual and family wellness, the importance of respect for human diversity, social justice empowerment etc. By going through this unit, a clear understanding can be gained about the community values.

4.13 KEYWORDS

Values
Family wellness
Sense of Community
Human Diversity
Social Justice

Empowerment

Citizen Participation

Collaboration

Community Strengths

Empirical Grounding

4.14 CHECK YOUR PROGRESS

1.Explain the values of Community Psychology.

2. Explain the core values of community psychology.

3. Discuss Individual and family wellness.

4. Explain the concept of respect for human diversity.

4.15 ANSWERS TO CHECK YOUR PROGRESS

1. 4.3
2. 4.4
3. 4.5
4. 4.7

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BLOCK-2 COMMUNITY INTERVENTION PROGRAMMES

UNIT: 5 - COMMUNITY INTERVENTION PROGRAMMES

STRUCTURE

5.1 OBJECTIVES

After going through this unit you will be able to explain

- Meaning and definition of community intervention programme
- Types of Intervention
- Comprehensive Community Intervention
- Importance of Educational and Community based programmes
- Emerging issues in Educational and Community based programmes
- Community Programmes for traditional problems in clinics, hospitals and homes

5.2 INTRODUCTION

Many recent community intervention programs— particularly those that target risk factors and introduce protective factors to prevent antisocial behaviour—have been heavily influenced by public health approaches (Hyndman et al., 1992; Perry, Klepp, and Sillers, 1989). While many of the programs reviewed by the community psychologists, they nonetheless suggest that comprehensive prevention strategies that involve more than one entity (e.g., police and neighbourhoods), take place in a variety of settings (e.g., home and school), and are maintained for several years have the potential to positively affect that population. This is especially true for communitywide programs targeting risk and protective factors for alcohol, tobacco, and drug use.

5.3 MEANING AND DEFINITION OF COMMUNITY INTERVENTION PROGRAMMES

A community "is a social unit of any size that shares common values. Although embodied or face-to-face communities are usually small, larger or more extended communities such as a national community, international community and virtual community are also studied.

In human communities, intent, belief, resources,preferences, needs, risks, and a number of other conditions may be present and common, affecting the identity of the participants and their degree of cohesiveness".

An intervention is the act of inserting one thing between others, like a person trying to help. One could be the subject of a school intervention if teachers call parents about the bad grades of students.

Intervention comes from the Latin *intervenire*, meaning "to come between, interrupt." Often an intervention is intended to make things better. One common use of the word refers to a specific type of meeting, or intervention, that happens with the family and friends of a drug addict; they join together to try to convince the drug user to change their ways and live a healthier life.

Intervention comes from the Latin intervenire, meaning "to come between, interrupt."

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the act or fact of interposing one thing between or among others the act of intervening (as to mediate a dispute, etc.) The act of intervening, interfering or interceding with the intent of modifying the outcome. In medicine, an intervention is usually undertaken to help treat or cure a condition. For example, early intervention may help children with autism to speak. "Acupuncture as a therapeutic intervention is widely practiced in the United States," according to the National Institutes of Health. From the Latin intervenire, to come between.

5.4 TYPES OF INTERVENTION

Types of community interventions are described below:

- Citizen mobilization
- Situational prevention
- Comprehensive community interventions
- Mentoring
- Afterschool recreation programs,
- Strategies
- Policy change interventions
- Media interventions

Above mentioned eight types of community wide interventions examined by the community psychologists focused on several risk factors, including easy access to firearms and

drugs, community disorganization, and community norms or attitudes favoring antisocial behaviour. The interventions also focused on such protective factors as social bonding and clear community norms against antisocial behaviour. According to the studies and evaluations of these interventions examined by the Study Group, prevention strategies that cross multiple domains and that are mutually reinforcing and maintained for several years produce the greatest impact.

Citizen Mobilization

Programs that mobilize citizens to prevent crime and violence have the potential to reduce serious juvenile crime because they often address risk factors and offer the protective factors necessary to deter or intervene with serious juvenile offenders. The most common citizen mobilization programs are neighborhood block watch programs and citizen patrols.

Neighborhood block watch programs are based on the premise that residents are in the best position to monitor suspicious activities and individuals in their neighborhoods. Evaluations of three such programs, however, found little evidence that the programs have a significant effect on neighborhood crime. An evaluation of a citizen patrol program similarly found no significant effect on crime. Specific community mobilization programs are described below.

Situational factors:

Risk Factors for Health and Behaviour Problems

Community

- Availability of drugs.
- Availability of firearms.
- Community laws and norms favorable toward drug use, firearms, and crime.
- Media portrayals of violence.
- Transitions and mobility.
- Low neighborhood attachment and community disorganization.
- Extreme economic deprivation.

Family

- Family history of problem behaviour.
- Family management problems.

- Family conflict.
- Favorable parental attitudes and involvement in the problem behaviour.

School

- Early and persistent antisocial behaviour.
- Academic failure beginning in late elementary school.
- Lack of commitment to school.

Individual/Peer

- Alienation and rebelliousness.
- Friends who engage in the problem behaviour.
- Favorable attitudes toward the problem behaviour.
- Early initiation of the problem behaviour.
- Constitutional factors.

5.5 COMPREHENSIVE COMMUNITY INTERVENTIONS

Comprehensive community interventions hold promise for preventing offensive actions, because they address multiple risk factors in the community, schools, family, and the media by mounting a coordinated set of mutually reinforcing preventive interventions throughout the community. Given the scarcity of evaluations completed in this area, the only comprehensive community programs summarized in the Study Group's report are ones that have focused on reducing alcohol and substance abuse, including smoking. Three of them are described below.

Mentoring

Many communities have initiated mentoring programs in which adult mentors spend time with and act as role models for individual youth. Mentoring interventions may address several risk factors (including alienation, academic failure, low commitment to school, and association with delinquent and violent peers), while introducing protective factors (including opportunities for pro-social involvement and development of skills for and recognition of prosocial involvement, bonds with adults, healthy beliefs, and clear standards for behaviour).

Afterschool Recreation Programs

Programs that provide supervised recreation after school address the offensive risk factors of alienation and association with delinquent or violent peers and introduce several protective factors, including skills for leisure activities and opportunities to become involved with prosocial youth and adults.

Community Programs for traditional problems provides an opportunity to practice the skills that are needed to participate in finding solutions to the local issues that concern them. This helps to develop the important citizenship objectives of sustainable future and integrates skills of using experiential and enquiry-based strategies. It also integrates skills in the planning of values clarification and values analysis with the possible solutions so students can take action to help achieve a sustainable future.

Educational and community-based programs play a key role in:

- Preventing disease and injury.
- Improving health.
- Enhancing quality of life.

Health status and related health behaviours are determined by influences at multiple levels: personal, organizational/institutional, environmental, and policy. Because significant and dynamic interrelationships exist among these different levels of health determinants, educational and community-based programs are most likely to succeed in improving health and wellness when they address influences at all levels and in a variety of environments/settings.

Objectives:

Community Programs for traditional problems Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health, and enhance quality of life.

- To develop an understanding of Community Problem Solving, especially as it may be used in education for sustainable futures.
- To identify the skills students need to participate in Community Problem Solving.

- To explore questions and issues that may be encountered when teaching through Community Problem Solving.
- To identify teaching and learning strategies that may be used as part of a Community Problem Solving project.

5.6 IMPORTANCE OF EDUCATIONAL AND COMMUNITY-BASED PROGRAMS

Educational and community-based programs and strategies played an important role in reaching Healthy People objectives. Over the next decade, they will continue to contribute to the improvement of health outcomes all over the world.

Health and quality of life rely on many community systems and factors, not simply on a well-functioning health and medical care system. Making changes within existing systems, such as improving school health programs and policies, can effectively improve the health of many in the community.

For a community to improve its health, its members must often change aspects of the physical, social, organizational, and even political environments in order to eliminate or reduce factors that contribute to health problems or to introduce new elements that promote better health. Changes might include:

- Instituting new programs, policies, and practices.
- Changing aspects of the physical or organizational infrastructure.
- Changing community attitudes, beliefs, or social norms.

In cases where community health promotion activities are initiated by a health department or organization, organizers have a responsibility to engage the community. Realizing the vision of healthy people in healthy communities is possible only if the community, in its full cultural, social, and economic diversity, is an authentic partner in changing the conditions for health.

Education and community-based programs and strategies are designed to reach people outside of traditional health care settings. These settings may include:

Schools

Worksites

Health care facilities

Communities

Each setting provides opportunities to reach people using existing social structures. This maximizes impact and reduces the time and resources necessary for program development. People often have high levels of contact with these settings, both directly and indirectly. Programs that combine multiple if not all four settings can have a greater impact than programs using only one setting. While populations reached will sometimes overlap, people who are not accessible in one setting may be in another.

Using non-traditional settings can help encourage informal information sharing within communities through peer social interaction. Reaching out to people in different settings also allows for greater tailoring of health information and education.

Educational and community-based programs encourage and enhance health and wellness by educating communities on topics such as:

- Chronic diseases
- Injury and violence prevention
- Mental illness/behavioural health
- Unintended pregnancy
- Oral health
- Tobacco use
- Substance abuse
- Nutrition and obesity prevention
- Physical activity

5.7 EMERGING ISSUES IN EDUCATIONAL AND COMMUNITY-BASED PROGRAMS

Three emerging public health issues in the area of educational and community-based programs have been identified.

1. Evaluating coordinated school health programs as an intervention to reduce school dropout rates. Coordinated school health programs include:
    - Comprehensive school health education
    - Health services
    - Physical education
    - Nutrition services
    - Mental health and social services
    - Staff wellness
    - Family/community involvement
    - A healthy and safe environment
2. Establishing an evidence base for community health and education policy interventions to determine their impact and effectiveness.
3. Increasing the number and skill level of community health and other auxiliary public health workers to support the achievement of healthier communities.

There are eight major steps for guiding students through the process of Community Problem Solving:

- Taking action
- Selecting problems
- Investigating
- Planning actions
- Exploring community concerns
- Assessing and developing student skills
- Developing visions of a sustainable future
- Evaluating actions and changes

Community Problem Solving is a teaching and learning strategy that helps students learn to participate actively in addressing local community concerns, with a view to creating a more sustainable future.

Service learning

Service learning – through which students volunteer to work on projects in their communities (not necessarily problem-solving ones) – has a long tradition in education in some countries. Examples of service learning projects include: volunteering to assist in a hospital, kindergarten or other community centre; working in a youth conservation project; and developing a community education and information campaign around a topical issue.

Service learning is a common action that students and schools choose as a way of acting on – and achieving – the visions of a sustainable future that are developed during a Community Problem Solving project.

The impacts on the students: Attitudes to citizenship were also quite significant. Students showed positive, statistically significant impacts on three measures of civic development:

Acceptance of cultural diversity;

Service leadership; and

The overall measure of civic attitudes. The most direct measure of student attitudes towards service itself. Here, the students reported that they felt that:

They were aware of needs in their communities;

They believed that they could make a difference;

They knew how to design and implement a service project; and

They were committed to service now and later in life.

These are all good indicators of a very clear and positive contribution to active citizenship for a sustainable future.

5.8 COMMUNITY PROGRAMS FOR TRADITIONAL PROBLEMS IN CLINICS

The Community programs for traditional problems in Clinic focuses on issues impacting low- and moderate-income populations, emphasizing non-adversarial, transactional approaches to advocacy. Because the Clinic's primary concern is to solve clients' problems by the most effective means available, the Clinic also represents clients in litigation matters. Client work focuses on housing and homelessness, community, small-business and non-profit development, and policy initiatives designed to improve client communities. Students examine the government programs and regulatory infrastructure that provide the foundation for traditional community economic development work, as well as the benefits and limitations of using private-sector investment to further development objectives. Students also consider the impact of some of the intersecting issues, such as how access to banking services (or the lack thereof) may affect community and economic development.

Legal Clinic

A legal clinic or law clinic is a non-profit law practice serving the public interest. Legal clinics originated as a method of practical teaching of law school students, In the academic context, these law school clinics provide hands-on experience to law school students and services to various (typically indigent) clients. Students typically provide assistance with research, drafting legal arguments, and meeting with clients. In many cases, one of the clinic's professors will show up for oral argument before the Court. However, many jurisdictions have "student practice" rules that allow law-clinic students to appear and argue in court.

Types of activity

The clinics may include variety of activity:

Legal Aid Clinic is traditionally the most common type of Clinical education. Students under supervision of lectors provide pro bono legal aid to general public (usually to those who cannot otherwise afford it).

The Clinic serves best as a counsel for:

- Indigent individuals in wrongfully denied general relief from social services

- Farm workers living a substandard quality of life.
- Low-income residents fighting a tax rate increase.
- Residents seeking legal and economic assistance.
- Lewis further distinguishes:

- Simulations – students can learn from a variety of simulations of what happens in legal practice. For example, moot courts are commonplace. They have traditionally formed part of law school activity and introduce students to the intricacies of advocacy, at least before appellate courts. More ambitiously, some use mock trials, sometimes with professional actors, to convey the difficulties of, for example, introducing evidence and establishing facts in what may be the rapidly changing environment of a first instance tribunal. Other simulations can range from
  - negotiation exercises—whereby opposing groups of students learning the art of negotiation, rather than trial court litigation, by being given realistic case files and asked to resolve them in as economic and fair manner as possible
  - client interviewing exercises
  - transaction exercises-between groups of students such as buying and selling property or with individual students in e.g. drafting a will
  - legal drafting and writing programmes

  Although of exceptional value in teaching law, these simulations can lack the complexity of real client work, and the role play may not create the same demands that exist upon the legal practitioner.

- Placements: students can be sent out to work with practicing lawyers for short periods to encounter real problems, clients, and courts. They are then expected to bring back their experience to the law school and reflect upon it, using it to inform the remainder of their time spent in academic establishment. They are particularly attractive to some law schools, because that they can be arranged at little cost. On the other hand, the student's experience can vary greatly, and it is especially difficult for teachers to monitor what has happened in order to make use of it, and provide effective feedback. It is difficult to assess the student's progress.

Many clinics combine all the before mentioned activities. For example, at the beginning of the clinical program the students are thoroughly taught some area of law that the general program may teach only. Later they go through simulations to strengthen their practical knowledge. In the third part, they come to contact with real clients and solve legal issues (this can also be done via placements, for example in NGOs related to the area).

Clinical legal studies exist in diverse areas such as immigration law, environmental law, intellectual property, housing, criminal defence, criminal prosecution, American Indian law, human rights and international criminal law. Clinics sometimes sue big companies and government entities. This has led to push-back in courts and legislatures, including attempts to put limits on who clinics can sue without losing state subsidies.

5.9 COMMUNITY PROGRAMS FOR TRADITIONAL PROBLEMS IN HOSPITALS

Population health

Population health was one of the biggest ideas in healthcare, and it will likely maintain or gain momentum. In the next few years to come.

Hospitals' demand for population health expertise overwhelms the supply. Nearly 60 percent of health system and hospital CEOs ranked population health as the hardest skill set to find within the broader healthcare field, according to a 2014 American Hospital Association survey. Further, nearly half of executives polled identified

Community and population health management as a talent gap within their organizations. Some health systems are filling this gap by creating new C-suite positions: Quantifying population health is another challenge. Although healthcare leaders need to think creatively about how to improve the health of a geographic population, they should also maintain a healthy sense of scepticism about population health efforts. Amid excitement for population health, systems may oversimplify problems and overinvest in solutions only to see the same health outcomes.

To find success, hospital leaders may need to diminish their traditional reliance on "programs" and instead focus more on partnerships with community organizations and

nonprofits. Some health systems still act as autonomously as they can, ignoring a wealth of expertise and resources.

Shifting from volume- to value-based reimbursement

The move from volume- to value-based reimbursement is inevitable. For now, it's a matter of how quickly providers should make it. Move too fast, and hospitals risk losing revenue and implementing a strategy the market does not support. Move too slow, and they may lose partnership opportunities, experience and time that could have been spent modifying clinicians' behaviours and transforming practices.

Regulatory demands

Healthcare providers must adhere to numerous, complex regulations that set guidelines and expectations for quality, coding, reimbursement and overall care delivery. Although many of these regulations were designed to improve care and efficiency, many providers see them as burdensome and impractical.

Infection control, especially in light of Ebola

Hospital infection control and prevention programs discovered newfound fame in 2014, thanks in large part to the appearance of Ebola, which made the world to give attention to infection prevention can yield positive results.

Non-profit hospital

A non-profit hospital, or not-for-profit hospital, is a hospital which is organized as a non-profit corporation. Based on their charitable purpose and frequently affiliated with a religious denomination they are a traditional means of delivering medical care. Non-profit hospitals are distinct from government owned public hospitals and privately owned for-profit hospitals.

5.10 COMMUNITY BASED PROGRAMS FOR TRADITIONAL PROBLEMS IN HOMES

In recent years, the term "traditional problems" has become a rallying cry in families all over the country. Much of the recent public discourse about women who bear children outside of marriage seems to reflect an underlying assumption that appropriate values are something these women simply do not have. An alleged decline in values, been blamed for a myriad of social problems, including unemployment, poor health, school drop-out rates and an increase in juvenile crime. Since the blame for these problems has been placed on "the breakdown of the traditional family," it is not surprising that many people have concluded that the logical solution to the problem is the reunification of the traditional family structure.

The "good old days," in which values were presumably different and better. Consistent with such thinking, recent years have seen an increase in governmental programs and policy proposals at both the local and national levels aimed at bolstering the traditional family structure, or otherwise encouraging what are presumed to be "values."

As part of this discourse of social anxiety which can be termed as “ traditional problems in home”.

5.11 SUMMARY

The importance of the community programs for traditional problems in schools, clinics, hospital, home frequently surfaces in discussions surrounding community development. While, effective implementation of programs still remains a big Challenge. Successes of programs contribute to the stability and growth of the local economy. The impact on community harmony is another benefit health-care organizations can bring to the local economy. The problems in different settings can only be resolved by citizens active participation. Finding a solution to traditional problems can also play a part in community development activities. Supporting asset-building programs, which in directly facilitates to community development.

5.12 KEYWORDS

Community Intervention Programmes

Comprehensive community Interventions

Service learning

Legal clinic

Population health

5.13 CHECK YOUR PROGRESS

1. Define Community Intervention Programmes.
2. Explain the types of Interventions.
3. Discuss comprehensive community intervention.
4. Discuss the community programmes for problems in clinic, schools and hospitals.

5.14 ANSWERS TO CHECK YOUR PROGRESS

1. 5.3
2. 5.4
3. 5.5
4. 5.6, 5.8 & 5.9

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UNIT: 6 - DEALING WITH COMMUNITY PROBLEMS

STRUCTURE

6.1 OBJECTIVES

After going through this unit you will be able to explain

- Meaning and definition of community problems
- Types of community problems
- Suicide, stress factors of suicide, pathophysiology and its prevention
- Violence and its types
- Aggression

6.2 INTRODUCTION

In this unit let us analyze and understand the factors dealing with community problems. Problems are part of life. They go together with being alive. And every community has problems, too; they go together with being a community. That's just a fact of community problem is like people, try to solve their problems. Analyzing those problems helps in their solution. We'd be better off analyzing why that decline is taking place, why the problem is occurring, rather than simply jumping in and trying to fix it. A good analysis will lead to better long-run solutions. This section explains what analyzing community problem is about, and why it can be helpful and then how to do it.

6.3 MEANING AND DEFINITIONS OF COMMUNITY PROBLEM

Each and every community is different from the rest of other communities. Hence, what is considered as a problem in one community may not be considered as a problem in other communities? But still there are certain problems which all parts of the society do consider. There's a long list of community problems.

6.4 TYPES OF COMMUNITY PROBLEMS

There are a number of problems which usually are found in communities.

Below given factors are in broader sense, some of the major problems faced by community.

- Suicide
- Violence,
- Aggression

These problems are being discussed in detail as follows.

6.5 SUICIDE

Suicide (Latin suicide, from suicaedere, "to kill oneself") is the act of intentionally causing one's own death. Suicide is often carried out as a result of despair, the cause of which is frequently attributed to a mental disorder such as depression, bipolar disorder, schizophrenia, borderline, alcoholism, or drug.

Suicide is the "act of taking one's own life". Attempted suicide or non-fatal suicidal behaviour is self-injury with the desire to end one's life that does not result in death.

6.5.1 STRESS FACTORS OF SUICIDE

Factors such as financial difficulties or troubles with interpersonal relationships often play a role.

Risk factors

Factors that affect the risk of suicide include psychiatric disorders, drug misuse, psychological states, cultural, family and social situations, and genetics. Mental illness and substance misuse frequently co-exist. Other risk factors include having previously attempted suicide, the ready availability of a means to commit the act, a family history of suicide, or the presence of traumatic brain injury. For example, Socio-economic problems such as unemployment, poverty, homelessness, and discrimination may trigger suicidal thoughts.

Mental disorders

Mental disorders are often present at the time of suicide with estimates ranging from 27% to more than 90%.Of those who have been admitted to a psychiatric unit, their lifetime

Half of all people who die by suicide may have major depressive disorder; include schizophrenia (14%), personality disorders (14%), bipolar disorder, and posttraumatic stress disorder. Eating

disorders are another high risk condition.

Substance use

Substance abuse is the second most common risk factor for suicide after major and bipolar disorder. Both chronic substance misuse as well as acute intoxication are associated. When combined with personal grief, such as bereavement, the risk is further increased. In Adolescents who misuse alcohol, neurological and psychological dysfunctions may contribute to the increased risk of suicide.

Problem gambling

Problem gambling is associated with increased suicidal ideation and attempts compared to the general population.

Medical conditions

There is an association between suicidality and physical health problems such as chronic, traumatic brain injury, cancer, kidney failure (requiring haemodialysis), HIV, and systemic. The diagnosis of cancer approximately doubles the subsequent risk of suicide. The prevalence of increased sociality persisted after adjusting for depressive illness and alcohol abuse. In people with more than one medical condition the risk was particularly high.

Sleep disturbances such as insomnia and sleep apnoea are risk factors for depression and suicide. A number of other medical conditions may present with symptoms similar to mood disorders, including hypothyroidism, Alzheimer's, brain tumours, systemic lupus erythematosus, and adverse effects from a number of medications (such as blockers and steroids).

Psychosocial states

A number of psychological states increase the risk of suicide including: hopelessness, loss of pleasure in life, depression and anxiousness. A poor ability to solve problems, the loss of abilities one used to have, and poor impulse control also play a role. In older adults the perception of being a burden to others is important. Recent life stresses such as a loss of a family member or friend, loss of a job, or social isolation (such as living alone) increases the risk. Those who have never married are also at greater risk. Some may commit suicide to escape bullying or prejudice. A history of childhood sexual abuse and time spent in foster care are also risk factors.

POVERTY

Poverty is associated with the risk of suicide. Increasing relative poverty compared to those around a person increases suicide risk.

Media

The media, which includes the Internet, plays an important role. How it presents depiction of suicide may have a negative effect, with high volume, prominent, repetitive coverage glorifying or romanticizing suicide having the most impact.

Rational

Rational suicide is the reasoned taking of one's own life, although some feel that suicide is never logical. The act of taking one's life for the benefit of others is known as altruistic suicide. Mass suicides are often performed under social pressure where members give up autonomy to a leader. Mass suicides can take place with as few as two people, often referred to as a suicide pact. In extenuating situations where continuing to live would be intolerable, some people use suicide as a means of escape.

6.5.2 PATHOPHYSIOLOGY

There is no known unifying underlying pathophysiology for either suicide or depression. It is however believed to result from interplay of behavioural, socio-environmental and psychiatric factors. Low levels of brain-derived neurotrophic factor (BDNF) are both directly associated with suicide and indirectly associated through its role in major depression, posttraumatic stress disorder, schizophrenia and obsessive–compulsive disorder.

6.5.3 PREVENTION

Suicide prevention is a term used for the collective efforts to reduce the incidence of suicide through preventative measures. Treatment of drug and alcohol addiction, depression, and those who have attempted suicide in the past may also be effective. Although crisis help lines are common. In young adults who have recently thought about suicide, cognitive behavioural therapy appears to improve outcomes. Economic development through its ability to reduce poverty may be able to decrease suicide rates. Efforts to increase social connection,

especially in elderly males, may be effective. The World Suicide Prevention Day is observed annually on September 10 with the support of the International Association for Suicide Prevention and the World Health Organization.

Mental illness

In those with mental health problems a number of treatments may reduce the risk of suicide. Those who are actively suicidal may be admitted to psychiatric care either voluntarily or involuntarily. Possessions that may be used to harm oneself are typically removed. Some clinicians get patients to sign suicide prevention contracts where they agree to not harm themselves if released. If a person is at low risk, outpatient mental health treatment may be arranged. Short-term hospitalization has not been found to be more effective than community care for improving outcomes in those with borderline personality disorder who are chronically suicidal.

There is tentative evidence that psychotherapy, specifically, therapy reduces suicidality in adolescents as well as in those with borderline personality disorder. It may also be useful in decreasing suicide attempts in adults at high risk. Evidence however has not found a decrease in completed suicides.

Suicide legislation

In India, suicide used to be illegal and surviving family could face legal difficulties. The government of India decided to repeal the law in 2014.

6.6 VIOLENCE

Violence is defined by the World Health Organization as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation". However, generally, anything that is excited in an injurious or damaging way may be described as violent even if not meant to be violence (by a person and against a person).

All violence is shocking; perhaps the most disturbing one occurs in the form of domestic violence. Domestic violence has been challenging case for state authorities to regulate to curtail it. In this section we shall examine the dimensions related to violence.

Domestic violence

It is violence committed by one family member or cohabiting individual against another. The most common forms of domestic violence are parents, husbands abusing wives, although there are also cases of wives abusing their spouses and of children abusing their parents. In families where wives are beaten by their husbands, children are also at risk. Witnessing Violence is a risk factor for long-term and mental health problems. Abused children's experience many risks; they show signs of chronic stress, including difficulties in schools and problems with concentration.

Reducing family violence

Family violence is a matter of grave societal concern and, since it is multiply determined, must be addressed by a variety of approaches. For example, reporting laws require certain individuals, such as physicians, to report suspected cases of child abuse, and some localities provide a toll free number for calls from general public.

There has some reformatory steps taken to gain control over domestic violence, shelters for battered women and their children provide protection and, often, various social services such as legal referrals, psychological counseling, and employment assistance.

Work place violence

Workplace violence refers not only to the more physically violent incidents, but also to the more subtle forms of violence, such as coercion, intimidation, threats, and harassment. In fact, although the media focuses on more serious violence, the incidents that actually occur most frequently in the workplace are threats to violence.

Violence in many forms is preventable. There is a strong relationship between levels of violence and modifiable factors such as concentrated poverty, income and gender inequality, the harmful use of alcohol, and the absence of safe, stable, and nurturing relationships between

children and parents. Furthermore, violence often has lifelong consequences for physical and mental health and social functioning and can slow economic and social development.

6.6.1 TYPES OF VIOLENCE

Violence can be divided into three broad categories:

1. Self-directed violence
2. Interpersonal violence
3. Collective violence

Violent acts can be:

- physical
- sexual
- psychological
- emotional

1. Self-directed violence

Self-directed violence is suicidal behaviour and self-abuse. It includes suicidal thoughts, attempted suicides, deliberate self-injury , suicides. Self-abuse, self-mutilation.

2. Interpersonal violence

Interpersonal violence is divided into two subcategories: Family and intimate partner violence– that is, violence largely between family members and intimate partners,, taking place which causes physical, sexual or psychological harm, including physical aggression, sexual coercion, and psychological abuse and controlling behaviours.

3. Collective violence

Collective violence suggests possible motives for violence committed by larger groups of individuals or by states. Collective violence that is committed to advance a particular social agenda includes, for example, crimes of hate committed by organized groups, terrorist acts and mob violence. Political violence includes war and related violent conflicts, state violence and similar acts carried out by larger groups.

Violence has a broad range of outcomes – including physical, psychological harm, social

problems, deprivation and maldevelopment. Violence may not necessarily result in injury or death, but nonetheless poses a substantial burden on individuals, families, communities and health care systems worldwide. These consequences can be immediate, as well as latent, and can last for years after the initial abuse.

Community violence – violence between individuals who are unrelated, and who may or may not know each other, generally taking place outside the home. The former group includes forms of violence such as child abuse, intimate partner violence and abuse of the elderly. The latter includes youth violence, random acts of violence, rape or sexual assault by strangers, and violence in institutional settings such as schools, workplaces, prisons and nursing homes.

Child maltreatment

Child maltreatment is the abuse and neglect that occurs to children under 18 years of age. It includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power. Exposure to intimate partner violence is also sometimes included as a form of child maltreatment Child maltreatment is a global problem with serious lifelong consequences.

Youth violence

Youth violence refers to violence occurring between youths, and includes acts that range from bullying and physical fighting, through more severe sexual and physical assault to homicide.

Youth violence has a serious, often lifelong, impact on a person's psychological and social functioning. Youth violence greatly increases the costs of health, welfare and criminal justice services; reduces productivity; decreases the value of property; and generally undermines the fabric of society.

Prevention programmes shown to be effective or to have promise in reducing youth violence include life skills and social development programmes designed to help children and adolescents manage anger, resolve conflict, and develop the necessary social skills to solve problems; schools-based anti-bullying prevention programmes; and programmes to reduce access to alcohol, illegal drugs and guns.

Elder maltreatment

Elder maltreatment is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person. This type of violence constitutes a violation of human rights and includes physical, sexual, psychological, emotional; financial and material abuse; abandonment; neglect; and serious loss of dignity and respect.

Factors of violence

Violence cannot be attributed to a single factor. Its causes are complex and occur at different levels. To represent this complexity, the ecological, or social ecological model is often used.

Psychology

The causes of violent behaviour in humans are often a topic of research in psychology. Neurobiologist Jan Volakis emphasizes that, for those purposes, "violent behaviour is defined as intentional physically aggressive behaviour against another person."

Media

Research into the media and violence examines whether links between consuming media violence and subsequent aggressive and violent behaviour exists. Media violence may increase aggression.

Prevention

The most significant factor for reducing violence in a society is the guidance and discipline of children as they mature. More important preventative measures are showing children love and understanding.

Life skills in youth

Evidence shows that the life skills acquired in social development programmes can reduce involvement in violence, improve social skills, boost educational achievement and improve job prospects. Life skills refer to social, emotional, and behavioural competencies which

help children and adolescents effectively deal with the challenges of everyday life.

Gender equality

Evaluation studies are beginning to support community interventions that aim to prevent violence against women by promoting gender equality.

Cultural norms

Rules or expectations of behaviour – norms – within a cultural or social group can encourage violence.

Criminal justice

One of the main functions of law is to regulate violence. Law enforcement is the main means of regulating non-military violence in society.

Public health

The public health approach is a science-driven, population-based, and interdisciplinary, primary prevention. The public health approach is interdisciplinary, drawing upon knowledge from many disciplines including medicine, epidemiology, sociology, psychology, criminology, education and economics. Because all forms of violence are multi-faceted problems.

From a public health perspective, prevention strategies can be classified into three types:

1) Primary prevention – approaches that aim to prevent violence before it occurs.
2) Secondary prevention – approaches that focus on the more immediate responses to violence, such as pre-hospital care, emergency services.
3) Tertiary prevention – approaches that focus on long-term care in the wake of violence, such as rehabilitation and reintegration, and attempt to lessen trauma or reduce long-term disability associated with violence.

A public health approach emphasizes the primary prevention of violence, i.e. stopping them from occurring in the first place.

The public health approach is an evidence-based and systematic process involving the following four steps:

1. Defining the problem conceptually and numerically, using statistics that accurately

describe the nature and scale of violence.

2. Investigating why the problem occurs by determining its causes and correlates, the factors that increase or decrease the risk of its occurrence.
3. Exploring ways to prevent the problem by using the above information and designing, assessing the effectiveness of programmes through outcome evaluations.
4. Disseminating information on the effectiveness of programmes and increasing the scale of proven effective programmes. This step also includes re-evaluation to ensure their effectiveness in the new setting.

Human rights

The human rights approach is based on the obligations of states to respect, protect and fulfil human rights and therefore to prevent, eradicate and punish violence. It recognizes violence as a violation of many human rights: the rights to life, liberty, autonomy and security of the person; the rights to equality and non-discrimination; the rights to be free from torture and cruel, inhuman and degrading treatment or punishment; the right to privacy; and the right to the highest attainable standard of health.

6.7 AGGRESSION

The word “Aggression” the term aggression comes from the Latin aggressio, meaning attack. A psychological sense of "hostile or destructive behaviour.

Aggression is a behaviour which is intended to injure another person. Accidentally injuring someone is not an aggressive act because there is no intent to harm.

Aggression can be distinguished in terms of antisocial aggression and prosocial aggression. Normally one thinks of aggression as bad; but some aggressive acts are good. Many aggressive acts are actually dictated by social norms and are therefore described as prosocial.

Some aggressive acts that fall between prosocial and antisocial might be labelled as sanctioned aggression. This kind of aggression includes acts that are not required by social norms but are well within their bounds; they do not violate accepted moral standards.

Another vital distinction is between aggressive behaviour and aggressive feelings such as

anger. Our overt behaviour does not always reflect our internal feelings.

Aggressive behaviours come in many forms. Words as well as deeds can be aggressive. Aggression refer to emotions and attitudes. A main mechanism that determines human aggressive behaviour is past learning.

Aggression is overt, often harmful, social interaction with the intention of inflicting damage or other unpleasantness upon another individual. It is a virtually universal behaviour among animals. It may occur either in retaliation or without provocation. In humans, frustration due to blocked goals can cause aggression. Submissiveness may be viewed as the opposite of aggressiveness.

In the social sciences and behavioural sciences, aggression is a response by an individual that delivers something unpleasant to another person. The individual must intend to harm another person. Aggression can take a variety of forms which may be expressed physically or communicated verbally or non-verbally: Two broad categories of aggression are commonly distinguished. One includes affective(emotional) and hostile, reactive, or retaliatory aggression that is a response to provocation, and the other includes instrumental, goal-oriented or predatory, in which aggression is used as a mean to achieve a goal. An example of hostile aggression would be a person who punches someone who insulted him or her. An instrumental form of aggression would be armed robbery.

Aggression may occur in response to non-social as well as social factors, and can have a close relationship with stress coping style.

Reduction of aggressive behavior

Aggressive behaviour is major problem for human societies. Individual crime and large scale social violence are harmful both to individual well being and to the general social fabric. All societies expend much energy to control this tendency toward violence; it is vital to understand how to reduce aggressiveness. However every solution proves to have its own risks and unintended consequences. Let us look systematically at the possible techniques for systematically at the possible techniques for reducing aggressive behaviour.

Punishment and retaliation

It seems obvious that the fear of punishment or retaliation will reduce aggressive behaviour. The threat of punishment or retaliation however is not a simple way of reducing aggression. As suggested earlier, children who are frequently punished for being aggressive tend to become more aggressive themselves.

There are lots of factors which may contribute for aggression in an individual. They are: Genetics

Culture

Situational factors

Alcohol

Pain and discomfort

Frustration

6.8 SUMMARY

This unit has dealt with the various community problems like suicide, the factors affecting suicide, its psychopathology, prevention. It also has dealt with violence and its types, aggression and its consequences.

6.9 KEYWORDS

Community problems

Suicide

Risk factors

Substance abuse

Gambling

Poverty

Mental illness

Violence

Aggression

6.10 CHECK YOUR PROGRESS

1. Explain the Meaning and definition of community problems.
2. Explain types of community problems
3. Discuss Suicide and the factors causing suicide.
4. Explain the different types of violence.

6.11 ANSWERS TO CHECK YOUR PROGRESS

1. 6.3
2. 6.4
3. 6.5 & 6.5.1
4. 6.6 & 6.6.1

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UNIT: 7- DISASTER MANAGEMENT

STRUCTURE

7.1 OBJECTIVES

After going through this unit, you will be able to explain

- Meaning and definition of disaster management
- Types of disasters
- Disaster prevention
- Phases and personal activities in emergency management
- Disaster management as a profession
- Disaster management in India

7.2 INTRODUCTION

Disasters have a major and long-lasting impact on people long after the immediate effect has been mitigated. Any disaster can interrupt essential services, such as health care, electricity, water, sewage/garbage removal, transportation and communications. The interruption can seriously affect the health, social and economic networks of local communities and countries. Events covered by disaster management include acts of terrorism, industrial sabotage, fire, natural disasters (such as earthquakes, hurricanes, etc.), public disorder, industrial accidents, and communication failures. Now, in this unit we shall focus on consequential factors pertaining in this regard.

7.3 MEANING AND DEFINITION OF DISASTER MANAGEMENT

Disaster management is the creation of plans through which communities reduce vulnerability to hazards and cope with disasters.

The United Nations defines "a disaster as a serious disruption of the functioning of a community or a society. Disasters involve widespread human, material, economic or environmental impacts, which exceed the ability of the affected community or society to cope using its own resources".

The Red Cross and Red Crescent societies define disaster management "as the organisation and management of resources and responsibilities for dealing with all humanitarian

aspects of emergencies, in particular preparedness, response and recovery in order to lessen the impact of disasters".

7.4 TYPES OF DISASTERS

There is no country that is immune from disaster, though vulnerability to disaster varies. There are four main types of disasters:

1. **Natural disasters**: including floods, hurricanes, earthquakes and volcano eruptions that have immediate impacts on human health and secondary impacts causing further death and suffering from (for example) floods, landslides, fires, tsunamis.
2. **Environmental emergencies**: including technological or industrial accidents, usually involving the production, use or transportation of hazardous material, and occur where these materials are produced, used or transported, and forest fires caused by humans.
3. **Complex emergencies**: involving a break-down of authority, looting and attacks on strategic installations, including conflict situations and war.
4. **Pandemic emergencies**: involving a sudden onset of contagious disease that affects health, disrupts services and businesses, brings economic and social costs.

7.5 DISASTER PREVENTION

Poorly planned relief activities can have a significant negative impact not only on the disaster victims but also on donors and relief agencies. So it is important that physical therapists join established programmes rather than attempting individual efforts.

Local, regional, national and international organizations are all involved in mounting a humanitarian response to disasters. Each will have a prepared disaster management plan. These plans cover prevention, preparedness, relief and recovery

There are activities designed to provide permanent protection from disasters. Not all disasters, particularly natural disasters, can be prevented, but the risk of loss of life and injury

can be mitigated with good evacuation plans, environmental planning and design standards. In January 2005, 168 Governments adopted a 10-year global plan for natural disaster risk reduction called the Hyogo Framework. It offers guiding principles, priorities for action, and practical means for achieving disaster resilience for vulnerable communities.

Disaster preparedness: These activities are designed to minimise loss of life and damage – for example by removing people and property from a threatened location and by facilitating timely and effective rescue, relief and rehabilitation. Preparedness is the main way of reducing the impact of disasters. Community-based preparedness and management should be a high priority in physical therapy practice management.

Disaster relief: This is a coordinated multi-agency response to reduce the impact of a disaster and its long-term results. Relief activities include rescue, relocation, providing food and water, preventing disease and disability, repairing vital services such as telecommunications and transport, providing temporary shelter and emergency health care.

Disaster recovery: Once emergency needs have been met and the initial crisis is over, the people affected and the communities that support them are still vulnerable. Recovery activities include rebuilding infrastructure, health care and rehabilitation. These should blend with development activities, such as building human resources for health and developing policies and practices to avoid similar situations in future.

Disaster management is linked with sustainable development, particularly in relation to vulnerable people such as those with disabilities, elderly people, children and other marginalised groups. Health Volunteers Overseas publications address some of the common misunderstandings about disaster management.

Emergency planning ideals

If possible, emergency planning should aim to prevent emergencies from occurring, and failing that, should develop a good action plan to mitigate the results and effects of any emergencies. As time goes on, and more data becomes available, usually through the study of emergencies as they occur, a plan should evolve. The development of emergency plans is a

cyclical process, common to many risk management disciplines, such as Business Continuity and Security Risk Management, as set out below:

- Recognition or identification of risks
- Ranking or evaluation of risks
    - Responding to significant risks
    - Tolerate
    - Treat
    - Transfer
    - Terminate
    - Resourcing controls
    - Reaction Planning
    - Reporting & monitoring risk performance
    - Reviewing the Risk Management framework

There are a number of guidelines and publications regarding Emergency Planning, published by various professional organisations such as ASIS, FEMA and the Emergency Planning College. There are very few Emergency Management specific standards and emergency management as a discipline tends to fall under business resilience standards.

In order to avoid, or reduce significant losses to a business, emergency managers should work to identify and anticipate potential risks, hopefully to reduce their probability of occurring. In the event that an emergency does occur, managers should have a plan prepared to mitigate the effects of that emergency, as well as to ensure Business Continuity of critical operations post-incident. It is essential for an organisation to include procedures for determining whether an emergency situation has occurred and at what point an emergency management plan should be activated.

Implementation ideals

An emergency plan must be regularly maintained, in a structured and methodical manner, to ensure it is up-to-date in the event of an emergency. Emergency managers generally follow a common process to anticipate, assess, prevent, prepare, respond and recover from an incident.

Pre-incident training and testing

Emergency management plans and procedures should include the identification of appropriately trained staff members responsible for decision-making when an emergency occurs.

Communicating and incident assessment

Communication is one of the key issues during any emergency, pre-planning of communications is critical. Miscommunication can easily result in emergency events escalating unnecessarily.

Once an emergency has been identified a comprehensive assessment evaluating the level of impact and its financial implications should be undertaken. Following assessment, the appropriate plan or response to be activated will depend on a specific pre-set criterion within the emergency plan. The steps necessary should be prioritised to ensure critical functions are operational as soon as possible.

7.6 PHASES AND PERSONAL ACTIVITIES IN EMERGENCY MANAGEMENT

Emergency management consists of five phases: prevention, mitigation, preparedness, response and recovery.

Prevention:

Prevention focuses on preventing the human hazard, primarily from potential natural disasters or terrorist attacks. Preventive measures are taken on both the domestic and international levels, designed to provide permanent protection from disasters. Not all disasters, particularly natural disasters, can be prevented, but the risk of loss of life and injury can be mitigated with good evacuation plans, environmental planning and design standards.

Mitigation:

Personal mitigation is a key to national preparedness. Individuals and families train to avoid unnecessary risks. This includes an assessment of possible risks to personal/family health and to personal property, and steps taken to minimize the effects of a disaster, or take procure insurance to protect them against effects of a disaster.

Preventive or mitigation measures take different forms for different types of disasters. In earthquake prone areas, these preventive measures might include structural changes such as the installation of an Earthquake Valve to instantly shut off the natural gas supply, and the securing of items inside a building. In flood prone areas, houses can be built on poles/stilts. In areas prone to prolonged electricity black-outs installation of a generator.

Preparedness:

Preparedness focuses on preparing equipment and procedures for use when a disaster occurs. This equipment and these procedures can be used to reduce vulnerability to disaster, and the impacts of a disaster or to respond more efficiently in an emergency.

Preparedness measures:

Disasters take a variety of forms to include earthquakes, tsunamis or regular structure fires. The Red Cross states that it responds to nearly 70,000 disasters a year, the most common of which is a single-family fire.

The basic theme behind preparedness is to be ready for an emergency and there are a number of different variations of being ready based on an assessment of what sort of threats exist. Usually in the emergency situations certain basic items are provided for relief, the list includes:

- Three-day supply of non-perishable food.
- Three-day supply of water
- Flashlight
- First aid kit and manual.
- Sanitation and hygiene items

- Matches and waterproof container.
- Whistle.
- Extra clothing.
- Kitchen accessories and cooking utensils
- Special needs items, such as prescription medications, eyeglasses and hearing aid batteries.
- Items for infants, such as infant food, diapers, bottles.

Response:

All emergency preparation efforts revolve the bottom two sections of Maslow's hierarchy of needs. Emergency preparedness goes beyond immediate family members. For many people, pets are an integral part of their families and emergency preparation advice includes them as well.

Emergency preparedness also includes more than physical items and skill-specific training. Psychological preparedness is also a type of emergency preparedness and specific mental health preparedness resources are offered for mental health professionals by organizations such as the Red Cross. These mental health preparedness resources are designed to support both community members affected by a disaster and the disaster workers serving them.

CDC has a website devoted to coping with a disaster or traumatic event. After such an event, the CDC, through the Substance Abuse and Mental Health Services Administration(SAMHSA), suggests that people seek psychological help when they exhibit symptoms such as excessive worry, crying frequently, an increase in irritability, anger, and frequent arguing, wanting to be alone most of the time, feeling anxious or fearful, overwhelmed by sadness, confused, having trouble thinking clearly and concentrating, and difficulty making decisions, increased alcohol and/or substance use, increased physical (aches, pains) complaints such as headaches and trouble with "nerves."

Donations are often sought during this period, especially for large disasters that overwhelm local capacity. Due to efficiencies of scale, money is often the most cost-effective donation. Money is also the most flexible, and if goods are sourced locally then transportation is minimized and the local economy is boosted.

Medical considerations will vary greatly based on the type of disaster and secondary effects. Survivors may sustain a multitude of injuries to include lacerations, burns, near drowning, or crush.

Recovery

The recovery phase starts after the immediate threat to human life has subsided. The immediate goal of the recovery phase is to bring the affected area back to normalcy as quickly as possible. During reconstruction it is recommended to consider the location or construction material of the property.

The most extreme home confinement scenarios include war, famine and severe epidemics and may last a year or more. Then recovery will take place inside the home. Planners for these events usually buy bulk foods and appropriate storage and preparation equipment, and eat the food as part of normal life. A simple balanced diet can be constructed from , whole-meal wheat, beans, dried milk, corn, and cooking oil. One should add vegetables, fruits, spices and meats, both prepared and fresh-gardened, when possible.

7.7 DISASTER MANAGEMENT AS A PROFESSION

Professional emergency managers can focus on government and community preparedness. Training is provided by local, state, and private organizations and ranges from public information and media relations to high-level incident command and tactical skills.

Educational opportunities are increasing for those seeking undergraduate and graduate degrees in emergency management or a related field.

Principles

In 2007, Dr. Wayne Blanchard of FEMA's Emergency Management Higher Education Project, at the direction of Dr. Cortez Lawrence, Superintendent of FEMA's Emergency Management Institute, convened a working group of emergency management practitioners and academics to consider principles of emergency management. This was the first time the principles of the discipline were to be codified. The group agreed on eight principles that will be used to guide the development of a doctrine of emergency management. Below is a summary**:**

1. **Comprehensive** – consider and take into account all hazards, all phases, all stakeholders and all impacts relevant to disasters.
2. **Progressive** – anticipate future disasters and take preventive and preparatory measures to build disaster-resistant and disaster-resilient communities.
3. **Risk-driven** – use sound risk management principles (hazard identification, risk analysis, and impact analysis) in assigning priorities and resources.
4. **Integrated** – ensure unity of effort among all levels of government and all elements of a community.
5. **Collaborative** – create and sustain broad and sincere relationships among individuals and organizations to encourage trust, advocate a team atmosphere, build consensus, and facilitate communication.
6. **Coordinated** – synchronize the activities of all relevant stakeholders to achieve a common purpose.
7. **Flexible** – use creative and innovative approaches in solving disaster challenges.
8. **Professional** – value a science and knowledge-based approach; based on education, training, experience, ethical practice, public stewardship and continuous improvement.

7.8 DISASTER MANAGEMENT IN INDIA

The National Disaster Management Authority is the primary government agency responsible for planning and capacity-building for disaster relief. Its emphasis is primarily on strategic risk management and mitigation, as well as developing policies and planning. The National Institute of Disaster Management is a policy think-tank and training institution for developing guidelines and training programs for mitigating disasters and managing crisis response.

The National Disaster Response Force is the government agency primarily responsible for emergency management during natural and man-made disasters, with specialized skills in search, rescue and rehabilitation. The Ministry of Science and Technology also contains an agency that brings the expertise of earth scientists and meteorologists to emergency

management. The Indian Armed Forces also plays an important role in the rescue/recovery operations after a disaster.

7.9 SUMMARY

Disaster management however, does not avert or eliminate the threats; instead it focuses on creating plans to decrease the impact of disasters. Failure to create a plan could lead to damage to assets, human mortality, and lost revenue. In this unit you have understood about the disaster, its consequences on human life, its impact upon the life, lifestyle and the after effects of the disaster. Even after the disaster situation is over the after effects do not subside immediately. Sometimes they leave a permanent mark on the individuals who went through these situations causing psychological problems also. All these are dealt in this unit in detail.

7.10 KEYWORDS

Disaster

Disaster management

Emergency

Relief

Response

Recovery

Mitigation

7.11 CHECK YOUR PROGRESS

1. Explain the meaning and definition of disaster management.
2. Explain the types of disasters.
3. What is disaster prevention?
4. Explain the phases and personal activities in emergency management.
5. Discuss disaster management as a profession.

7.12 ANSWERS TO CHECK YOUR PROGRESS

1. 7.3

2. 7.4
3. 7.5
4. 7.6
5. 7.7

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UNIT: 8 - CRIME AND JUVENILE DELINQUENCY

STRUCTURE

8.1 OBJECTIVES

After going through this unit, you will be able to explain

- Meaning and definition of crime and juvenile delinquent
- Classification of crime
- Psychosocial factors of criminal behaviour
- Types of Juvenile delinquency
- Risk factors for juvenile delinquency
- Prevention and Treatment of juvenile offending

8.2 INTRODUCTION

Actions which are considered to be disobedience against the prevailing criminal law of the country, such actions always been under scanner of provisions of the law to maintain the law and order of the society towards harmony. Any act of an individual that violates prevailing codes of conduct and which criminal or civil penalties may be imposed, whether or not the perpetrator has been identified. Such let us discuss the consequential order of crime.

8.3 MEANING AND DEFINITION OF CRIME AND JUVENILE DELINQUENCY

Crime: Crime is commonly defined as "an intentional act in violation of the criminal law committed without defense or excuse, and penalized by the state as misdemeanor".

It can be an omission or a failure to act, as in failure to pay income taxes or failure to come to the aid of the persons in distress, if the law obliges one to do so. Criminal behaviour, therefore, refers to the broad span of behaviour which violates the criminal code.

Juvenile delinquent: A juvenile delinquent "is a person who is typically under the age of 18 and commits an act that otherwise would have been charged as a crime if they were an adult. Depending on the type and severity of the offense committed, it is possible for persons under 18 to be charged and tried as adults".

Juvenile delinquency, also known as "juvenile offending", is participation in illegal behaviour by minors (juveniles, i.e. individuals younger than the statutory age of majority). Most legal systems prescribe specific procedures for dealing with juveniles, such as juvenile detention centers, and courts.

Juvenile crimes can range from status offenses (such as underage smoking), to property crimes and violent crimes. Sometimes, Juvenile offending can be seen in most adolescent behaviour. This is because most teens tend to offend by committing non-violent crimes, only once or a few times, and only during adolescence. Repeated and/or violent offending is likely to lead to later and more violent offenses. When this happens, the offender often displayed antisocial behaviour even before reaching adolescence.

8.4 CLASSIFICATION OF CRIMINAL BEHAVIOUR

It refers to the broad span of behaviour which violates the criminal code.

The psychopath:

One of the most intriguing observations in criminal behaviour is the phenomenon of psychopaths, the clinical or diagnostic group of individuals who demonstrate certain behavioural, cognitive, and neuropsychological characteristics that are not usually found in general population.

Psychopaths, as a general category, should not be confused with sociopaths or antisocial personality disorders. The term “sociopath” is most often used by sociologists and criminologists to refer to a person who repetitively in conflict with the law, with apparently limited capacity to learn from past experiences.

Sociopaths was also used in 1952 the American Psychiatric Association to describe a wide variety of behaviours, such as sexual deviations, alcoholism and dissocial/antisocial reactions.

The term “antisocial personality” is rapidly coming into disuse, however. It is most often used by mental health clinicians to refer to an adult person who displays serious habitual misbehaviour or deviant behaviour, especially when the behavioural pattern involves direct and

harmful actions against others. Mental health professionals reserve the term “conduct disorder” to refer to similar behavioural patterns demonstrated by children.

The term “psychopath” refers to an individual who exhibits a discernible pattern that differs from the general population in its level of sensitivity, empathy, compassion, and guilt. The typical, true psychopath (also called primary psychopath) may or may not engage in criminal activity, but he or she does demonstrate callous and unemotional feelings toward others and lack concern for societal rules and regulations.

It is important that we underscore the predisposition factor. Whether a person who is neuropsychological predisposed ultimately engages in criminal behaviour depends on the person’s learning history, cognitive expectancies, and the situation at hand. Theoretically, if the person has learned to meet needs for excitement and stimulation in ways that run counter to society’s rules, and if socialization(conditioning) has done little to generate anxiety when codes are violated, then antisocial behaviour is likely to result.

Although psychopaths as a group do not pursue consistent criminal careers, those that do have continual contact with the criminal justice system because of frequent offending are referred to as criminal psychopaths. Their criminal behaviour runs the gamut of petty theft and fraud to murder, criminal psychopaths are especially vicious and violent, and their motivations for the violence are sometimes difficult to identify. Criminal psychopaths frequently engage in violence as a form of revenge or retribution, or during a bout of heavy drinking.

8.5 PSYCHOSOCIAL FACTORS OF CRIMINAL BEHAVIOUR

In their efforts to explain criminal behaviour, psychologists tend to focus on principles associated with learning or conditioning. Learning can be problematic for some individuals. Behaviour that enables us to obtain rewards or avoid punishing circumstances is likely to be repeated when similar conditions reoccur. This is known to be instrumental learning. The rewards may be physical (money, material, goods), psychological (feelings of control over one’s life), or social (improved status). Even behaviours that are considered antisocial or criminal may bring rewards that are worth the psychological risks and costs.

Instrumental learning, the concept has been referred to, is a process which, too many psychologists, offers the most easily grasped explanation of criminality. People who commit crimes are seeking to gain or avoid something. The reinforcements may seem straightforward, but they can be deceptively complex. Some antisocial behaviour may be directed at gaining the social approval of a significant subgroup, such as a youth gang, or the psychological feeling of personal control over one's plight, and it may be independent of the obvious material gain promised by successful completion of the crime. The behaviour also may be intended to gain reward in more than one area.

If the eventual reinforcement makes the investment worthwhile, the behaviour is likely to be repeated. Therefore, criminal behaviour will continue to be practiced if it is materially, socially, or psychologically lucrative.

8.6 TYPES OF JUVENILE DELINQUENCY

Juvenile delinquency, or offending, can be separated into three categories:

- Delinquency, crimes committed by minors, which are dealt with by the juvenile courts and justice system.
- Criminal behaviour, crimes dealt with by the criminal justice system.
- Status offenses, offenses that are only classified as such because one is a minor, such as truancy, also dealt with by the juvenile courts.

Developmental theory: According to the developmental research of Moffitt (2006), there are two different types of offenders that emerge in adolescence. One is the repeat offender, referred to as the life-course-persistent offender, who begins offending or showing antisocial/aggressive behaviour in adolescence (or even childhood) and continues into adulthood;

Secondly, age specific offender, referred to as the adolescence-limited offender, for whom juvenile offending or delinquency begins and ends during their period of adolescence. Because most teenagers tend to show some form of antisocial, delinquent behaviour during adolescence, it is important to account for these behaviours in childhood in order to determine whether they will be life-course-persistent offenders or adolescence-limited offenders.

Although adolescence-limited offenders tend to drop all criminal activity once they enter adulthood and show less pathology than life-course-persistent offenders, they still show more mental health, substance abuse, and finance problems, both in adolescence and adulthood, than those who were never delinquent.

Gender Roles and Sex differences: Juvenile delinquency occurrences by males are largely disproportionate to the rate of occurrences by females. This great gap between the crimes reinforces the connotations of traditional masculinity to be the centre of violence, aggression, and competition. This is largely based on the notion that as males, it is their duty to take what they feel they deserve through these means to define them and play the role of provider and independent figure. However, these delinquencies are not as prevalent in females in that they are expected to be more docile individuals and rely solely more on dependent characters, alleviating them from the need of committing delinquencies. Because aggression is not a desired characteristic, it has caused more commotion when females perform crimes that are often attributed to males.

The acts of delinquency begin with the juvenile's expectations of their perceived roles through the direction of adults of both genders. Sandra Lee Bartky expresses these claims thoroughly in her work Foucault, Femininity, and the Modernization of Patriarchal Power by examining close observation of diction, action, and decorum. Boys learn to take as much space as possible when sitting, dress appropriately to stand out, and speak more demanding to assert his position and gain respect from fellow male peers. This expectation of leadership rarely enforced through peers largely dictates that delinquencies arise when male feel that they cannot assert or claim such respect through legal and practical means, thus enforcing violence is merely extenuating a desired trait to gain such position. Thus, delinquent behaviour is expressed as an outlet especially to those of lower socioeconomic backgrounds that cannot gain precedence through conventional means.

Gender role for females is to become more unnoticeable, a follower that does not need to stand out. Because of their condition to be more docile and dependent, the instinctive need to gain precedence is not as highly valued. Even respect comes in the form of different terms, as it is through how appropriately she conducts herself that seems innocent. This is also influenced by fellow peers such as mothers and other female figures apart from the authoritative male figure. In

this instance, there is no need to urge to commit delinquency as the female is expected to rely on the male for his expected role as provider. It is through the act of needing to become dependent that enforces the feminine characteristics to seem as an alternative to delinquency. In fact, it has been largely stated that while masculinity induces such violent behaviour, femininity is seen as the antithesis to delinquency. Furthermore, it is assumed that because femininity and masculinity are portrayed to be opposites, they contain bipolarity in society that forms an explanation to the staggering disproportionate ratio between convicted delinquents.

Data confirms that sex differences in crime relate to attitudes of legal authority as well as developmental stages with parents, prompting the undifferentiated behaviour that associates with a risk of promoting delinquent behaviour. From the gender roles expectations to convergence theory and differentiation, these psychological factors shape the risk of delinquency that juveniles may intend to act upon. More importantly, these suggestive studies are still being researched to promote safer behaviour for juveniles.

Racial differences: It is important to keep the following in mind: poverty, or low socio-economic status are large predictors of low parental monitoring, harsh parenting, and association with deviant peer groups, all of which are in turn associated with juvenile offending.

8.7 RISK FACTORS FOR JUVENILE DELINQUENCY

The two largest predictors of juvenile delinquency are

1. parenting style, with the two styles most likely to predict delinquency being

    - "permissive" parenting, characterized by a lack of consequence-based discipline and encompassing two subtypes known as

    - "neglectful" parenting, characterized by a lack of monitoring and thus of knowledge of the child's activities, and
    - "indulgent" parenting, characterized by affirmative enablement of misbehavior
    - “authoritarian" parenting, characterized by harsh discipline and refusal to justify discipline on any basis other than "because I said so";

2. Peer group association, particularly with antisocial peer groups, as is more likely when adolescents are left unsupervised.

Other factors that may lead a teenager into juvenile delinquency include poor or low socioeconomic, poor school readiness/performance and/or failure, peer rejection, or attention deficit hyperactivity disorder (ADHD). There may also be biological factors, such as high levels of serotonin, giving them a difficult temper and poor self-regulation, and a lower resting heart rate, which may lead to fearlessness. Most of these tend to be influenced by a mix of both genetic and environmental factors.

Individual risk factors: Individual psychological or behavioural risk factors that may make offending more likely include low intelligence, impulsiveness or the inability to delay gratification, aggression, lack of empathy, and restlessness. Other risk factors that may be evident during childhood and adolescence include, aggressive or troublesome behaviour, language delays or impairments, lack of emotional control (learning to control one's anger), and cruelty to animals. Teenagers are more prone to Risk-taking, which may explain the high disproportionate rate of offending among adolescents.

Family environment and peer influence: Family factors that may have an influence on offending include: the level of parental supervision, the way parents discipline a child, particularly harsh punishment, parental conflict or separation, criminal parents or siblings, parental abuse or neglect, and the quality of the parent-child relationship. Some have suggested that having a lifelong partner leads to less offending.

Juvenile Delinquency, which basically is the rebellious or unlawful activities by kids in their teens or pre-teens, is caused by four main risk factors namely; personality, background, state of mind and drugs. These factors may lead to the child having low IQ and may increase the rate of illiteracy.

Children brought up by lone parents are more likely to start offending than those who live with two natural parents. It is also more likely that children of single parents may live in poverty, which is strongly associated with juvenile delinquency. However once the attachment a child feels towards their parent(s) and the level of parental supervision are taken into account, children

in single parent families are no more likely to offend than others. Conflict between a child's parents is also much more closely linked to offending than being raised by a lone parent.

If a child has low parental supervision they are much more likely to offend. Many studies have found a strong correlation between a lack of supervision and offending, and it appears to be the most important family influence on offending. When parents commonly do not know where their children are, what their activities are, or who their friends are, children are more likely to truant from school and have delinquent friends, each of which are linked to offending. A lack of supervision is also connected to poor relationships between children and parents. Children who are often in conflict with their parents may be less willing to discuss their activities with them.

Adolescents with criminal siblings are only more likely to be influenced by their siblings, and also become delinquent, if the sibling is older, of the same sex/gender, and warm. Cases where a younger criminal sibling influences an older one are rare. An aggressive, non-loving/warm sibling is less likely to influence a younger sibling in the direction of delinquency, if anything, the more strained the relationship between the siblings, the less they will want to be like, and/or influence each other.

Peer rejection in childhood is also a large predictor of juvenile delinquency. Although children are rejected by peers for many reasons, it is often the case that they are rejected due to violent or aggressive behaviour. This rejection affects the child's ability to be socialized properly, which can reduce their aggressive tendencies, and often leads them to gravitate towards anti-social peer groups. This association often leads to the promotion of violent, aggressive and deviant behaviour. This often leads to an impulsive and aggressive reaction. Hostile attribution bias however, can appear at any age during development and often lasts throughout a person’s life. Children resulting from unintended pregnancies are more likely to exhibit delinquent behaviour. They also have lower mother-child relationship quality.

8.8 PREVENTION AND TREATMENT OF JUVENILE OFFENDING

Delinquency prevention is the broad term for all efforts aimed at preventing youth from becoming involved in criminal, or other antisocial, activity. Because the development of delinquency in youth is influenced by numerous factors, prevention efforts need to be

comprehensive in scope. Prevention services may include activities such as substance abuse education and treatment, family counselling, youth mentoring, parenting education, educational support, and youth sheltering. Increasing availability and use of family planning services, including education and contraceptives helps to reduce unintended pregnancy and unwanted births, which are risk factors for delinquency. Education is the great equalizer, opening doors to lift themselves out of poverty.... Education also promotes economic growth, national productivity and innovation, and values of democracy and social cohesion. Prevention through education aides the young person to interact more effectively in social contexts therefore diminishing need for delinquency.

8.9 SUMMARY

The position taken in this section is that criminal behaviour defies easy explanations. Crime cannot be explained solely by external factors (instrumental) or internal factors (psychological). Therefore, the most effective approach toward reduction and partial control of criminal and delinquent offending behaviour is to understand it. this understanding can emerge not only from continued psychological research activity directed at the learning, maintenance, and extinction processes of criminal and delinquent offending behaviour, but also at the theoretical development, which ultimately could translate into realistic policies and procedures to be adopted by the spirit of the psychology and law relationship, it behaves the science of psychology to pursue empirical investigations that may help lead to the formulation of legal policies that insure the safety of the members of society without massive curtailment of freedom.

8.10 KEYWORDS

Crime
Juvenile delinquency
Antisocial personality
Developmental theory
Racial differences

8.11 CHECK YOUR PROGRESS

1. Define crime and juvenile delinquency.
2. Explain the classification of crime.
3. Explain the psychosocial factors of criminal behavior.
4. Explain the types of juvenile delinquency.
5. Discuss the risk factors for juvenile delinquency.

8.12 ANSWERS TO CHECK YOUR PROGRESS

1. 8.3
2. 8.4
3. 8.5
4. 8.6
5. 8.7

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BLOCK-3 MANAGING THE COMMUNITY PROBLEMS

UNIT-9 COMMUNAL VIOLENCE (RIOTS)

STRUCTURE

9.1 OBJECTIVES

After going through this unit, you will be able to explain

- Communal Violence
- Meaning and definition of Communal Violence
- Causes of Communal Violence
- Factors contributing Communal violence
- Consequences of Communal Violence
- Prevention measures of Communal Violence

9.2 INTRODUCTION

A society or a community consists of different groups of people. People belonging to different caste, culture, creed, religion and different ethnic group. Our country is a country where we find number of differences in all these groups. Still our country is said to be unique as we find unity in diversity. In the normal situations people live harmoniously even with the differences, but there are certain situations when due to some misunderstandings, differences of opinions, thoughts, customs or values and priorities , there arises some issues which may lead to a situation where people may try to stand and stick on to their opinions or priorities, in this process they may become aggressive fighting for a cause. These situations lead to clashes, disputes, and sometimes violent actions. This later turns up into communal violence. This unit deals with communal violence, its causes, factors contributing communal violence, consequences, and also the measures for the prevention of communal violence.

9.3 MEANING AND DEFINITION OF COMMUNAL VIOLENCE

Communal violence is a form of violence which occurs across any ethnic group or a community with other communities. Usually people have an instinctual behaviour of relating to one's own community whichever community they belong. When any issue arises, which shows a threat to one's community the individuals become aggressive in their thoughts as well as behaviour. In a society there are different of kinds of people belonging to different communities.

We can see a healthy and harmonious society when people belonging to these different communities live and share same geographical area, place, and different aspects of life but still be different in their own ways. But sometimes there may arise differences in the preferences, opinions, values, way of living and when these differences become too broad in its spectrum there arises the reason for standing and fighting for one's preferences, values and other aspects. Individuals when they stand for or fight for these it becomes natural that the individual becomes aggressive. The aggressiveness may be verbal or physical, during these aggressive behavioural outbursts it is common that the individual in trying to attack the other individual may blame the person, group, family, caste, community etc. The violent parties feel solidarity for their respective groups, and the victims are chosen based upon the group members.

The violence which occurs between two different communities is called as communal violence. When there is a communal violence it affects the peace and system, organization of the community. Usually in India, we can see the communal violence occurring in between people belonging to different castes, different religions and different language speaking people. Sometimes communal violence may occur for things which are of not so much importance. Communal violence behaviour may spread very fast due to rumours and false information. Many innocent people become victims in communal violence. In communal violence aggressive and mass hypnotized behaviour can be seen. Communal violence is a serious social evil and it does not have any leadership and it is not led by a leader. Communal violence is a form of hatred and revengeful qualities. It affects the socioeconomic progress of the society. It violates the basic human rights. It creates communal tensions in the minds of the people. It destroys the harmony and peace of the society.

The term communal violence includes conflicts, riots and other forms of violence between communities of different religious faith or ethnic group.

The term communal violence for first used by the British colonial authorities in the early 20^{th} century to refer to the violence between religious, ethnic and disparate groups in its colonies.

The Indian law defines communal violence as "any act or series of acts, whether spontaneous or planned, resulting in injury or harm to the person and or property, knowingly or

unknowingly directed against any person by virtue of his or her membership of any religious or linguistic minority, in any state in the Union of India"

9.4 CAUSES OF COMMUNAL VIOLENCE

There are a number of factors which lead to the communal violence. Sociologists, Political scientists and Psychologists has given their own explanation regarding the communal violence. According to the Psychologists **rumour** becomes the main reason for the spread of the communal violence. The faulty and exaggerated rumours serve as a very important factor in the spread of the communal violence. As rumours spread very fast even for the minute things, it may provoke a community to act violently responding to a faulty rumour. These kinds of communal violence have occurred in the past many times as observed and studied by the experts. **Faulty perceptions** of an incident may also lead to communal violence. **Prejudice** serves as a major cause in the communal violence.

There are different kinds of situations in different parts of the country, different countries, and different parts of the world in which communal violence has taken place in the history. A careful study of these have led to the knowledge that in most of these situations the communal violence has resulted when there is a degradation of rule of law, the state fails to or is widely seen as unable to provide a definite order, security and equal justice, which then leads to mass mobilization, which is usually followed by radicalization of anger among one or more communities and ultimately which has led to violent mobilization. The various situations in which the targeted mass violence by a few from one community against innocent members of other community, suppression of complaints, an inaction of the state or the authority to handle and solve the issues in the initial stages by interfering may lead to communal violence.

A lot of researches have also shown that **ethnic segregation** may also be a strong reason for communal violence. Ethnic segregation means that even when a small minority group of individuals prefer to live in ethnically homogeneous settings due to the fear of other ethnic group, it may result in a very high degree of ethnic segregation. These kinds of ethnic segregation may decrease the possibility of positive contact between two different ethnic groups.

9.5 FACTORS CONTRIBUTING TO COMMUNAL VIOLENCE

Our country is a country which has people belonging to a wide variety of caste, culture, creed, race and religions. But still we see quite a good harmony in between these groups due to the attitudes, values and morals which is being followed by all people belonging to this country. Hence, it is proudly said to be unity in diversity. Usually people belonging to different communities do live together with some differences here and there. But there are certain factors which create an imbalance in these harmonious circumstances. The factors may be external in the surroundings or it may be internal that is within the individual. The factors like mistrust and disharmony in the society about other communities may be the one of the reasons. The major factors which may affect and create communal violence are being discussed here.

1. **Mass Media**: It is the responsibility of the Mass Media to present the actual facts to the people. But it is also the ethical responsibility of the Mass Media to be careful enough to take necessary precautions to prevent to present certain incidents or facts which may disturb the peace and harmony of the Nation. The fastest delivery of the information in the media in the form of breaking news provides only bits of information, watching which people assume things and may jump into a wrong conclusion. The responsibility of media is to present the objective, unbiased information, also keeping in the mind their moral responsibilitiy. In certain situations, they may be forced to present unrealistic and biased information due to certain pressures untold. Sometimes the audio and visual clippings may provoke emotional responses by the people watching these on the media. Apart from these sometimes due to the high competition between different channels, newspapers and other forms in media they may try to exaggerate the actual situation or sometimes the facts may not be presented from all the dimensions, these situations may create an emotional turmoil in the people who come across this kind of information. This may trigger the communal violence.
2. **Social Media**: Previously people used to depend only on the radio, T.V, and newspapers to get to know any information. Today with the invent and utilization of technology people depend on the latest modes of communication in which Social Media has occupied a major role. Any news and information to be spread is usually uploaded by people in this social media. As there is an opportunity for uploading or posting information people many

times without checking whether the piece of news or information, they have received is true or not whether it is going to affect the peace, harmony of the people or whether it is genuine information or a fake one without realizing all these they may post the information. As the utilization of Social Media is very high in present day situation it spreads very fast with some more added comments by the people who go through this. This in turn provokes the feelings of people belonging to different communities leading to become the cause of violence.

3. **Lack of Value based Education**: It is the utmost priority of the education system to inculcate value based education in preparing individuals for the future. When individuals are not equipped with value based education at home, at school and if they are not encouraged to follow the ethics and values in their work place and follow certain ideologies it becomes easy to be misled as they may overlook the difference between good and bad, right and wrong, truth and lie, they may blindly follow what is in trend as they think it may be right. All these kinds of various contributing factors may lead to communal violence.
4. **Majority and Minority**: The group in majority always feels that it knows what is right for the progress of the country, hence it is natural that the minority should also accept and follow their decisions, the smaller groups feel that their opinions does not matter and this results in opposing and leads to violent acts.
5. **Religious interference**: In a country where there are different religions, few of the religious leaders belonging to different religions sometime may become the triggers for communal violence.
6. **Reports about religions**: The various studies and reports given by the Government authorities about the religions, religious aspects may create a psychological threat in the mind of the people belonging to those religions and in the response to those threats they may react by giving rise to violence in the view of saving oneself from the perceived threat. Caste based violence are common in this aspect.
7. **Psychological intolerance**: Today's modern life filled with competition makes people feel insecure due to deprivation which leads to the development of mistrust, people get irritable easily, they are always at tension for one or the other things, they are feeling

devoid of many things, a feeling of left alone, prejudiced mind about the other communities all these aspects make them react violently even at the slightest provocation.

9.6 CONSEQUENCES OF COMMUNAL VIOLENCE

Communal violence leads to a variety of problems in the society. There is a great loss of many things for the individual as well as the society. The loss may be of the resources, life of people during clashes, peace of society, physical loss, loss of money and property, psychological insecurity created in the people's mind and a variety of other problems. A list of consequences is given below:

1. **Economic loss**: During the time of communal violence, loss of property may occur. When there are clashes between groups and communities' people tend to become aggressive and gather in mob. Mob mentality is unpredictable they may destroy the public property, government property, individual's property.
2. **Violation of Human Rights**: Whenever communal violence occurs it leads to loss of life of people involved in it, and also of many individuals who are innocent and involved in it. The innocent ordinary people become victims of communal violence. This is completely the violation of human rights. People lose their freedom to move around freely because of the fear of being attacked or injured. They may have to stay at home just for the sake of protection of their life. They may have to compromise with lots of things even without their willingness. All these are the violation of human rights.
3. **Social dissonance**: Sometimes much communal violence occurs because of social issues and interests. It may affect the cohesiveness of the society. It may cause a serious and long standing communal disharmony. It affects the country's image in the face of the world context.
4. **Psychological fear**: When people come across being victims of the communal violence a continuous fear tension, stress, and an unexplained hovering psychological fear stays in the minds of the individuals who were targeted or who saw these things in front of their eyes.

5. **Development of distrust**: People usually make friends in the society with all kinds of people coming from different communities, culture, and religion and share their lives with them. But in a situation where communal violence occurs and when they become target of these, people start suspecting their own friends who were so close once now they start suspecting and also mistrusting them thinking that as they belong to that community they may also be a reason for trouble.
6. **Creates hatred among people**: In general people start suspecting and hating the whole community. An incident which must have taken place in far remote place affects people everywhere breaking the whole societies into different communities. This makes people suspect everything around them, and everyone around them. They start hating people belonging to different communities, religions.

9.7 PREVENTION MEASURES OF COMMUNAL VIOLENCE

The important characteristics of the Community Psychology is its focus upon preventing rather than treating Social and Psychological problems. To achieve this goal the Community Psychology boosts up the individual skills. It also makes certain environmental changes which can prevent the occurrence of the problems.

It is the responsibility of the Government and also the citizens of the country to maintain and abide to the law and order of the country. A nation where there is communal harmony will make good progress in its development and achievement in all fields. Hence it is of utmost importance to join hands to prevent communal violence and establish a safe and secure nation for all the citizens residing in the country. Certain steps can be taken and certain measures can be implemented to achieve this objective. Some of the major measures to prevent communal violence are discussed here.

1. The administration should always be keen in its observations about any kind of intolerance being seen or developing in the different sectors of the society.
2. Preventive measures about removing prejudice about other communities should be the responsibility of all the religious leaders as well as preachers.

3. The motto of live and let others live should the way of living in all the people belonging to different communities.
4. The provocative speeches or incidences should be taken care immediately if by chance they occur.
5. Trained authorities like police should not only control people or punish them when found guilty but also help them make to understand their mistakes.
6. If any sensitive areas or localities are identified then the administration should take care that people residing there do not possess any weapons, guns, revolvers or other corrosive materials, if found those things need to be ceased to prevent the possible harm.
7. If in case anywhere communal violence has started the media should be instructed to provide only the necessary information without any highlighting or colouring it with other emotional feedback.
8. In case any communal violence occurs, the administration should immediately take action for a probe and get into the root cause and also the find out the people who are the root cause for this incident. Further, punishment need to be given for those if found guilty. This would create an awareness and people would be scared to create any such nuisance in future.
9. Government should always maintain an emergency fund in case these occur for the safety and rescue of the victims.
10. Today it has become the necessity to keep a watchful eye on the media and the social media to avoid the provocative actions. If found the laws for the media should be implemented and the cybercrime department should make sure to track the people involved in provoking people with respect to communities.

9.8 SUMMARY

This unit has provided a clear understanding about the communal violence, how it may start, its causes, factors contributing to communal violence, its consequences, the social, economic and psychological consequences, and how these communal violence upsets the functioning of the society in totality is being discussed. The psychologists and community psychologists do quite a number of studies to find the causes so that preventive measures can be

taken. The role of a psychologist is to help people develop awareness for the prevention of these issues and help to find a harmony in living in the society.

9.9 KEYWORDS

Communal Violence
Communal Riots
Mass media
Social media
Value based education
Majority
Minority
Religion
Intolerance

9.10 CHECK YOUR PROGRESS

1. Explain the meaning and definition of Communal Violence.
2. What are the causes of Communal Violence?
3. Discuss the factors contributing Communal violence.
4. Explain the consequences of Communal Violence.
5. What are the prevention measures of Communal Violence?

9.11 ANSWERS TO CHECK YOUR PROGRESS

1. 9.3
2. 9.4
3. 9.5
4. 9.6
5. 9.7

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UNIT-10 NATURAL DISASTERS

STRUCTURE

10.1 OBJECTIVES

After going through this unit, you will be able to explain

- Meaning and definition of Natural Disasters
- Types of Natural Disasters
- Tsunami
- Earthquake
- Draughts
- Chemical Disasters
- Role of Psychologist in the Natural Disaster management

10.2 INTRODUCTION

Natural disasters or ecological disasters may occur at any time. It is important to understand the causes and the occurrence of these to relate to the changes it can bring. These disasters bring not only environmental changes but also the behavioural and psychological changes in the individual. These disasters often have a pattern if we observe those and anticipate those we can well be prepared to counter and avoid the negative consequences as much as possible. This unit provides a clear understanding about the natural disasters, its consequences, psychological consequences, and the role of a community psychologist in handling that disaster after effects to help people.

10.3 MEANING AND DEFINITION OF NATURAL DISASTERS

The term **disaster** means a sudden calamity event which brings huge damages, loss and destruction and devastation to life and property. The damage caused by the disasters vary from one disaster to another. They usually cause immeasurable damage and it varies from one geographical location, climate to another. Disasters affects the social conditions, economic conditions, political conditions, cultural conditions and mainly the psychological conditions of the people.

The term natural disaster itself indicates that they are caused by the nature. Our mother nature is always very kind to us, that is to the human life. But there are certain times when there are certain variations in the atmosphere and the nature, which are not in the favour of human life. These events which occur in the atmosphere of the earth brings a situation where it leads to loss of lives, property and it upsets the human life. These kinds of events can be called as natural disasters. **Natural disasters** can be defined as "a major adverse event resulting from natural processes of the Earth". Examples for natural disasters are floods, hurricanes, earthquakes, tsunami, storms, and other geological processes.

According to WHO "A natural disaster is an act of nature of such magnitude as to create a catastrophic situation in which the day to day patterns of life are suddenly disrupted and people are plunged into helplessness and suffering, and , as a result, need food, clothing, shelter, medical and nursing care and other necessities of life, and protection against unfavourable environmental factors and conditions".

Natural disasters can cause loss of life, loss of property and it leaves a major economic damage, the severity of the damage depends upon the kind and the degree of the disaster and also upon the intensity of its occurrence. Sometimes the disaster may be a single event at one time like an earthquake, or sometimes the same incident may occur with a limited time duration for a greater number of times making the people unable to bear the shock it has created and affecting upon the ability to cope and recover.

On the surface level disasters may seem to affect the property and life, loss of life, but that is not the end. People who have survived in these disasters undergo a psychological trauma due to the fact that they have been the victims and also witnessed the disaster, the way it upset their life, took away from them their precious things, their family members, their shelter and made them helpless by making them as a mute spectator snatching away their ability to do anything rather than just watching all these things happen in front of their eyes . Disasters do affect the individuals present and also the future life of the individuals.

10.4 TYPES OF NATURAL DISASTERS

Natural disasters are those disasters created by the nature. There are number of different types of natural disasters. The major ones are floods, Tsunami, hurricane, earthquakes, volcano, landslide, storms, wildfires etc.

10.5 TSUNAMI

Floods: A flood is an overflow of water which leads to the submerge of the land. Flood is defined as the temporary covering of the land by water which is usually not covered by water. This means the flowing water moving far away from its regular path flows overly upon the land surface due to its pressure and the increase in its amount which has made the level of water to rise more than the usual. Flood occurs when there is increase in the volume of the waterbody such as river, lake.

Tsunami: The word Tsunami means 'harbour wave' or a tidal wave. It is the series of water waves which has raised in its volume, generally in an ocean. Tsunami waves are not like the normal waves of the sea. Tsunami refers to the rapidly rising tide. Hence it is referred as a tidal wave. Tsunami generally consists of a series of large and high waves with a gap periods ranging from minutes to hours. These waves are called as wave trains. The waves are not like the normal and regular ones but they rise till tens of meters. The impact of tsunami is high in its coastal areas, but the destructive power and its parallel and side effects disrupts the human life not only near the ocean but the surrounding geographical areas.

Tsunamis are the giant waves caused by earthquakes or volcanic eruptions under the sea. Tsunami wave's travel inland, they build up to higher and higher heights as the depth of the ocean increases. They travel in the speed of jet planes over the deep sea water.

10.6 EARTHQUAKE

Earthquake is a sudden vibration of the earth surface caused due to the sudden release of energy beneath the surface of the earth. Earthquake is caused by vibration, shaking and sometimes the displacement of the ground. An earthquake occurs as the result of a sudden

release in the energy in the earth's crust that creates seismic waves. Earthquakes are caused by the rupture of geological faults, volcanic activity, landslides, mine blasts and also due to nuclear tests.

Earthquakes results in significant loss of life, property, multiple injuries widespread damage to property and infrastructure. After the earthquake people has to rebuild their homes, re-establish their business, on one side they themselves must have faced physical injuries, the family members may have faced physical injuries or sometimes their loved ones may not have survived, in spite of all these they have to get back to the normal life which is very hard to digest. The loss of economic security, the reestablishment of the physical shelter, its cost, expenses, medical expenses, all these create a huge amount of psychological tension, burden, frustration, etc. Sometimes the people who are affected feel so miserable and guilty to be surviving when their family members could not survive take an extreme steps of decision due to guilt that they commit suicide unable to bear the separation and become lonely and survive. In this context, there are major concerns for the mental health and well being of those affected.

Psychological consequences of the earthquake

There are numerous psychological consequences which occur due to the after effects of an earthquake in the individual's surviving. The major one's are discussed here:

1. **Anxiety and Depression**: The occurrence of an earthquake turns the life of individuals upside down. Everything gets upset, there is a big question mark in the mind of the people what next? Where to start? Can I make things work again? Will I be able to accept the loss and move on? The remembrance of the actual incident occurring in their dreams as a nightmare makes them get mentally exhausted, expectation of one more earthquake if it happens, the thought disturbs and make them become numb. All these leads to anxiety, a free floating anxiety which may lead to obsession compulsions also. The signs of depression are seen in these individuals. The symptoms like loss of sleep, fatigue, decreased interest in daily activities, irritability, an inability to concentrate are all common in people in the post-earthquake situations.

2. **Hypervigilance**: It is seen that the survivors of earthquake often experience hypervigilance. Any unexpected slight noise may startle them, any sudden touch by a person or a pet also will make them scream because of the expectation of the dreadful situation. The physical body is in high alert due to the brain mechanism of survival instinct.
3. **Earthquake phobia**: The individual is always having a fear in his mind which is deep rooted after the incident of the earthquake. The focus tends to be a desire to control the possibility of another earthquake occurring. Even when the individual knows that he is unable to control the impending failure, it results in anxiety.
4. **Mental Block**: The survivors of the earthquake and other natural disasters have a continuous problem of the feelings of thoughts which keep troubling them. It becomes very necessary for them to have a routine so that they can stick on to it and keep themselves away by being bothered by the thoughts of the incident of the earthquake.
5. **Post Traumatic Stress Disorder**: The individuals who have been the victims of the earthquake suffer from the post traumatic stress disorder. They exhibit all the symptoms of the PTSD. Few individuals do recover from the after effects of the earthquake but many of them suffer from PTSD. The symptoms involve intense fear, flashbacks, and nightmares.

10.7 DROUGHTS

The planet earth provides us all the necessary things for our survival. The basic requirements like air, water, food, and shelter everything is provided by the mother nature. The human life goes smooth because of these, but in certain places, in certain situations this kind of favourable environment is not seen. There may be shortage of drinking water, or sometimes to an extreme there may be a severe shortage of the water for all the survival needs. This kind of a serious shortage of water for days together or months together will lead to a problem for the survival of human as well as animal life. This kind of situation is what is called as drought. A **drought** is an event of prolonged shortages in the water supply, it may be in the atmospheric level that is below the level of precipitation, or surface water or ground water shortage. Drought

is a serious stressor. Chronic stress which arises in the situations of drought in the minds of the people may make them experience stress and depression.

The situation of the drought may last for days or months together, sometimes even years. A situation where this exceeds for more than 15 days it is termed as drought. It affects the ecosystem, animal life, human life and plants or crops also. In totality there is an imbalance created in the environment. Once the biological, zoological and human life is affected it will directly lead to the problems of economy of that region. When this drought continues people find it extremely hard to survive in those areas, which in turn will become the cause of migration of people from that locality to another locality where they can survive.

Consequences of drought

Droughts bring about various kinds of problems, it may be environmental, social, or economic problems. Drought affects food production, human health, brings lots of diseases.

The negative effects of drought affect the human life. People exposed to continuous heat, a lack of water to drink, at the same time high level of pollution, failed crop growth at one hand raised cost of food commodities on the other makes people to find it difficult to survive.

Psychological consequences of drought

Apart from the physical consequences as these situations create a burden, economic burden, problems in health, the adults and parents worried about themselves as well as their children's health all these factors contribute to the psychological stress and continued stress gives rise to problems in mental health. Drought brings severe problems with it. The major ones being hunger, insufficient food supply, malnutrition, mass migration, famine, social unrest, etc.

Studies conducted upon drought and its effects on human life has shown that people suffer from anxiety and depression. It has also been found that this has led to the rise in suicidal rates in the people in those areas. Drought causes financial hardships, farmers suffer crop loss, stay in debt, with the continuous burden of the economic need for survival for oneself and the

family members , on top of it to face the crop loss added to it the agricultural loans, debts they have taken all these aggravate the psychological burden for the individual unable to bear these and still trying to lead a respectful life becomes a psychological burden for the individual. All these factors make the individual move into depressive thoughts and feelings of ideas of committing suicide to escape this never ending problems. This leads to suicidal attempts, and the act of suicide itself.

Droughts affects family life, it increases stress, worry, it increases irritability, fear, isolation, health loss, sleep disturbances etc.

10.8 CHEMICAL DISASTERS

Disasters may be natural or sometimes human made. Till now we have discussed about the various natural disasters, their effects psychological consequences and also the role of a Psychologist in helping the people who are undergoing or survived from these natural disasters. In this section we are going to discuss the manmade disaster or accident in this category there are many to discuss, but we will be focusing on the major one that is Chemical disaster. **Chemical disaster** is an unintentional release of one or more hazardous substances which could harm human health and the environment. Chemical disasters are the chemical accidents which could occur under certain circumstances. Examples of chemical disasters are: fires, explosions, leakages, release of toxic substances, hazardous materials etc.

Chemical disasters may lead to a longer term health effects from chemicals. They may usually occur as a result of chemicals over a long period of time. The long term effects depends upon the duration the individual is exposed to the chemicals. This may include:

- Weakens the immune system
- It may result in damage to the organs
- Leads to development of allergies
- Asthama
- Eyes irritation or burning
- Problems in breathing
- Vomiting

- Fainting
- Nausea
- Becoming unconscious
- In extreme cases leads to death of the individual
- It may affect reproductive problems and birth defects
- Effects in mental, physical development and intellectual development of children

10.9 EFFECTS OF NATURAL DISASTERS

Natural disaster may occur unexpectedly, but the consequences are very clear. Any kind of disaster will always leave behind number of effects which cannot be reversed or which does not heal even after long duration after the occurrence of the event. The major effects of any natural disaster can be understood as follows:

- They disrupt the normal life of people.
- It affects the basic requirement of living like food, water and shelter.
- It affects the physical and psychological health of the individuals.
- It effects the economic stability of the individual as well as the society.
- It creates emergency situation.
- It leaves behind catastrophic physical and psychological consequences.

10.10 PSYCHOLOGICAL EFFECTS OF NATURAL DISASTERS

The consequences of natural disasters are not limited to economic loss only it spreads all over into all areas of life. Its expression is different in different age groups, i.e., the adult's way of expressing their loss, the women, the children who are still in the process of understanding and developing trust upon oneself, their parents and life may react differently. Children may run away from their home unable to understand and analyze the situation, they may lose hope in life, become sober, dull uninterested in everything, feel being left out. The psychological trauma leaves a permanent mark on the tender minds of the growing children.

Psychological consequences:

- Feelings of anxiety
- Emotional distress
- Constant worrying
- Trouble sleeping
- Symptoms of depression
- Post traumatic stress disorder
- Major depressive disorder
- Substance abuse disorder
- Generalized anxiety disorder
- Panic disorder
- Phobia
- Nonspecific distress
- Perceived distress

Natural disasters create a very strong devastating impact upon the psychological health of an individual. Disasters do threaten the personal safety of the individual, it disrupts the family functioning and the family structure. Children and adolescents are very much affected psychologically due to the encounter of natural disasters.

10.11 ROLE OF PSYCHOLOGIST IN THE NATURAL DISASTER MANAGEMENT

Helping the survivors in the rehabilitation

The role of a community psychologist is to actively participate in the rehabilitation programmes to be conducted for the survivors of the natural disaster's victims. The state and the Government immediately take up the rescue activities needed to help the victims struck in the natural disasters. Once they are being rescued from the place of the incident of the natural disaster it is very important to take care of the health of those survivors. The necessary care for the physical health and recovery is the responsibility of the medical staff. The psychologists use intervention programmes to remove the fear in the minds of the victims.

They focus upon the recovery, but the most important role here is of the psychologists

- to remove the fear from the minds of the survivors,
- to bring back the hope that things will become normal,
- to make them come out of the panic which is caused as they have witnessed the disaster and the loss of life, property in front of their eyes.
- They facilitate in the expression of the feelings associated with the trauma.
- Help them learn coping skills

The treatment methods utilized in recovery

- Art therapy
- Relaxation therapies
- Occupational therapies
- Music therapy
- Catharsis
- Ventilation of feelings
- Group discussions

In the process of treatment, the psychologist during the interaction do find out that the survivors of the disasters experience a wide variety of psychological problems depending upon their personality, their ability to withstand the situation, the severity of the effect of the disaster on them and their family members. The most commonly found psychological problems in these people are a sense of loss, hopelessness, frustration, uncertainty, sadness, depression, panic, guilt.

It becomes the responsibility of the larger community to take care of the smaller groups who are suffering from natural disasters. In context with the droughts, the community by large should extend its helping hands for the people surviving in the drought areas. The necessary medical services, economic relaxation for paying back the debts, taking care of the health of the children and old people, making certain arrangements to provide drinking water, if the situation is too serious the Government should make some arrangements for temporary shifting of the people from that locality, providing them shelter, medical services. Most importantly the psychological support should be provided by arranging the community psychologists and the counselling psychologists to give necessary counselling and help them overcome the stress, despair, and to make them have a positive outlook, to instill hope in them about the future.

10.12 SUMMARY

This unit has provided a detailed understanding about the natural disasters its occurrence, consequences, the way it affects human life and the ways to handle it. The community psychologist plays a major role in planning and providing help to the survivors of these disasters.

10.13 KEYWORDS

Natural Disasters
Floods
Tsunami
Earthquake
Droughts
Chemical Disasters

Psychological trauma
Disaster management

10.14 CHECK YOUR PROGRESS

1. Explain the meaning and definition of Natural Disasters.
2. Name are the different types of Natural Disasters?
3. Explain the consequences of Tsunami, earthquake and droughts.
4. Explain the effects of Chemical Disasters.
5. Discuss the effects of Natural Disasters.
6. Explain the Psychological effects of Natural Disasters.
7. Discuss the role of Psychologist in the Natural Disaster management.

10.15 ANSWERS TO CHECK YOUR PROGRESS

1. 10.3
2. 10.4
3. 10.5,10.6 & 10.7

4. 10.8
5. 10.9
6. 10.10
7. 10.11

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UNIT- 11 MANAGING COMMUNITY PROBLEMS

STRUCTURE

11.1 OBJECTIVES

After reading this unit you will be able to understand the following:

- Types of Prevention of community problems
- How to collect information about community problems
- Analyzing community problems
- Need for analyzing community problems
- Methods to determine the causes of community problems
- Developing and using criteria and processes to set priorities
- Analysis using baseline measures
- SWOT Analysis

11.2 INTRODUCTION

While we traditionally think of a community as the people in a given geographical location, the word can really refer to any group sharing something in common. This may refer to smaller geographic areas -- a neighbourhood, a housing project or development, a rural area or to a number of other possible communities within a larger, geographically-defined community. These are often defined by race or ethnicity, professional or economic ties, religion, culture, or shared background or interest.

A community problem can be defined as a perceived gap between the existing state and a desired state, or a deviation from a norm, standard, or status quo. Examples of community Problems include: Adolescent pregnancy, access to clean drinking water, child abuse and neglect, crime, domestic violence, drug use, environmental contamination, ethnic conflict, health disparities, HIV/ AIDS, hunger, inadequate emergency services, inequality, jobs, lack of affordable housing, poverty, racism, transportation, violence etc.

Some of the criteria which can be considered when identifying community problems are listed below:

- The problem occurs too frequently **(frequency**)

- The problem has lasted for a while (**duration**)
- The problem affects many people (**scope, or range**)
- The problem is disrupting to personal or community life, and possibly intense (**severity**)
- The problem deprives people of legal or moral rights (**equity**)
- The issue is perceived as a problem (**perception**)

Although many problems turn out to have several solutions (the means to close the gap or correct the deviation), difficulties arise where such means are either not obvious or are not immediately available. Citizen participation in community projects can help identify and solve problems. Community leaders can implement public forums and listening sessions into community building and use the results to shape their projects. In the public forum or public problem-identification and problem-solving session, citizens discuss important issues such as health problems. The facilitators can lead a discussion of various aspects of the issue like the community's strengths and potential problems. A transcript of their ideas about the dimensions of the issue--and what can be done to solve problems and preserve strengths--provides a basis for subsequent planning.

11.3 PREVENTION OF COMMUNITY PROBLEMS: NATURE AND TYPES

Community problems can be managed by using preventive measures. Preventive measures can be of three types- Primary, Secondary and Tertiary.

1. **Primary prevention**: Primary prevention activities promote community wellbeing and prevent problems. Primary prevention focuses on reducing or removing risk factors by changing the environment and the community, as well as, family and individual life styles and behaviours. This includes education and anticipatory guidance to develop and maintain behaviours of people in the community.
2. **Secondary prevention**: Secondary prevention focuses on strategies to stop or slow the progression of the existing problem. Secondary prevention activities target the groups or areas which are more susceptible to problems because of prevailing conditions or environmental factors.

3. **Tertiary prevention**: Tertiary prevention is directed at managing and rehabilitating the persons affected by the problem, to reduce complications, improve their quality of life and productivity.

Levels of Intervention

Intervention is a purposefully planned activity, program, policy, or other action designed with the intent of changing a behaviour, risk factors, environmental condition, or aspect of health status for an individual, target group, community, organizations, or the population at large. It includes a range of planned change efforts designed to ultimately improve the quality of life of the people and prevent problems.

Intervention approaches are also categorized into three levels

- individual-focused (personal)
- community-focused (population or subgroup)
- system-focused (procedures, rules, regulations, policy and law)

1. Individual-focused interventions aim to produce changes in knowledge, behaviour of individuals either singly or in small groups. These interventions involve direct client contact including face to face visits and other personalized contact such as by telephone or by interactive computer program. They allow the greatest amount of tailoring and personalization to the client's needs.

2. Community-focused interventions aim to reach and bring about changes in large numbers of the population. They are targeted to groups or subgroups of the community, but cannot be personalized.

3. System-focused interventions create changes in organizations, policies, laws or structures. The focus is not on individuals or communities, but on the systems that serve them.

11.4 COLLECTION OF INFORMATION ABOUT COMMUNITY PROBLEMS

Quantitative information is crucial to building awareness and gathering support for community issues. Hard data analysis provides a concrete approach for assessing, planning, and implementing community projects. It can be a valuable tool in comparing community problems across geographic regions and across periods of time. Data can be gathered through focus groups, public forums, and surveys.

The advantages of having this information are enormous. Some of these advantages include:

- ***Knowledge*** - Knowing the facts is a stark way of determining the size of the gap between a vision of a healthy community and the reality in which the community lives. Gathering information/ baseline data is an excellent way to show the magnitude of the problem.
- ***Credibility counts***– If credible information about the exact number of people affected by the issue is availablethen it greatly helps in finding and convincing potential funders and evaluators
- ***Awareness leads to change*** -Statistics can be used to raise community awareness of a number of things such as (i)how serious the problem is, (ii) how well (or how poorly) a community is doing in relation to other communities or to the nation as a whole, and (iii) how well a coalition is attacking the problem at hand.

The various steps involved in collection of information/ data about community problems are listed below:

1. Agree on the value and purpose of the information that you will collect

2. Identify the method of collecting information (e.g. surveys, public forums and listening sessions etc.)

3. Determine when you want to use this data

4. Determine exactly what you want to know

5. Determine who will find the information

6. Train the people who will be collecting the information

7. Identify possible sources of information

8. Set limits as to how much information you want to collect

7. Collect and tabulate the data**.**

8. Identify gaps in your knowledge

9. Continue to review and collect information on a regular basis

10. Compare data for a community with that of other communities, or that of the nation as a whole**.**

11.5 ANALYZING COMMUNITY PROBLEMS

Analyzing community problems is a way of thinking carefully about a problem or issue before acting on a solution. It first involves identifying reasons a problem exists, and then (and only then) identifying possible solutions and a plan for improvement. The techniques for analyzing community problems require simple logic, and sometimes the collection of evidence. Analysing community problems becomes especially important under the following conditions:

- When the community problem is not defined very clearly
- When little is known about the community problem, or its possible consequences
- When you want to find causes that may improve the chance of successfully addressing the problem
- When people are jumping to solutions much too soon
- When you need to identify actions to address the problem, and find collaborative partners for taking action.

11.5.1 NEED FOR ANALYZING COMMUNITY PROBLEMS

Analyses of community problems is essential in order to have a deeper understanding of the problem and to better the odds of coming up with a successful solution. Other advantages of analysing community problems are:

- To effectively identify what the problem or issue is.
- To understand what is at the heart of a problem.
- To determine the barriers and resources associated with addressing the problem.
- To develop the best action steps for addressing the problem.

11.5.2 METHODS TO DETERMINE THE CAUSES OF COMMUNITY PROBLEMS

The ultimate goal of analysing community problem is to understand the problem better and to deal with it more effectively. Hence the method to determine the causes of community problem should be chosen keeping in mind, the above mentioned goal. Some of the specific ways to determine the causes of the problem are listed below:

1. Justify the choice of the problem.
2. State/ frame the problem without implying a solution or blaming anyone
3. Identify whose behaviour and/or what and how environmental factors need to change for the problem to begin to be solved.
4. Analyze the root causes of the problem by using one or more analytical methods such as critical thinking and the “But Why?” technique.
5. Identify the restraining and driving forces that affect the problem. .
6. Find any relationships that exist among the different community problems within the same community.
7. Identify personal factors that may contribute to the problem.
8. Identify environmental factors and overarching factors such as poverty, living conditions, official policy, and economic conditions that may contribute to the problem.
9. Identify targets and agents of change for addressing the problem (e.g. parents, teachers etc.).

11.6 DEVELOPING AND USING CRITERIA AND PROCESSES TO SET PRIORITIES

Criteria are standards for making a judgment. They provide guidelines for making decisions. The criteria used for examining a particular set of issues may be different from those used for another set, depending on the community, the conditions that are in place at the time of the decision, the needs and concerns of the people making the decision and other factors.

Priority is the order of importance in which one thing falls in relation to another. Like a set of criteria, priorities may change with changes in the community, or with changes in people's concerns or knowledge.

When a community assessment has uncovered a number of issues – perhaps issues in different areas, such as health, economics, and racial attitudes – developing a set of criteria for deciding how important each one is to address is crucial to effective action. Without considering what its standards are beforehand, a planning group may be reduced to each member's intuition or particular pet issue, and descend into argument and eventual chaos. That's a worst-case scenario, but any level of confusion or aimless flailing can be avoided by establishing some agreed-upon criteria for determining what to tackle when.

Two sets of criteria will be needed here. First criteria will provide the guidelines for choosing one or more issues to work on. The second criteria will help in determining what strategies and approaches are likely to be most effective in addressing the issues. The other necessary ingredient for cooking up a successful intervention or initiative is a decision-making process that will allow a planning group to choose criteria and approaches rationally and wisely.

In general, the ideal process is participatory and inclusive, involving all stakeholders – those affected by or concerned with the issues at hand – and the community at large. It's best if it includes both people with technical expertise in the relevant fields – health, social policy, employment, etc. – and people grounded in the community. With that mix, criteria are likely to reflect best practices and good theory as well as real community needs, wishes, and norms.

To ensure community support, the fact that there is an inclusive process, developed at least in part by input from the participants in it, may be as important as the actual form of the process.

The advantages of developing and using criteria and processes to set priorities are mentioned below:

- It creates a structure that makes setting priorities more systematic and more likely to reflect the realities of the community.
- It helps ensure the most important issues for a community are addressed. Using a set of criteria and a good decision-making process makes it much more probable that one will get the priorities right.
- It provides an opportunity to involve the community in the effort and to get community buy-in. Any effort is far more likely to succeed if the community feels ownership of it and supports it.
- An inclusive criteria-setting process makes sure that community members, especially those most affected by issues, have a clearer understanding of what's important to the community and of which issues actually have the greatest impact on people's lives.
- Establishing criteria in a structured and inclusive way ensures that the process is an open one, and that any concerns are raised. It is essential to include those who are most affected by the problem.
- The process of selecting criteria allows an opportunity to educate stakeholders who may not have had this kind of experience before about how to make informed, systematic decisions.

11.7 ANALYSIS USING BASELINE MEASURES

In order to make a change in a community, one of the first things that needs to be done is to figure out how many the different factors and trends being examined are happening in the first place. One needs to find out how prevalent any problems and positive tendencies are, how often things happen, the duration and intensity of most incidents, etc. The things one needs to keep

track of in order to obtain this sort of information are called baseline measures. In other words, the baseline is the standard against which one will measure all subsequent changes implemented by in the program. We call them baselines because they're usually shown as lines in graph form to easily show changes over time. Sometimes people may call them other names: reference points, adaptation levels, anchors, or norms. Baselines are essential for making judgments about people and things.

Interpretations against a baseline are the way most policy decisions get made. Good decisions will depend on good collection and utilization of baseline data. Comparison to a baseline is the standard against which policy success is judged. Experts generally consider determining baseline measures of behaviour to be the first phase in any sort of behaviour modification program, followed by implementation of the program and finally a follow-up phase in which the results are measured and analysed.

The advantages of using baseline measures are mentioned below:

(i) Baseline measures can tell us whether the efforts are working.

To plan a truly effective program, one has to know how much of an effect effort are having. One needs to have an idea of the level of the problem without the efforts being a factor to know whether one is really making a difference at all.

(ii) A baseline can help us make sense about something that might be too massive and complicated to understand otherwise.

A question like 'How well are our schools working?' might be overwhelming to try to answer. However, keeping track of baselines, such as standardized test scores or high school graduation rates, can help us better understand the bigger picture.

(iii) A baseline can help us decide whether this is a good time to start an intervention or whether a particular intervention is appropriate.

Say one is working to decrease fatal car accidents in a county by starting a program to encourage seat belt use. Getting some idea of how many people in the county are consistently using their seat belts will help one decide whether he/she should spend any time and resources on such a

project. The rate of seat belt use will be the baseline measure. If 98% of local citizens are already using their seat belts most of the time, one may want to explore other possible interventions.

(iv) Baseline measures can sometimes tell us if an intervention isn't necessary at all.

A good, accurate baseline measure could show us that there really isn't a problem at all or that the problem isn't grave enough to require immediate intervention.

(v) Baseline measures can help us determine if the methods being used aren't working.

If there is no change in the behaviour compared to the baseline, one needs to come up with a more effective method to solve the community problem.

However, a method or intervention may take some time to produce the desired effect. Behaviour change may not show up immediately. One must wait a while before concluding that a method or an intervention isn't working.

11.8 SWOT ANALYSIS

SWOT stands for: **S**trength, **W**eakness, **O**pportunity, **T**hreat. A SWOT analysis guides you to identify your organization's strengths and weaknesses (S-W), as well as broader opportunities and threats (O-T). Developing a fuller awareness of the situation helps with both strategic planning and decision-making. SWOT also offers a simple way of communicating about the initiative or program and an excellent way to organize information gathered from studies or surveys. The purpose of performing a SWOT is to reveal positive forces that work together and potential problems that need to be recognized and possibly addressed.

SWOT analysis can offer helpful perspectives at any stage of an effort. One might use it to:

- Explore possibilities for new efforts or solutions to problems.
- Make decisions about the best path for the initiative. Identifying the opportunities for success in context of threats to success will help in clarifying directions and choices.
- Determine where change is possible. If one is at a juncture or turning point, an inventory of his/ her strengths and weaknesses can reveal priorities as well as possibilities.

- Adjust and refine plans mid-course. A new opportunity might open wider avenues, while a new threat could close a path that once existed.

Steps for conducting SWOT analysis are listed as follows:

1. Designate a leader or group facilitator who has good listening and group process skills, and who can keep things moving and on track.
2. Designate a recorder to back up the leader if the group is large.
3. Introduce SWOT method and its purpose in the organization by giving a quick example based on a shared experience or a well-known public issue.
4. Divide your stakeholders into smaller groups and direct them to create a SWOT analysis in format such as charts, columns, matrices etc.
5. Designate a recorder for each group.
6. Gather information from the groups and to share the differing groups' ideas and perceptions
7. Discuss and record the results.
8. Prepare a written summary of the SWOT analysis to share with participants for continued use in planning and implementation.

11.9 SUMMARY

Developing a plan for identifying local needs and resources can help change makers understand how to improve their communities in the most logical and efficient ways possible. Understanding a community is crucial to being able to work in it. Failing to understand it will make it difficult to connect with community members and to negotiate the twists and turns of starting and implementing a community initiative or intervention. An extremely important part of any community assessment, therefore, is to start by finding out as much about the community as possible–its physical and geographical characteristics, its culture, its government, and its assumptions. By combing through existing data, observing, and learning from community members, one can gain an overview of the community. When analyzing real community problems, the analysis may show multiple reasons behind the problem. The analysis may not always be easy. The solution may be more difficult still. Community problems exist precisely

because they often resist clear analysis and solution. They persist despite our efforts. They can be real challenges. Analysis, including the analytic methods, can take us a long way. With good analysis, some resources, and enough determination, even the most troublesome problems can be addressed, and ultimately, solved.

11.10 KEY WORDS

Community problem can be defined as a perceived gap between the existing state and a desired state, or a deviation from a norm, standard, or status quo.

Primary prevention activities that focus on reducing or removing risk factors by changing the environment and the community.

Secondary prevention focuses on strategies to stop or slow the progression of the existing problem.

Tertiary prevention: Tertiary prevention is directed at managing and rehabilitating the persons affected by the problem.

Criteria are standards for making a judgment.

Priority is the order of importance in which one thing falls in relation to another.

Baseline is the standard against which one will measure all subsequent changes implemented by in the program.

SWOT stands for: **S**trength, **W**eakness, **O**pportunity, **T**hreat.

11.11 CHECK YOUR PROGRESS

1) Describe different types of preventive measures for managing community problems.

2) Write a note on collection of information about community problems.

3) Discuss the methods used to determine the causes of community problems

4) What are the advantages of using criteria and processes to set priorities?

5) Describe how community problems can be analysed using baseline measures.

6) Elaborate on SWOT Analysis.

11.12 ANSWERS TO CHECK YOUR PROGRESS

1)11.3 2) 11.4 3) 11.5.2 4) 11.6 5) 11.7 6) 11.8

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UNIT-12 ROLE OF PSYCHOLOGISTS IN SOCIAL PROBLEMS

STRUCTURE

12.1 OBJECTIVES

After going through this unit, you will be able to explain:

- Meaning and definition of Social Problems
- Causes of Social Problems
- Consequences of Social Problems
- Role of a Psychologist in solving Social Problems
- Role of administration
- Role of Non-Professionals in solving Social Problems

12.2 INTRODUCTION

In this block in the previous units we have discussed about the communal violence, its causes, consequences and the role of a Psychologist in helping the society overcome and solve these problems. We have also discussed in the last unit about the natural disasters, its types, consequences, and ways of helping those survivors of the natural disasters. In the present unit we will be discussing about the social problems, its causes, consequences and the role of a Psychologist in solving the social problems.

12.3 MEANING AND DEFINITION OF SOCIAL PROBLEMS

Every society can function well and effectively only when the members of the society abide to the rules and follow it. The smooth functioning of the society is very important for the progress of the nation. But sometimes the individuals or the group of individuals may go against the rules, systems, law and order which create problems in the society.

According to Richard C. Fuller and Richard Myers, “social problems are behaviour patterns or conditions that are considered objectionable or undesirable by many members of the society”.

A social problem is a condition which is not ideal and which disrupts the balance of the society. It is defined as “any undesirable condition or situation that is judged by an influential

number of persons within a community to be intolerable and to require group action toward constructive forms".

Social problems are those factors which occur in a society but which are harmful for the smooth functioning of the society, they affect and damage the society. The term social problem is usually used to denote or describe problems with a particular area or group of people in the world. Social problems differ from one society to another, one country to another. It is purely specific of that particular society. Some of the major and common social problems are: antisocial behaviour, drug abuse, racial discrimination, economic deprivation, unemployment, high crime rates, violence, terrorism etc.

12.4 TYPES OF SOCIAL PROBLEMS

The social problems are different from one country to another. The number of problems does vary on the context and they keep changing with the years. But there are certain problems which the society faces which do hinder into the progress of the nation making these issues need to be focused so that it can be solved. The major social problems our country is facing are being discussed here:

12.5 POVERTY

Poverty is one of the biggest social problems our country is facing. **Poverty** can be understood as the condition in which the individuals due to inadequate income or unwise expenditures do face a situation where they cannot provide enough for their physical and mental efficiency, and also cannot provide for their dependents. Poverty can be said when an individual is unable to meet his and his family members basic needs for their survival.

As defined by Goddard, J.G "Poverty is the insufficient supply of those which are requisite for an individual to maintain himself and those dependent upon him in health and vigour". Poverty is a problem of economic differences.

Poverty affects in individual in number of ways. It affects the individual psychologically also, it has been found that problems with self-regulation and behavioural difficulties are found in the children belonging to poverty group. There has been found that people do have a poor mental health with a number of adjustment problems. Due to poor economic condition they are

devoid of education facilities which in turn leads to under development of their abilities and capacities.

The research conducted in this area has shown that poverty has a wide range of negative effects upon the physical and mental health of the children. Due to poor hosing, homelessness, lack of health and medical facilities they are undernourished, fall sick easily, have low immunity, prone to diseases due to unhygienic environment. Apart from this they have less access to education, even if they get they may become school dropout, poor academic achievement, chronic stress, behavioural problems, emotional problems, anxiety, depression are also seen. These things make them go for smoking, drinking, drugs the major social problems, etc. These lead to the other social problems like child labour, child abuse etc. Due to the fact that they are devoid of luxurious things, facilities that other people are enjoying in the society they tend to be angry, aggressive and violent in their behaviour. This makes them get into physical fights easily making them to jump into theft, robbery, crime.

12.6 CHILD LABOUR

Due to the economic conditions in the people coming under the poverty even the small children are forced to work to feed themselves or their family members. This act of working of a child for the sake of earning is called as **child labour**, which according to our country law is a punishable act. The Indian Government has made a law which states that the dangerous work or activities that could harm the mental, spiritual, moral or social development of girls or boys under the age of 18 is prohibited according to the child labour act of 1993.

The term child labour is defined as the work that deprives the children of their childhood, their potential, their dignity, and which is harmful to their physical and mental development. Child labour affects the physical health of the children, it affects the nutritional status, physical growth, work related illnesses, musculoskeletal pain, HIV infection, infectious disease, tuberculosis, eyestrain, general weakness, tiredness, exhaustion, body injuries, backaches, burns, ling disease cuts, physical injury, chronic cough, diarrhea, hearing loss, bone fractures, etc.

Child labour brings with it lots of psychological problems, behavioural problems, there are more chances of physical abuse, sexually abuse, psychological health is also affected.

12.7 UNEMPLOYMENT

Unemployment term refers to the individuals who can be employable and do seek a job but are unable to get a job. Unemployment may be caused due to various reasons, like the demand from the external factors, the supply, or the worker. Job is a requirement of every adult in today's world according to their ability and educational qualification. It is also very important from the viewpoint of fulfilling one's basic needs without being dependent on others. When the individual is not employed it will bring number of problems both economical and psychological. It makes individual emotionally problematic due to various consequences created by the unemployment. It affects the mental health of the individual. It leads to anxiety, depression, substance abuse, inferiority complex, guilt, suicidal thoughts, suicide attempts, violence, loss of sense of self-worth, etc.

The research conducted in this area shows that unemployment damages emotional health and undermines the social fabric of the society. (Eisenberg and Lazarsfield 1938).

Unemployment affects the individual's mental health, it affects his sense of self-worth, self-efficacy, self-esteem, etc.

12.8 GENDER DISCRIMINATION

It is the right of any individual to be treated in equality whatever gender they are that is whether it is a boy or a girl they should not be discriminated and devoid of any opportunity only because they belong to that gender. Equal treatment irrespective of the gender is everyone's right. But it is seen in our country and few other countries how a girl is being not given the due importance for her identity, her wishes, desires, ambitions, her dreams and her achievements. She is treated as less always compared to the other gender. This is a major social problem. Until and unless a society provides equal opportunities and treat the individuals belonging to different gender equally, the society is considered to be unfair, and it itself is blocking the path of success of a nation.

But in certain situations, an individual may be not given certain benefits, or opportunities or they be stopped doing something just because of their gender. This kind of treatment is what we understand as discrimination. **Gender discrimination** is the unequal treatment of an individual

or a group of individuals based upon their gender. Gender discrimination is also known as sexual discrimination, it is any action that specifically denies opportunities, privileges or rewards to a person or a group because of the gender. When the gender becomes the sole reason in deciding whether the individual should be given something or not is understood as gender discrimination.

Gender discrimination is said when a person is treated differently because they are male or female, rather than on the basis of their individual skills or capabilities. Discrimination based on the gender is a common civil rights violation which may include sexual harassment, pregnancy discrimination, unequal pay for women in the workplace for the same kind of the job for which the male co-worker is paid higher than the female.

Gender discrimination is seen in the way how a person is being spoked to, how he or she is being discouraged by doing certain things, the way restrictions are being posed to them, verbal abuse, physical abuse, controlling the individual in words and action, taking away the opportunity of participating, restrictions imposed on their movement, speech and even in the act of meeting people. In the situations where the individual deserves to be praised for her achievement she is being overlooked just because of the gender and demeaning the work she does, considering her work as inferior compared to the other gender person's performance, these situations may be at the home, school, and workplace or in the larger society.

Consequences of gender discrimination

- Loss of opportunities
- Loss of freedom
- Physical abuse
- Sexual abuse
- Violation of human rights
- Women feeling insecure
- Moving into depressive state due to discrimination
- Feelings of helplessness
- Aversion towards society
- A mistrust towards the system

12.9 VIOLENCE AGAINST WOMEN

Violence in itself is a social problem. Discrimination also is another social problem, violence and discrimination targeted towards women in particular is termed as violence against women. The most unethical behaviour in the society. Every individual has every rights to live respectfully, they have the basic human right to be treated equally irrespective of their gender. But still certain group of people do think and feel that all the liberties should be enjoyed by only the males and females do not have any rights to question their behaviour even when they are wrong. This kind of an illusionary attitude, a wrong perception, a mind filled with discrimination is the reason for the violence against women.

Violence against women is also known as gender-based violence and sexual and gender-based violence. They are the violent acts exclusively committed against women or girls. These kinds of violent activities are committed in the form of hate against women just because they are female. It can be any form. This kind of violence arises from a sense of entitlement, superiority. It shows the unequal power hold between the two gender. This violence is a very crucial social evil where women are forced into a subordinate position compared to men. This kind of violence is seen as the subjugation of women, whether in society in general or in an interpersonal relationship.

There are different forms of violence done on women. A list of these are given below:

- Rape
- Domestic violence
- Sexual harassment
- Female infanticide
- Acid throwing
- Prenatal sex selection
- Honour killings
- Dowry
- Forced marriage

All these forms of violence and still many more types and forms which may not even reported or come to light are all a serious issue and a violation of women's human rights.

According to the reports WHO has given that about 1 in 3(35%) of women worldwide must have experienced either physical or intimate partner violence in their lifetime.

The effects of this violence is so severe that it not only affects the girls or women at that moment but leaves them with a permanent scar in their minds which make them feel insecure, inferior, worthless, depressed, humiliated, hatred towards oneself for not being able to protect oneself and guard one's self- respect, in certain cases the guilt of the inability to protect oneself, the shame, humiliation makes them take an extreme step of committing suicide for the sole reason that there is no escape from this and no one to rescue them from this violence.

12.10 CRIME

Crime is breaking of the law which can be punished by the government authorities. According to Paul Tappan crime is defined as "an intentional act or omission in violation of criminal law, committed without defense or justification and sanctioned by the state as a felony or misdemeanour.

An act of crime involves harm towards other individuals, towards human conduct, which is not desired. The legal proceedings will determine and decide which acts of an individual are to be considered as an act of crime. Different acts which threaten the life, property and the well-being of the individual may be considered as crime depending upon the laws of the country. Examples of crime are: threat and harassments, domestic violence, sexual assaults, child abuse, gang violence, etc.

Cybercrime is the crime where using the internet an individual is being cheated or identity theft is done. The various forms of crime committed in online mode by giving misleading information, theft of personal information, are all considered as cybercrime and strict actions and laws are also very actively functioning to prevent, identify, find the culprit and punish them once the crime is being proved.

In this unit the major social problems are being discussed and there are some more major crimes which are already being discussed in the other units of this course. To avoid repetition the problems like juvenile delinquency, alcoholism, drug abused are not repeated here.

12.11 CAUSES OF SOCIAL PROBLEMS

Social problems are those problems which affect the society in its smooth functioning and the development and progress of the nation. Many social problems are created by the people involved in it even without the awareness that they are contributing for the negative effects to the society which finally may return to them in other forms. People knowingly or unknowingly involve in the social problems, they practice these social evils without the awareness that they are doing so. There are number of causes, like peer pressure, family pressure, faulty attitudes, lack of information, the wrong assumptions, economic reasons, psychological causes, sometimes the wrong mental set , faulty perceptions , a clash between minority and majority, fight for equality in wrong ways, all these may be the reasons to name few lot more to be listed which are still being researched so that preventive measures can be taken.

12.12 CHARACTERISTICS OF SOCIAL PROBLEMS

Social problems are deviations from the ideal situation. They may be caused due to the pathological social conditions. They are usually interconnected. Social problems do affect all sections of the society. Social problems differ from one society to another. The moment the society feels a certain issue need to be focused as it is coming in the way of progress of the nation it is considered to be a social problem. A social problem which might have been considered as major in the past may lose its effect due to certain other changes and some problems do not stay as problems after few years due to various reasons. Social problems arise due to various aspects in the society itself as a collective result of some thoughts, attitudes, prejudice, stereotypes and the way people create certain barriers in their mind, hence it is the result of collective things created in the society. For the removal of the social problems also a collective effort is needed.

12.13 ROLE OF A PSYCHOLOGIST IN SOLVING SOCIAL PROBLEMS

The role of a psychologist is very important in solving the social problems. The society is made up of a large group of individuals coming together. If a social problem has to occur then obviously it must be the result of these individual's thoughts, opinions, prejudice, attitudes,

interaction, expectations, and a collective action influencing each other internally. If a social problem has to be solved the role of a psychologist is to help the individuals at the individual level in correcting their thoughts, shaping right thoughts, changing the thought patterns, facilitating for the change and acceptance of the new perspective of looking at things, situations and being selective in making right decisions without jumping into wrong conclusions.

At the same time as a social psychologist to identify the harmful attributes and recommend to the authorities to implement relevant rules, regulations, changes, new ways to curb the social evils and to design plans to prevent, control and keep a close watch on the situations which may trigger these social problems. Behaviours can be changed whether at the individual level or at the group level or even if it is a mob.

A social psychologist and community psychologist being an expert in understanding the phenomena of the group, mob and by large the social behaviour should be able to plan measures for the smooth functioning of the society. Social problems usually cannot be eradicated from the root level within a short span but that does not mean that it cannot be removed. There has to be strict rules, actions, behaviours triggering social problems need to be punished, awareness about the rights of everyone in the society should be made specific. The concept of equality of life need to be made understood by the members of the society of all levels. Law enforcement, rules, penalty, punishment strictly followed in all the cases if found guilty would create an awareness and a fear in the members of a society to prevent themselves from committing mistakes of those sort. An implementation of value based education would help the future generations to be more morally responsible for oneself as well as the society.

12.14 ROLE OF ADMINISTRATION IN SOLIVNG SOCIAL PROBLEMS

As there is a difference in the presence of a social problem, even they are different in their characteristics, features, frequency, occurrence, visibility, etc. keeping these aspects in mind each problem has to be analyzed from the multidimensional view of the individual, his way of thinking, the reason behind becoming the part in committing or involving in creation of the social problems. Then necessary measures need to be taken differently for different problems based upon its effects. Each social problem even though they are interconnected they need to be

dealt individually and separately. Necessary rules, guidelines for each social problem need to designed.

Child labour: The strict law enforcement should be done for the people who exploit children for the sake of work. The laws against child labour should be further tightened and strictly enforced.

Providing educational opportunities, compulsory education for children in free of cost, and with motivation for education to avoid child labour.

Access to education serves to break the vicious cycle of poverty and child labour.

Gender bias: Education serves to remove the misconceptions and wrong notions and helps individuals to treat both genders equally.

Various efforts and laws should be enforced by the government to ensure that the situations should not give an opportunity for social problems.

To avoid various types of discrimination empowerment programmes should be implemented

Gender discrimination, violence against women can be prevented by sensitizing the issue, educating people about their rights, and also empowering women to stand and fight for their own rights.

The government can implement certain laws and enforce legislation to develop and implement policies which can promote equality for women in marriage, divorce, and custody laws, inheritance laws, ownership of assets, etc. Keeping a watchful eye upon the payment methods to avoid discrimination of salary based of gender.

12.15 ROLE OF NONPROFESSIONALS IN SOLVING SOCIAL PROBLEMS

Non-professionals can also be understood as those individuals who contribute their service towards the society. They may be the social workers who work for the welfare of the society. Social work deals with the internal aspects of the human minds like values, beliefs, emotions, and problemsolving capacities of people, but also the external aspects like

neighbourhoods, schools, working conditions, social welfare systems, political systems, etc. They provide an encompassing service to people in need. They help in the society at the need of the hour.

These non-professionals help in a number of ways following certain principles:

Ethical principle: Their primary goal is to help people in need and to address the social problems. They acquire knowledge regarding these social problems and acquire skills to help people understand the consequences and overcome out of these social problems.

Social justice: They create awareness about social justice. They pursue social change and encourage people to do so. They fight on behalf of the oppressed and vulnerable people. They focus on issues like poverty, unemployment, discrimination, and social injustice. They strive hard to get access to needed information, services, equality of opportunities, etc.

Importance to dignity and worth of the person: They respect the inherent dignity and worth of a person. They treat each individual with dignity, respect inspite of the economic, cultural, and social status differences. They try to enhance the capacity, opportunity and help the individuals to respect their own needs.

Importance of human relationships: They recognize the importance of the human relationships. They involve all the people concerned with the individual whom they are helping. The support of the relationships involved is very important in bringing the morale up, in building emotional strength, in improving the psychological strength of an individual to deal with the odds. It is important to promote, restore, maintain, and enhance the well-being of the individual.

Integrity: These non-professionals behave in a trustworthy manner. They are aware of the ethical principles, mission, and are always consistent with them.

12.16 SUMMARY

This unit has given a detailed understanding about the various social problems, its causes, consequences, its characteristics. This helps a student of psychology to understand and develop a new and analytical perspective in understanding the social problems. The major problems like poverty, child labour, unemployment, gender discrimination, violence against women, crime is

being discussed with its causes, measures of prevention. The role of a psychologist, the administration, non-professionals in solving these social problems are being discussed in this unit.

12.17 KEYWORDS

Social Problems

Poverty

Child labour

Unemployment

Gender discrimination

Violence against women

Crime

12.18 CHECK YOUR PROGRESS

1. Explain the meaning and definition of Social Problems.
2. Discuss different types of social problems.
3. What is Poverty?
4. Explain Child labour and its consequences.
5. Discuss unemployment and its consequences.
6. Explain Gender discrimination and Violence against women.
7. What is Crime?
8. Explain the causes of Social Problems?
9. What are the characteristics of Social Problems?
10. Explain the role of a Psychologist in solving Social Problems.
11. Explain the role of administration in solving Social Problems.
12. Explain the role of non-professionals in solving Social Problems.

12.19 ANSWERS TO CHECK YOUR PROGRESS

1. 12.3
2. 12.4

3. 12.5
4. 12.6
5. 12.7
6. 12.8 & 12.9
7. 12.10
8. 12.11
9. 12.12
10. 12.13
11. 12.14
12. 12.15

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BLOCK- 4: REHABILITATION

UNIT :13 REHABILITATION

STRUCTURE

13.1 OBJECTIVES

After going through this unit, you will be able to explain

- Meaning and definition of Rehabilitation
- Need for Rehabilitation
- Issues in Rehabilitation
- A brief history of Rehabilitation Psychology
- The role of Rehabilitation Psychologists
- Types of Rehabilitation
- The difference between Habilitation and Rehabilitation

13.2 INTRODUCTION

Rehabilitation is a widely-understood concept that refers to the restoration (return to a state of functional health or work, and the like) of people, places or things. Rehabilitation psychology is a specialty area within the field of psychology that assists individuals with injuries or illness, most of which are chronic, traumatic and/or congenital, in achieving optimal physical, psychological and interpersonal functioning. This can include treatment of traumatic brain injury, dementia, stroke, substance abuse disorders, chronic pain, and more. Rehabilitation psychologists can work in a variety of settings. They can work in acute-care hospitals, agencies that assist with multiple sclerosis, cerebral palsy, and other diseases of the nervous system, assisted living centers, long-term care facilities, health clinics, hospitals, drug rehabilitation centers, or physical therapy centers.

13.3 MEANING AND DEFINITION OF REHABILITATION

Rehabilitation, as we understand it, is a widely-understood concept that refers to the restoration (return to a state of functional health or work, and the like) of people, places or things. However, the concept of rehabilitation psychology is sometimes misunderstood in much the same way as disabilities i.e. both cognitive and physical are misunderstood. This misunderstanding is on account of the fact that this branch of psychology is a fairly recent occurrence, despite its function was being undertaken by psychologists earlier. By definition, rehabilitation psychology is a specialty area within the field of psychology that assists

individuals with injuries or illness, most of which are chronic, traumatic and/or congenital, in achieving optimal physical, psychological and interpersonal functioning. This can include treatment of traumatic brain injury, dementia, stroke, substance abuse disorders, chronic pain, and more. Rehabilitation psychologists assist individuals who have disabilities and chronic illnesses; the disability may be congenital or acquired -- for example, an accident or stroke. This is a specialized area within psychology that focuses on the study and application of psychological knowledge and skills on behalf of individuals with disabilities and chronic health conditions, in order to maximize health and welfare, independence and choice, functional abilities, and social role. This is a way to make sure that an individual's health and welfare, independence and choice, functional abilities, and social roles are at the individual's highest capabilities.

Rehabilitation psychologists can work in a variety of settings. They can work in acute-care hospitals, agencies that assist with multiple sclerosis, cerebral palsy, and other diseases of the nervous system, assisted living centres, long-term care facilities, health clinics, hospitals, drug rehabilitation centres, or physical therapy centres. Psychologists in general provide psychotherapy and administer assessments. Assessments may be neurological (testing memory and other cognitive functions) or psychological (assessing emotional handling of disability-related issues). Rehabilitation psychology duties may overlap with those of health psychologists. Rehabilitation psychologists sometimes work alongside neuropsychological specialists. They often collaborate with other health and medical professionals, for example, physical therapists.

13.4 NEED FOR REHABILITATION

The statistics stated below are from the US, the necessity for this branch was first felt there due to the following reasons

1. The Centre for Disease Control and Prevention estimates that there are currently more than 16-million people with cognitive impairment living in the US – a total equal to twice the population of New York City.
2. According to DoSomething.org, people with a physical disability make up the largest minority group in the US – a figure equal to an astounding 74.6 million people.

3. According to the latest reports released by the US Census (2010), nearly 56.7 million, or 19-percent of the population have a disability, and the trend of people needing assistance is increasing.

With disabilities and problems rooted in lifestyle and living being a part of today's world, the role of rehabilitation took on a whole new meaning as well. Though public health departments are entrusted with the duties of taking care of the health of all populations, studies indicate that many health professionals continue to be ill-prepared to meet the complex psychosocial needs of people with cognitive and/or physical disabilities. That is where rehabilitation psychologists come in, to provide services within a network of psychological, biological, social, environmental, and even political environments. People in this field assist individuals, their families and caregivers, and others within the individual's social and community network, to achieve rehabilitation goals through intervention, therapeutic support, education, consultation, and advocacy. In addition to assistance to individuals and their families, rehabilitation psychologists also provide advice about disabilities and the impact of disabilities to government agencies, schools, attorneys and courts, insurance companies and private employers, as well as advocate for improvement in quality of life for people with disabilities and their families. They also work with other interdisciplinary and/or multidisciplinary professionals to expand opportunities and help facilitate individual functioning and participation in employment, relationships education, and in the community.

As people with disabilities, from all cultures and walks of life, continue to fight against social discrimination, rehabilitation psychologists continue to break down these barriers in relation to psychological treatment, by finding more and more opportunities to reframe the way society defines problems related to disability.

13.5 ISSUES IN REHABILITATION

- Quality of life versus Quantity of life: Rehabilitation focuses continually on improving the quality of the person's life, not merely maintaining life itself.
- Care versus Cure: Many conditions are irreversible; therefore, the focus of care is related to adaptation and acceptance of an altered life rather than to resolve an illness.

- High cost of Interdisciplinary care versus long term care: Rehabilitation is expensive and success is sometimes seen as a return to productive employment. If the individual became sufficiently independent that no caregiver was required.

13.6 A BRIEF HISTORY OF REHABILITATION PSYCHOLOGY

The rehabilitation movement is thought to have evolved from private charitable organizations, veteran's programs, and through partnerships with state and federal agencies, in the United States of America. From there, the National Council on the Psychological Aspects of Disability, a forerunner of APA's Division 22, was formed. The Great Society – a set of domestic programs launched by Democratic President Lyndon B. Johnson in 1964–65, and the passage of the Rehabilitation Act of 1973 also greatly affected the growth of the field. As far back as WWII, rehabilitation psychologists met both the educational and vocational needs of the veterans of war, especially those with a disability. In order to best serve this area, a rehabilitation psychologist would blend medical – which explains the disability and what is necessary to restore health, vocational – guidance to make job and personal decisions, and mental health – assisting and supporting the person when adjusting to his or her surroundings, friends, and family.

Although the APA established the division of rehabilitation psychology in 1958, as an organization for psychologists concerned with the psychological and social consequences of disability, it wasn't until August of 2015 that the APA Council of Representatives approved recognition of Rehabilitation Psychology as a specialty in professional psychology. (The APA defines a specialty as an area of professional psychology practice, which can be characterized by a distinctive configuration of competencies for specified problems and populations).

The Division of Rehabilitation Psychology was established in 1958 as an organization of psychologists concerned with the psychological and social consequences of disability, and with ways to prevent and resolve problems associated with disability. This branch includes diverse research and service interests, and include psychologists working in rehabilitation facilities, medical central hospitals and clinics, colleges and universities, private practices, government programs, social service agencies and schools.

Beginning of Rehabilitation Psychology

Rehabilitation Psychology was established in 1958, one of the earliest Divisions in APA. Psychologists have worked in medical rehabilitation settings for more than a half century, long before psychologists were regularly involved in other health care settings. It conducted the early research on individual, interpersonal and social changes related to changes in appearance and physical capacity, as well as the social psychology of stereotyping and prejudice faced by persons with disability. It helps psychology understand the world of work, how this can be affected by impairment and disability, and issues about vocational rehabilitation. Rehabilitation Psychologists have worked to change attitudes towards persons with disability from pity, charity and aversion to understanding, acceptance and "differently abled" expectations. Rehabilitation Psychology initiated a focus on issues of children and adolescents with disabilities and chronic conditions, recognizing the need for special health and social care for these individuals.

Present day Rehabilitation Psychology

The Foundation for Rehabilitation Psychology was established in 2010.In a Rehabilitation Psychology primary care model, services are provided to individuals with disability and their families throughout the life span, as needed, in brief interventions. Rehabilitation Psychologists work and advocate with persons with disabilities to eliminate attitudinal, policy and physical barriers, and to emphasize employment, environmental access, and social role and community integration. They conceptualize, test and implement new theoretical understandings of personal and social adjustment to disability, and the interaction with social role and vocational functioning.

The Future of Rehabilitation Psychology

- Increasing involvement in how data are conceptualized and used to define policy issues, structure and manage health care systems, and understand health- and cost-related consumer decisions in regards to persons with disabilities.
- Increasingly serve as program directors, e.g., in sub-acute traumatic brain injury treatment programs, and in pain management and work restoration programs.
- Formulate new models of psychological service delivery, including home care, para-professionals supervised under practice guidelines and critical paths, and others.

- Coordinate multi-disciplinary and multi-agency resources to facilitate self-sufficiency and community integration for persons with disabilities.
- Contribute to injury prevention and health habit promotion to reduce the incidence of disabling conditions.
- Continue to advocate with and for persons with disabilities within a changing health care environment, and build strength through unity with other health care psychologists.
- Physical therapists help patients by providing rehabilitation therapy.
- Usually, Physical Therapists work with patients who have recently been injured or who have suffered the debilitating effects of a disease or illness, such as stroke patients losing mobility in parts of their body

Psychologists in this context provide psychotherapy and administer assessments. This specialty developed as a result of the need to reintegrate veterans to begin with, but today's rehabilitation psychologists more often work with the civilian disabled population, including the elderly. Some rehabilitation psychologists have extended this field by even specializing in working with children. They deal with children with conditions ranging from spina bifida to traumatic brain injury. They provide comprehensive evaluations, conduct individual and family therapy, write educational prescriptions, and carry out neuro-rehabilitative interventions as needed.

Rehabilitation psychologists also work at the societal level to make the lives of the disabled better. They carry out research and may be involved in program development and administration. Those in vocational rehabilitation improve lives for individuals with psychiatric illnesses as well as physical ones.

While it's true that over the years, prevailing attitudes (and laws) have changed regarding social expectations and treatment of people with physical and/or cognitive disabilities, many stigmas remain and people remain misinformed. Too many people with disabilities continue to find limited opportunities in the areas of employment, public services, and public accommodations (among others) because of social attitudes, lack of knowledge, and discrimination.

The field of rehabilitation psychology has seen tremendous change, as well as exceptional growth over the past several decades, and there doesn't seem to be a slowdown anytime soon. This is due in part because of the development of training and education guidelines. An increased understanding and the on-going research of current healthcare problems that confront our world are also some that behavioural management specialists, including rehabilitation psychologists, are now thought to substantially influence. Not long ago, rehabilitation of people with traumatic brain injury was one of the fastest growing areas in all of healthcare, and rehabilitation psychologists led the way to treatment. Treatments included assessment of psychological needs and intervention, and ranged from referrals for services and therapy, to implementation of behaviour-management plans for individuals hospitalized for long periods of time. However, a new focus for rehabilitation psychology, includes the need for rehabilitation psychologists to expand their clinical practices, modify their training model, involve themselves in improving disability policies, and broaden the scope of their research efforts. Corporations, too, can get help for disability and chronic illness advice/help and employee benefit services can benefit greatly from the knowledge and expertise of rehabilitation psychologists.

13.7 THE ROLE OF REHABILITATION PSYCHOLOGISTS

Rehabilitation psychologists conduct relevant and often significant research regarding the lifelong implications, of disability on individuals, as well as on the society as a whole. Their range of research often includes:

- Chronic illness
- Identification of co-morbidities
- Use and effectiveness of assessment tools
- Effectiveness of intervention strategies
- Risk factors for disability
- Coping needs and resources
- Community re-entry
- Aging resources and costs

Today, rehabilitation psychologists serve a wider scope of diverse populations than ever before, including:

- People with brain injuries
- People with spinal cord injuries
- The aged
- Individuals with neuromuscular disorders
- Those with chronic pain
- People with medical conditions, such as:
    - Cancer
    - Multiple sclerosis
    - Developmental disorders
    - Psychiatric disability
    - Substance abuse
    - Deafness or hearing loss
    - Intellectual disability
    - Blindness and vision loss
    - Impairments compounded by educational or other disadvantages

Rehabilitation psychologists also specialize in the link between language, culture, sexual orientation, gender, ethnicity and mental health. They also work with people struggling with sensory, addiction, and psychological health problems.

After interventions or assessments, rehabilitation psychologists assist patients with:

- Adapting to new situations
- Locating a support network
- Locating assistance and support services
- Learning how to utilize technology so they can live independently

Rehabilitation psychologists organize and manage rehabilitation programs, public-education campaigns, and group therapy sessions for people struggling with disabilities and chronic pain. Rehabilitation psychologists are employed at:

- Acute-care hospitals
- Agencies that assist with multiple sclerosis, cerebral palsy, etc.
- Assisted-living centres
- Long-term care facilities
- Health clinics
- Hospitals
- Drug rehabilitation centres
- Physical-therapy centres

Rehabilitation psychologists can also be found at government agencies, veterans' hospitals, and colleges and universities, conducting research and teaching too. Rehabilitation psychologists evaluate and assist people struggling with the following conditions:

- Cognitive issues
- Chronic health conditions
- Developmental disabilities
- Emotional problems
- Psychosocial problems

Regardless of whether an individual develops or is born with a disability, rehabilitation psychologists help them cope with their disabilities, so they can live normal and happy lives. Rehabilitation psychologist are also looking back to what worked in the past, and modifying their use to fit new regimens for treatment.

Rehabilitation psychology is a very broad area of psychology, and it covers a wide range of different psychological problems. Many rehabilitation psychologists specialize in certain areas, and they only work with certain types of patients. They know that all patients are different, and what works for one may not necessarily work for another. Despite these facts, there are a few common duties that a rehabilitation psychologist might have.

- Rehabilitation psychologists are often responsible for assessing their patients to determine what is wrong with them. This usually involves observing their behaviours, interviewing them, and possibly interviewing their loved ones.
- If the situation warrants it, loved ones might also ask a rehabilitation psychologist to help with staging an intervention. An intervention is a process used to intervene in a patient's life to stop him from participating in harmful behaviour. Interventions are particular common in cases of addiction.
- After assessing and diagnosing a patient, a rehabilitation psychologist is also usually responsible for recommending a course of treatment. In most cases, these psychologists will be able to help the patients. Treatment often includes different types of therapy, including one-on-one therapy, group therapy, and family therapy. During therapy sessions, a rehabilitation psychologist will usually lend a compassionate and non-judgmental ear. He will also help his patient and guide him toward overcoming future hurdles in life and become more self-reliant.

Rehabilitation, is not something that can be accomplished solely by the psychologist and the patient. It is a team effort. These professionals will often help their patients discover and set up a support network of trusted family and friends that have the patients' best interests in mind. Support networks such as these are excellent for when patients are feeling discouraged or even hopeless in their progress. Rehabilitation psychologists might work in a number of different health facilities. This can include hospitals, physical therapy centers, long-term care centers, drug and alcohol rehabilitation centres, psychiatric hospitals, and mental health clinics. These professionals might also be employed by halfway houses, detention centers, and social service offices. Some rehabilitation psychologists also choose to open their own practices. Job prospects are currently excellent for rehabilitation psychologists. In fact, job growth has been projected to increase by 15 percent during the next few years. Compared to other psychology related professions, jobs for rehabilitation psychologists are increasing at a high rate. This is attributed to improvements in medical technology, higher life expectancies, and the aging baby boomer population.

1 3.8 TYPES OF REHABILITATION

Most people deal with all sorts of problems throughout the course of their lives. Depending on the person and the type of problem, these problems can usually be worked through with relative ease. Some problems, however, aren't so easy to work through, and they make it hard to function in everyday life. These can include emotional problems, cognitive, developmental and social problems, as well as physical addiction. Overcoming severe forms of these problems will often require professional help and guidance.

This branch of psychology focuses on treating individuals dealing with disabilities and problems that make living normal lives difficult. Professionals in this field try to help people with these types of problems adjust and work toward leading happy and healthy lives. Psychologists work with a wide variety of people. Clients may have a variety of physical, sensory, neuro cognitive, behavioural, emotional, and/or developmental disabilities. They may also work with people who have been diagnosed with spinal cord injuries, brain injuries, strokes and other problems that can come along with aging, amputations, neuromuscular disorders, chronic pain, cancer, AIDS, multiple sclerosis, and limb weakness. Some work with people who have developmental disorders such as mental retardation or autism. Psychiatric disability, substance abuse, impairments in sensory functions might also be something a rehabilitation psychologist might work with. This area of psychology involves treating a broad range of problems. Some of the problems that rehabilitation psychologists treat may be

- **Mental or emotional**, and they may include such things as depression, anxiety, developmental disabilities, and learning disabilities. Other problems that rehabilitation psychologists treat might be physical, such as addiction or chronic pain. Problems that rehabilitation psychologists treat might be chronic or acute, and they might also be congenital or acquired
- Of late rehabilitation psychology is seen to be playing an important role in psychological interventions during the **sport injury rehabilitation** process. Many sport injury rehabilitation programs are now integrating psychological interventions into the treatment regimens in order to expedite both physical and psychological recovery, as rehabilitation psychologist’s work alongside sports psychologists, surgeons, physiotherapists, exercise scientists, athletic coaches, and dieticians to determine treatment, and facilitate healing.

- In the past ten-years, researchers have devoted a great deal of time exploring the psychological impact of injury to athletes, which in turn has generated studies into the psychological adjustment most athletes endure when dealing with an injury; how they perform after an injury, what, if any, mental adjustments they go through, and the emotional impact of their injury. But head injuries are not exclusive to the NFL, or football in general, as recent findings show soccer athletes are (and have for years) experienced repetitive head injuries. Wrestling and boxing athletes are also gaining attention as doctors continue to seek the help of psychologists to treat low, moderate and high neuro-cognitive injuries.

- With serious injury, most athletes will experience one or more of the following **emotional episodes**: Anger, Denial, Depression, Bargaining or Acceptance. A rehabilitation psychologist can help an athlete deal with these emotions by helping him or her accept the injury, set goals for recovery, focus on objectives, and help set a timeline to meet their goals. And although the psychological impact of an injury can sometimes affects an athlete long after the injury is healed, a rehabilitation psychologist can help an athlete from the onset of the injury, through rehabilitation, and back to full competition.

- **Neurological Rehabilitation**, where patients suffering from strokes, neuromuscular disease, certain types of head trauma and spinal cord injury are treated. The objective here is to direct the patient to positivity as also make him self-dependent. Thereby the individual is aided in beginning a life that is healthy and productive in emotional, social, psychological and physical terms.

- **Cardiac Rehabilitation** program is designed to help people with heart problems. Such persons are advised on the modes by which they could lead healthy and stress free lives,

- The goals of **Pediatric Rehabilitation** psychologists are to promote healthy development in children with disabilities through psychological services, advocacy education and research, as a voice for the rights of children with disabilities, and to identify factors that weaken the capabilities of children with disabilities. Thankfully, in recent years parents, teachers, school officials (including school psychologists), and the community as a whole have strived to gain more insight and understanding of children with disabilities, and

there has been an increase in the involvement of society as a whole in developing advocacy for these children.

- **Medical Rehabilitation** includes medical programs that help a person perform better in all his daily physical and mental activities. Medical rehabilitation is a follow up treatment after any kind of treatment program.

- **Vocational Rehabilitation** aids individuals who find it difficult to get employment or retain it after they have gone through certain situations that caused mental or physical disability in them.

Thus, we observe that rehabilitation psychology is an ever expanding field today, with immense scope. Its importance is felt in almost every area where individuals require adaptation of any kind. In addition to technology, the human's aspect as in the care and counseling provided by the psychologists trained in this track specifically is undeniable.

13.9 THE DIFFERENCE BETWEEN HABILITATION AND REHABILITATION:

Most of us are familiar with the term rehabilitation and are even comfortable with the role of "rehab" services. Despite understanding the term there is a general tendency to confuse the terms Habilitation with Rehabilitation. Thus, though **Habilitation and Rehabilitation** both focus on the act of learning skills, the primary **difference between** the two is that **habilitation** focuses on learning new skills whereas **rehabilitation** focuses on regaining skills lost. Habilitation and rehabilitation are both often linked with health-related issues that have led to a disability. With habilitation, an individual may have been born without the abilities, skills or knowledge and must learn them. With rehabilitation, an individual may have suffered a disease or injuries from an accident that left him or her without the knowledge, skills or abilities and rehabilitation with a professional helps him or her regain these abilities. Although both habilitation and rehabilitation work toward gaining skills through physical, mental and occupational therapy, the approaches may be different and personalized. For example, with rehabilitation, a therapist may work with the individual to recall feelings or knowledge to regain the skill, whereas with habilitation, a professional works to teach the skills for the first time to an

individual. The goal of both habilitation and rehabilitation is to enable those with disabilities to maintain maximum independence. Adults can also benefit from habilitative services, particularly those with intellectual disabilities or disorders such as cerebral palsy who may benefit from services at different points in their life to address functional abilities.

13.10 SUMMARY

In society we across a number of social problems, treating the individuals who are suffering from those problems is very important from the viewpoint of the individual and as well as the society. The treatment does not only focus on solving the current but also taking care that the individual does not relapse into the same problem. To do this rehabilitation is done which makes the individual strong enough not to relapse into the same problems. This unit has focuses upon rehabilitation, its need the issues and a brief history about the rehabilitation, the role of a psychologist, types of rehabilitation, difference between habilitation and rehabilitation.

13.11 KEYWORDS

Rehabilitation

Habilitation

Emotional rehabilitation

Neurological rehabilitation

Medical rehabilitation

Vocational rehabilitation

13.12 CHECK YOUR PROGRESS

1. Define Rehabilitation.
2. Explain the need for rehabilitation.
3. Discuss the issues in rehabilitation.
4. Write a note on the brief history on rehabilitation.
5. Explain the role of a psychologist in rehabilitation.
6. Explain the differences between habilitation and rehabilitation.

13.13 ANSWERS TO CHECK YOUR PROGRESS

1. 13.3
2. 13.4
3. 13.5
4. 13.6
5. 13.7
6. 13.9

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UNIT:14 - APPROACHES TO PSYCHO-SOCIAL REHABILITATION

STRUCTURE

14.1 OBJECTIVES

After going through this unit, you will be able to explain

- Meaning and definition of Psycho-Social Rehabilitation
- Functions of Psycho-Social Rehabilitation
- A brief history of Psycho-Social Rehabilitation
- Principles of Psycho-Social Rehabilitation
- Models of Psycho-Social Rehabilitation

14.2 INTRODUCTION

More than two thousand years ago, Hippocrates' observation that our own well-being is affected by our settings established a fundamental cornerstone for Western medicine. There appear to be many sociological factors that can affect a person's adjustment to disability. People with any disabling condition must face the task of adjusting to their conditions, disabilities, and to their environment. According to Lazaras and Folkman (1984), psychological stress results from a particular relationship between the person and the environment, one that persons with disabilities often may perceive as either taxing or exceeding their resources and endangering their well-being.

14.3 MEANING AND DEFINITION OF PSYCHO-SOCIAL REHABILITATION

Psychosocial rehabilitation or PSR is a process that facilitates the opportunity for individuals who are impaired, handicapped by a mental disorder or disabled to reach their optimal level of independent functioning in the community. It is also known as psychiatric rehabilitation, and sometimes even simplified to 'psych rehab' by providers. All because it is the process of restoration of community functioning and well-being of an individual diagnosed in mental health or any form of mental or emotional disorder, such an individual who may be considered to suffer from a psychiatric disability. Psychiatric rehabilitation services are collaborative, person-directed, and individualized, an essential element of the human services spectrum, and should be evidence-based. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living,

working, learning and social environments of their choice." (United States Psychiatric Rehabilitation Association, 2011).

International Association of Psychiatric Rehabilitation Services (IAPSRS) "Practice Guidelines for the Psychiatric Rehabilitation of Persons with Severe and Persistent Mental Illness in a Managed Care Environment" states that a practitioner will:

- Foster hope, self-esteem, and empowerment
- Encourage advocacy, peer support, and self-help
- Support consumer-identified community goals
- Promote education, role models, & self-determination
- Teach life, stress, & symptoms management skills
- Facilitate community-based normative experiences

Psychosocial rehabilitation is not a practice but instead is a field of academic study or discipline, similar to social work or political science. It promotes personal recovery, successful community integration and satisfactory quality of life for persons who have a mental illness or mental health concern. Psychosocial rehabilitation services and supports are collaborative, person directed, and individualized, and an essential element of the human services spectrum.

The targets of Psychosocial rehabilitation or PSR are

- To enable patients to attain their optimal functioning.
- To enable patients to live independently
- To empower patients to understand and manage their illness effectively
- To encourage involvement of families in care

Psycho-Social Rehabilitation thus is a process initiated by a health or mental health professional, in collaboration with the patient's family and community, and supported by policy planners , focused on developing and implementing and individualized programme that seeks to maximize the patient's assets and minimize disabilities in the area of socio-occupational functioning, cantering around the philosophy of mobilizing and utilizing resources available to the community, with the objective of aiding the concerned patient. PSR focuses on treating the consequence of a mental illness rather than the very illness itself. It looks into the disability that

results from the psychiatric illness with the primary goal of role functioning that is necessary for the patient to continue with life.

14.4 FUNCTIONS OF PSYCHO-SOCIAL REHABILITATION

The treatment of mental illness underwent a dramatic shift in the United States during the 1960‘s and the 1970‘s with the introduction of psychotropic medications. Before the development and introduction of these medications, individuals with psychiatric disabilities were institutionalized for decades, with many individuals living out their lives in institutions (Smart, 2001). The passage of the Mental Health Centers Act of 1963 (P.L. 88-164) caused a major shift in the type of care provided for people with psychiatric disabilities. Subsequent amendments defined the specific services that mental health centres were required to provide (Peterson et al., 1996) serving as the catalyst for more movement toward the development of a decentralized community-based treatment system. However, many individuals with psychiatric disabilities were released from state hospitals after years of institutionalization prior to the establishment of necessary community support systems. The deinstitutionalization effort ultimately resulted in the discharge of many thousands of people with psychiatric disabilities into communities that were neither prepared nor willing to accept them (Gerhart, 1990; Rogers, Anthony, & Jansen, 1991).

The new directions in psychiatric rehabilitation include a variety of strategies to increase the community integration and independence of people with psychiatric disability. Unfortunately, many rehabilitation professionals are neither aware nor appropriately prepared to provide the level of services that are needed by individuals with psychiatric disabilities to re-enter the community and function in the workplace. (a) the complexities of psychiatric disabilities, (b) the significance of work for individuals with psychiatric disabilities, and (c) intervention approaches.

People with psychiatric disabilities experience numerous limitations in everyday functioning, some of which include difficulties with interpersonal situations, (e.g., misinterpreting social cues, inappropriate responses to situations), problems coping with stress (including minor hassles, such as finding an item in a store), difficulty concentrating, and lack of energy or initiative (Bond, 1995). Whether persons with psychiatric disabilities have never

learned social skills or have lost them, most of these individuals have marked skill deficits in social skills and interpersonal situations (Bond, 1995). Traditionally, medication and psychotherapy were the two major treatment approaches for people with psychiatric disabilities, with little attention given to preventing or reducing functional limitations or handicaps to social performance. Traditional approaches such as medications, hospitalization, and dynamic psychotherapy have had limited effectiveness when applied to the socialization and work aspects of individuals with psychiatric disabilities (Chan et al., 1998).

The preferred modes of intervention include strengthening both the client's skills and the level of environmental supports. Client skill strengthening approaches involving social and independent living skills training, symptom management, and job finding clubs have been recognized as having a strong positive effect for individuals with psychiatric disabilities. Critical environmental support strengthening approaches include family behaviour management and the use of peer groups in the transition to community living. Supported employment has been cited as a crucial service component that places equal emphasis on the strengthening of client skills and environmental supports (Xie, Dain, Becker, & Drake, 1997).

Community treatment of the person who has a psychiatric disability needs to include a focus on teaching coping skills that are necessary to live as independently as possible in the community. It is the presence or absence of such skills that is often the determining factor related to rehabilitation outcomes, rather than the client's actual psychiatric symptoms. Rehabilitation programs must encompass the development of learning or relearning of skills and competencies required for successful interpersonal and social functioning as well as those needed for specific vocational pursuits.

According to Anthony, Cohen, and Farkas (1990), the preferred method of increasing a client's capacities in social situations is a skills-training approach. In such an approach, the intent is to identify those specific client skill deficits that are preventing the person from functioning more effectively in his or her living, learning, and/or work community. For example, clients may need help in learning social skills, interpersonal skills, coping skills, personal hygiene, and self-care, as well as symptom management (Corrigan, Rao, & Lam, 1999). Bellack, Mueser, Gingerich, and Agresta (1997) described social skills as interpersonal behaviours that are normative and/or socially sanctioned. They include such elements as dress and behaviour codes;

rules about what to say and not to say; and stylistic guidelines about the expression of affection, social reinforcement, interpersonal distance, and so forth. Deficits in these areas can make it quite difficult for a person with a psychiatric disability to establish and maintain relationships that are necessary for social integration.

Becker & Drake, (1994) in their study show that like other people, individuals with psychiatric disabilities wish to lead normal lives and view work as a signifier of normal adult life In Western culture, work is highly valued and is considered a socially integrating force; however, many persons with severe psychiatric disabilities have been excluded from the world of work (Ahrens, Frey, & Senn Burke, 1999).

Employment can serve as a normalizing factor since individuals who are unemployed and lack alternative societal roles are often stigmatized. Through work, individuals can obtain daily structure and may also develop a network of interpersonal contacts (Bond, Drake, & Becker, 1998). Involvement in work can help combat negative symptoms by facilitating a higher level of self-esteem and perceived quality of life (Fabian, 1992; Van Dongen, 1996). Therefore, the mission of psychiatric rehabilitation is to assist persons with long-term psychiatric disabilities increase their functioning so they are successful and satisfied in the environments of their choice with the least amount of ongoing professional assistance (Anthony, et al., 1990). Comprehensive psychiatric rehabilitation programs combined with effective medication management help such individuals meet the challenges of managing their disability (Liberman, Corrigan, & Schade, 1989).

Psychiatric rehabilitation programs have sought to develop strategies to increase the community integration of people with psychiatric disabilities, including schizophrenia. To help people with psychiatric disabilities become and remain integral members of society, rehabilitation, vocational training, and assistance in work settings are essential. However, in many communities, the majority of people with psychiatric disabilities have only two options: to be unemployed or to work in entry-level positions with low pay and little chance of advancement (Carling, 1995). Work is a key component, some would argue the most important component, of services designed to achieve community integration. In the context of psychiatric rehabilitation, work can be seen both as an outcome and as a highly effective treatment modality in enhancing meaningful community integration (Ahrens, et al., 1999).

14.5 A BRIEF HISTORY OF PSYCHO-SOCIAL REHABILITATION

This branch came into existence around the 1960s and 1970s, when the process of de-institutionalization in the US meant that many more individuals with mental health problems were able to live in their communities rather than being confined to mental institutions. Medication and psychotherapy were the two major treatment approaches, with little attention given to supporting and facilitating daily functioning and social interaction. Therapeutic interventions often had little impact on daily living, socialization and work opportunities. There were often barriers to social inclusion in the form of stigma and prejudice. Psychosocial rehabilitation work emerged with the aim of helping the community integration and independence of individuals with mental health problems. "Psychiatric rehabilitation" and "psychosocial rehabilitation" became used interchangeably, as terms for the same practice.

By their very nature mental illnesses are chronic and prone to relapse, thus requiring a broad range of services, beyond pharmacotherapy. No treatment of mental disorder can be considered complete or adequate without giving due consideration to rehabilitation or aftercare services. The need for psychosocial rehabilitation also arose out of the increasing percentage of mental disorders across the globe.

The theoretical base for psychosocial then psychiatric rehabilitation is community support theory as the foundational theory; it is aligned with integration and community integration theories, psychosocial theories, and the rehabilitation and educational paradigms. Its fluid nature is due to variability in development and integration into other essential fields such as family support theories (for this population group) which has already developed its own evidence-based parent education models.

The concept of psychiatric rehabilitation is associated with the field of community rehabilitation and later on social psychiatry and is not based on a medical model of disability or the concept of mental illness which is often associated with the words "mental health". However, it can also incorporate elements of a social model of disability as part of progressive professional community field. The academic field developed concurrently with the formation of new mental health agencies in the US, now often offering supported housing services.

The Journal of Psychosocial Rehabilitation then renamed the Journal of Psychiatric Rehabilitation, traces the development of the field over a period of several decades. The academic discipline psychiatric rehabilitation has contributed new models of services such as supported education, has cross-validated models from other fields (e.g., supported employment), has developed the first university-based community living models for populations with "severe mental illness", developed institutional to community training and technical assistance, developed the degree programs at the university levels, offers leadership institutes, and worked collaboratively to expand and upgrade older models such as clubhouses and transitional employment services, among others.

14.6 PRINCIPLES OF PSYCHOSOCIAL REHABILITATION

The following Core Principles and Values are meant to further describe key elements of Psychosocial Rehabilitation practice. These principles and values are related to evidence-based PSR practices and informed by the lived experiences of individuals with mental health challenges. All psychiatric rehabilitation service providers should be guided by PRA's Code of Ethics and Multicultural Principles.

1. Psychosocial rehabilitation practitioners convey hope and respect, and believe that all individuals have the capacity for learning and growth.

2. Psychosocial rehabilitation practitioners recognize that culture and diversity are central to recovery, and strive to ensure that all services and supports are culturally relevant to individuals receiving services and supports.

3. Psychosocial rehabilitation practitioners engage in the processes of informed and shared decision-making and facilitates partnerships with other persons identified by the individual receiving services and supports.

4. Psychosocial rehabilitation practices build on strengths and capacities of individuals receiving services and supports.

5. Psychosocial rehabilitation practices are person- centred; they are designed to address the distinct needs of individuals, consistent with their values, hopes and aspirations.

6. Psychosocial rehabilitation practices support full integration of people in recovery into their communities, where they can exercise their rights of citizenship, accept the responsibilities and explore the opportunities that come with being a member of a community and a larger society.

7. Psychosocial rehabilitation practices promote self-determination and empowerment. All individuals have the right to make their own decisions, including decisions about the types of services and supports they receive.

8. Psychosocial rehabilitation practices facilitate the development of personal support networks by utilizing natural supports within communities, family members as defined by the individual, peer support initiatives, and self and mutual-help groups.

9. Psychosocial rehabilitation practices strive to help individuals improve the quality of all aspects of their lives, including social, occupational, educational, residential, intellectual, spiritual and financial.

10. Psychosocial rehabilitation practices promote health and wellness, encouraging individuals to develop and use individualized wellness plans.

11. Psychosocial rehabilitation services and supports emphasize evidence-based, promising, and emerging best practices that produce outcomes congruent with personal recovery. Psychosocial rehabilitation programs include program evaluation and continuous quality improvement that actively involve persons receiving services and supports.

12. Psychosocial rehabilitation services and supports must be readily accessible to all individuals whenever they need them; these services and supports should be well coordinated and integrated as needed with other psychiatric, medical, and holistic treatments and practices.

Psychiatric rehabilitation was developed and formulated as a new profession of community workers (not medical psychiatry which is a MD awarded by a Medical School) which could assist both in deinstitutionalization (e.g., systems conversion) and in community

development in the US. It represents the first Master's and Ph.D. classes in the US to specialize in a rehabilitation discipline focused on community versus institutions or campuses. In the US, it also represents a movement toward evidence-based practices, critical for the development of viable community support services. Psychosocial services, in contrast, have been associated with the term "mental health" as part of community support movement nationwide since the 1970s which has an academic and political base. These services, which have roots in education, psychology and mental health (and community services) administration, were basic funded services of new community mental health agencies offering community living and professionalized community support since the 1970s. Mental health service agencies or multi-service agencies in the non-profit and voluntary sectors form a critical delivery system for psychosocial services. In the 2000s, a sometime similar but sometimes alternative approach (variability and fidelity of provider implementation in the field) employs the concept of psychosocial recovery. Problems experienced by people with psychiatric disabilities are thought to include difficulties understanding or dealing with interpersonal situations (e.g., misinterpreting social cues, not knowing how to respond), prejudice or bullying from others because they may seem different, problems coping with stress (including daily hassles such as travel or shopping), difficulty concentrating and finding energy and motivation. People leaving psychiatric centers after long-term hospitalizations, an outdated practice, may also have need to assist with injuries that may have occurred and community integration.

Psychosocial rehabilitation (also termed psychiatric rehabilitation or PSR) promotes personal recovery, successful community integration and satisfactory quality of life for persons who have a mental illness or mental health concern. Psychosocial rehabilitation services and supports are collaborative, person directed, and individualized, and an essential element of the human services spectrum. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning and social environments of their choice and include a wide continuum of services and supports. (PSR/RPS Canada, 2013).PSR approaches are evidence-based best and promising practices in the key life domains of Employment, Education, Leisure, Wellness and Basic Living Skills as well as Family Involvement and Peer Support and Peer Delivered services. Because of their demonstrated effectiveness and recovery orientation, these approaches should be widely

available to people living with long term mental illness and/or substance use problems. Distinctive and defining features of PSR approaches:

- PSR approaches build upon the assessed strengths of persons rather than their deficits and problems. In other words PSR approaches are strengths based--they are based on the assessment of a person's strengths as the basis for individualized goal setting and recovery. This is a major difference from traditional, illness-based approaches which focus on problems and deficits.

- Psychosocial rehabilitation approaches are collaborative; person directed and individualized. They assist individuals in rediscovering skills and accessing the community resources needed to live successfully and with a self-identified quality of life. Accordingly, PSR approaches involve the client setting goals rather than goals being set by others.

- PSR approaches support people to have a meaningful life focus on the determinants of good mental health, including employment, education, social supports, basic living skills, leisure and wellness.

- PSR approaches generally place persons in their chosen goal settings such as jobs and housing and then train and support them in those settings. Similarly, other training, such as social skills training takes place in the person's natural environments.

- PSR approaches are supported by scientific evidence as effective. PSR approaches include a number of best practices, which are strongly supported by evidence, such as supported employment and wellness programs, as well as promising practices with emerging evidence, such as peer support programs. PSR approaches promote recovery with full community living and improved quality of life. Some call this "getting a life".

Psychiatric rehabilitation can be a complex and formidable task. Without proper training and exposure to effective psychiatric rehabilitation strategies, the unprepared rehabilitation professional will easily be overwhelmed and may have difficulty contributing to successful intervention planning with individuals who have psychiatric disabilities. Moreover, the rehabilitation professional may lack the skills necessary to effectively negotiate important

adaptations for the individual with the psychiatric disability on the worksite, with co-workers and employers alike (McReynolds & Garske, 2002). The current unemployment rate for individuals with psychiatric disabilities is more than 85 percent (Nobel, Honberg, Hall, & Flynn, 2001), in part because individuals with psychiatric disabilities often struggle with a wide variety of challenges and needs which likewise challenge the rehabilitation professional. Strategies for helping people with psychiatric disabilities obtain meaningful work have changed significantly in recent years. Successful work assistance approaches appear to have a number of common characteristics and include individualized career planning, help with job access, and aid in job retention; peer support; coordination with other social services and benefits; and assurances of confidentiality (Carling, 1995).

14.7 MODELS OF PSYCHO-SOCIAL REHABILITATION

There are certain models given for Psycho-Social Rehabilitation. They are discussed as follows;

a) **The Recovery Model**: as described by Pratt, Gill, Barrett, and Roberts (1999) and as touted by Deegan (1988) and Anthony (1993), is a fundamental shift in perception regarding individuals with psychiatric disabilities. Recovery is viewed as a "reformulation of one's life aspirations and an eventual adaptation to the disease". Within this concept of recovery lies the belief that individuals with psychiatric disabilities can and do adjust to psychiatric disabilities by a process of acceptance of the disability and the development of a positive self-image. Further bolstering the recovery model are developments in improved medications, the use of supported employment, and the debunking of long-held myths perpetuating stigma and discrimination of individuals with psychiatric disabilities.

According to Bond (1995), psychiatric rehabilitation provides individuals with psychiatric disabilities the opportunity to work, live in the community, and enjoy a social life, at their own pace, through planned experiences in a respectful, supportive, and realistic atmosphere. Psychiatric rehabilitation typically involves helping individuals to gain or improve necessary interpersonal skills and provides a level of support required for

clients to obtain their goals. The mission of psychiatric rehabilitation, therefore, is to assist persons with long-term psychiatric disabilities increase their functioning so they are successful and satisfied in the environments of their choice with the least amount of ongoing professional intervention (Anthony et al., 1990).

According to Lamb (1988), no part is more important than giving clients a source of mastery over their internal drives, their symptoms, and the demands of their environments. Various models have been developed in the United States that have provided individuals with psychiatric disabilities opportunities of community integration that were heretofore not possible and are discussed as follows:

b) **Clubhouse Model**: is a comprehensive group approach that focuses on practical issues in informal settings (Bond, 1995). Clubhouses are community-based rehabilitation programs for people with psychiatric disability offering vocational opportunities, planning for housing, problem-solving groups, case management, recreational activities, and academic preparation. Individuals can learn or regain skills necessary to live a productive and empowering life. The Clubhouse Model provides for the societal, occupational, and interpersonal needs of the person as well as medical and psychiatric needs (Fountain House, 1999).

Developed at the Fountain House in New York, transitional employment (TE) is an integral part of the Clubhouse approach. Clients, or members as they are called are placed in part-time entry-level positions for three to nine months and are supervised by one another and/or rehabilitation professionals. Members work at a place of business in the community and are paid the prevailing wage rate by the employer. The placements are part-time and limited generally to 15 to 20 hours a week. The program is designed to develop a client's self-confidence, current job references, and improve work habits necessary to secure permanent employment (Anthony et al., 1990). TE continues to be an effective rehabilitation strategy in many mental health systems (Bond, 1995).

c) **Individual Placement and Support (IPS)**: The Individual Placement and Support (IPS) program was developed at the New Hampshire-Dartmouth Psychiatric Research Center (Becker & Drake, 1993). The IPS Model recognized that "work is so many things to so many people, we might define it simply as a structured, purposeful activity that we usually do in exchange for payment" (p. iii, Becker & Drake, 1993). The model draws from several psychiatric rehabilitation intervention models (e.g., ACT, choose-get-keep) in which clients choose from a range of work possibilities including full-time to various levels of part-time work to pre-vocational activities. Competitive employment is generally encouraged; however, non-paid employment options are likewise given consideration when deemed most appropriate for the particular individual's needs.

The vital component of the IPS model incorporates the success-driven concept of follow-along support provided by a core group of people who function as a team. The team generally consists of employment specialists, rehabilitation counselors, psychiatrists, and other mental health staff as needed. The treatment team approach provides a more seamless method of service delivery versus receiving separate services from various professionals in a non-coordinated manner. Clients are encouraged to be active and fully involved in the job-search process and are then supported through their employment with on-going follow-along (Becker & Drake, 1993).

d) **Community Support System**: The National Institute of Mental Health (NIMH) began the community support system (CSS) initiative in 1977. The intent was to assist states and communities in developing a broad array of services to assist people with psychiatric disability. This initiative eventually became known as the NIMH Community Support Program, with case management as one of the essential services (Anthony et al., 1990).

One of the leading models of CSS is the assertive community treatment (ACT) approach that works with clients on an individual basis providing services primarily in the client's home and neighborhood rather than in offices. ACT programs are staffed by a group of professionals who work as a treatment team in the community (Bond, 1995). In most ACT teams, staff provide a range of serves to clients in their natural surroundings which include,

but are not limited to, assisting with social service agencies, medication management, housing, employment, family issues, and teaching clients coping skills (Chinmanet al., 1999). ACT, first developed in Madison, Wisconsin, has spread throughout the United States in recent years, especially in the Midwest (Bond &Mc Donel, 1991). The ACT team maintains frequent contact with clients and assists with client's concerns around activities of daily living (i.e., budgeting money, shopping, housing, taking medication, employment, problem solving on the job).

Community-based treatment of persons with psychiatric disability, as provided in the ACT model, focuses primarily on the teaching of basic coping skills necessary to live and function as autonomously as possible in the community. These coping strategies consist of activities of daily living, vocational skills, leisure time skills, and social or interpersonal skills (Bond, 1995). Several characteristics of the ACT approach make it distinctive. The first of these is assertive outreach in which staff members initiate contacts rather than depending on clients to keep appointments. A second characteristic of ACT is its emphasis on continuity and consistency whereby care is ongoing and the services are integrated. Finally, ACT programs combine treatment and rehabilitation in a comprehensive and interdisciplinary approach (Bond, 1995). This case management approach has been widely adopted across the United States, especially for persons with psychiatric disability.

e) Supported Employment: Supported employment (SE) is another promising approach to helping people with psychiatric disability to succeed in the community. SE is one of the models of vocational rehabilitation that has been successful in helping individuals with psychiatric disability secure competitive employment (Ahrens, et al., 1999). It emphasizes direct placement in a community job, assistance in locating the job with the consumer, and ongoing job-related problem-solving and support after consumers obtain work. Individual placement is the key vocational strategy nationwide (Wehman & Revell, 1996). An evaluation of an SE program for persons with psychiatric disabilities found that clients were able to exercise more control over their career choices due to the client-centered approach used in SE programs (Block, 1992). By 1995, a national survey had identified 36,000 persons with mental illnesses who were employed in SE jobs (Wehman, Revell, & Kregal, 1997).

f) Supported Education: Although long overdue, another vocational improvement for people with psychiatric disability is in the area of education. Supported education programs have surfaced and expanded in the last few years, partly in response to problems experienced by people with psychiatric disability in more traditional vocational rehabilitation approaches (Moxley, Mowbray, & Brown, 1993). Like supported employment and supported housing, supported education takes a rehabilitation approach in providing assistance, preparation, and advocacy to individuals with psychiatric disabilities who desire to pursue post-secondary education or training (Mowbray, Bybee, & Shriner, 1996).Supported education as a program model has been nationally recognized as a promising method to improve employment rates (Anthony, 1994). A variety of supported education approaches have been identified, of which two of the most common are the structured classroom and on-site support (Mowbray, Moxley, & Brown, 1993). In the structured, or self-contained classroom, students attend classes with other students with psychiatric disability. In the onsite support model, students attend regular classes. Support is provided by the staff of the educational facility (Unger, 1990) and according to Mowbray and Megivern (1999), supportive education programs can and do work.

14.8 SUMMARY

Individuals with psychiatric disabilities have many of the same desires as other individuals in society – namely, to feel a part of the larger community. Work can, in many ways, help individuals with psychiatric disabilities achieve integration by providing a means to develop valued societal roles, reduce stigmatization, increase social connectedness, and serve as a normalizing factor. Rehabilitation professionals can play an integral and valuable part in the lives of individuals with psychiatric disabilities by integrating and implementing a variety of strategies designed to increase the community integration and independence of people with psychiatric disabilities through successful employment outcomes.

14.9 KEYWORDS

Psychosocial rehabilitation

Psychiatric rehabilitation

Recovery model

Clubhouse model

Community support system

14.10 CHECK YOUR PROGRESS

1. Explain the meaning and definition of Psycho-Social Rehabilitation.
2. What are the functions of Psycho-Social Rehabilitation?
3. Write a brief history of Psycho-Social Rehabilitation.
4. What are the Principles Psycho-Social Rehabilitation?
5. Discuss the Models of Psycho-Social Rehabilitation.

14.11 ANSWERS TO CHECK YOUR PROGRESS

1. 14.3
2. 14.4
3. 14.5
4. 14.6
5. 14.7

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UNIT: 15 - REHABILITATION PROGRAMS

STRUCTURE

15.1 OBJECTIVES

After going through this unit, you will be able to explain

- Rehabilitation for Alcoholics
- Alcohol Rehabilitation
- Rehabilitation program for Drug addicts
- Principles of Effective Treatment
- The different Rehab Centres
- Rehabilitation program for HIV/AIDS
- Empowerment of Self-help groups

15.2 INTRODUCTION

In the earlier two units the concept of rehabilitation and that of Psycho-social Rehabilitation was dealt with. The need and requirement of this program, the manner it was extended to include the social setting to enhance the recovery of the patient concerned and so on. In this unit we would focus on specific problems that need to be rehabilitated with.

15.3 REHABILITATION PROGRAM FOR ALCOHOLICS

Alcohol use disorder (which includes a level that's sometimes called alcoholism) is a pattern of alcohol use that involves problems controlling your drinking, being preoccupied with alcohol, continuing to use alcohol even when it causes problems, having to drink more to get the same effect, or having withdrawal symptoms.

Alcoholism is a chronic disease including uncontrolled drinking and preoccupation with alcohol. This could be due to both a physical and emotional dependence on alcohol. Like other chronic diseases, if left untreated, alcoholism can have serious, life-threatening consequences. Fortunately, there are effective treatment programs for alcoholism. While details vary from program to program, alcohol detox and alcohol rehab programs share certain essential components.

Alcohol dependency is a condition that is marked by an overpowering urge to drink alcohol. It's more common in people who have anxiety, depression or a lot of stress in their lives. Alcohol is an addictive drug and although many people drink safely, you can become psychologically and physically dependent on it. The symptoms include repeated alcohol consumption despite related legal and health issues. Those with alcoholism may begin each day with a drink, feel guilty about their drinking and have the desire to cut down on the amount of drinking. The treatment involves counseling by a healthcare professional. A detoxification program in a hospital or medical facility is an option for those who need additional assistance. Medications are available that reduce the desire to drink.

Alcohol detox is an important preliminary step in the management of alcoholism. It is a medically supervised period of alcohol withdrawal. During this period, a doctor may administer medications to control symptoms, and the individual is monitored by health professionals to ensure his or her safety. In addition to medical care during withdrawal from alcohol, the person usually also receives education about his or her alcohol problem and its treatment.

Medical management of alcohol withdrawal for people who are alcohol dependent is often necessary, because the symptoms of withdrawal can be dangerous. They can include:

- Sweats
- Nausea
- Vomiting
- Tremors
- Anxiety
- Agitation
- Paranoia
- Hallucinations
- Seizures

It is to be noted that not everyone has all these symptoms, and symptom can range from mild to severe. Typically, alcohol detoxification takes place in a regular medical ward of a

hospital, a specialized detoxification unit, or in an outpatient clinic. Detox, which may last a few days to more than a week, is an important and necessary preparation for treatment.

Now, Detoxification or 'detox' involves taking a short course of a medicine which helps to prevent withdrawal symptoms when you stop drinking alcohol. The most commonly used medicine for detox is chlordiazepoxide. This is a benzodiazepine medicine. Alcohol detox is an important preliminary step in the management of alcoholism. It is a medically supervised period of alcohol withdrawal. During this period, a doctor may administer medications to control symptoms, and the individual is monitored by health professionals to ensure his or her safety. In addition to medical care during withdrawal from alcohol, the person usually also receives education about his or her alcohol problem and its treatment. Medical management of alcohol withdrawal for people who are alcohol dependent is often necessary, because the symptoms of withdrawal can be dangerous.

15.4 ALCOHOL REHABILITATION

Alcohol rehabilitation takes place in a variety of settings:

Initial assessment: When a person is first admitted to an alcohol rehab program, he or she receives a thorough clinical assessment. The assessment is then used to help determine the best approach to treatment. It is also used to help develop the treatment plan. Alcohol rehab programs may be residential (a person lives on site during treatment) or outpatient. They all have these elements in common:

- **Hospital- or medical-clinic-based programs.** These programs offer both alcohol detox and alcohol rehab on an inpatient basis in specialized units. They are less common than they used to be, primarily because of changes in insurance.
- **Residential rehab programs**. These programs can last from a month to more than a year and take place in a residential environment. Often, the treatment is divided into a series of stages that the person goes through. For instance, in the beginning, a patient's contact with others, including friends and family, is strictly limited. The idea is to separate the person from their usual social environment associated with drinking, and to develop a

primary relationship with the other residents who are also recovering from alcoholism. Eventually, the person will be allowed more contact with people outside the residential community and may even go back to work or school, returning home to the treatment facility each day.

- **Partial hospitalization or day treatment**. These programs provide four to eight hours of treatment a day at a hospital or clinic to people who live at home. They typically run for three months and work best for people with a supportive family and a stable, sober home environment.
- **Outpatient programs**. These are run at hospitals, health clinics, community mental health clinics, counselor's offices, and residential facilities with outpatient clinics. Attendance requirements vary, and many of them are run in the evenings and on weekends to allow people to be able to continue working.
- **Intensive outpatient programs.** These programs require nine to 20 hours of treatment per week and run for two months to one year. They work best for people who are motivated to participate and who have supportive families and friends.

During the initial assessment, a counsellor will ask questions about:

- The amount of alcohol a person drink
- How long the person has been using alcohol
- Cultural issues around the use of alcohol
- The effect alcohol has had on the person's life
- Medical history
- Current medical problems or needs
- Medications being taken
- Mental health or behavioural issues
- Family and social issues and needs
- Legal and financial issues the person is confronting
- Educational background and needs
- Current living situation
- Home environment

- Employment history, stability, problems, and needs
- Previous experience with rehab or attempts to quit using alcohol

Typically, a psychiatrist or other medical doctor would also be a part of the initial evaluation to assess any additional psychiatric and medical problems that may be present. If it's determined during the initial assessment that there are urgent medical issues that need to be treated or that the person needs a detox program, the person may be referred to a hospital or other medical facility until his/her condition is stable enough to begin rehab. The strange thing is that, alcoholism cannot be cured as of now. Even if an alcoholic hasn't been drinking for a long time, he or she can still suffer a relapse. Not drinking is the safest course for most people with alcoholism. Yes, the silver lining to this cloud is that alcoholism can be treated.

Development of a plan: Following the assessment and, if needed, a detox program or other medical care, the person will be assigned a counsellor or case manager. Together, they will work out a detailed treatment plan that identifies problems, goals, and details about how to address the problems and reach the goals. That plan will be carried out by a team of trained individuals that can include a social worker, counsellor, nurse, psychologist, psychiatrist, or other professional.

Group and individual counseling: Counseling is an integral part of the treatment for alcoholism. Counseling gives the individual in rehab tools to accomplish important goals:

- Overcome denial
- Recognize problems
- Become motivated to solve problems
- Address mental health issues such as depression or anxiety disorders
- Change behaviour
- Re-establish healthy connections with family and friends
- Build new friendships with people who don't use alcohol
- Create a recovery lifestyle

Individual assignments: Throughout the rehabilitation process, the person will be given materials to read, listen to, and watch, will be asked to write about his or her experiences or responses to treatment, and given new behaviours to try.

Education about substance use disorders: Often, people who have a substance use disorder such as alcoholism are in a state of denial, believing their drinking is normal. In order to progress in recovery, they need to confront the fact that they do have a problem with alcohol and acknowledge the dangers that the problem present.

Life skills training: When someone who has been dependent on alcohol goes into recovery, he or she may need training in these areas: managing anger, stress, or frustration; employment skills; goal setting; spending leisure time; developing social and communication skills; and managing money and time.

Relapse prevention training: It's important that the person recovering from alcoholism learn to recognize situations that can trigger a relapse and how to avoid them.

Orientation to self-help groups: Most alcohol rehab programs require participants to join a self-help group after the program ends to help them continue on the path of recovery. Taking part in a self-help group is not considered part of treatment, but rather an essential part of maintenance.

Most rehab programs include orientation to other programs such as SMART, which uses cognitive methods to help people stay sober. Many programs also include treatment for mental disorders.

Medications are also sometimes used to help a person stay sober, such as the drug disulfiram (Antabuse), which causes an immediate, unpleasant (though safe) reaction of nausea and flushing if the person drinks while taking it. Naltrexone (Vivitrol, ReVia) is also used, sometimes in combination with Antabuse or other medicines, to block the euphoria from drinking and reduce the craving for alcohol, particularly in people who binge drink. Acamprosate (Campral) is another medication used to curb the desire to drink, and the anticonvulsant drug topiramate (Topamax) also has been shown in early research studies to help reduce drinking urges and behaviors. The anticonvulsant gabapentin (Neurontin) also has been shown in preliminary research to help reduce anxiety symptoms associated with alcoholism, and the drug divalproex (Depakote) has been shown to reduce drinking behavior in people with both bipolar disorder and alcoholism. Antidepressant medicines can help treat depression in people who are in recovery from alcoholism, but they have not been shown directly to curb drinking

behaviour, and tend to be less effective for depression when someone is actively and regularly still drinking.

Successful treatment has several steps:

- Detoxification (the process by which the body rids itself of a drug)
- Behavioural counselling.
- medication (for opioid, tobacco, or alcohol addiction)
- Evaluation and treatment for co-occurring mental health issues such as depression and anxiety.
- Long-term follow-up to prevent relapse.

15.5 REHABILITATION PROGRAM FOR DRUG ADDICTS

Drug rehabilitation is a term for the processes of medical or psychotherapeutic treatment, for dependency on psychoactive substances such as alcohol, prescription drugs, and street drugs such as cocaine, heroin or amphetamines. Such programs help drug addicts prepare to re-enter society. Drug addiction often changes a person's behaviour, which can affect all aspects of his or her life, including work and relationships. In drug rehab, patients do their best to regain their normal lives in a safe and healthy way.

There are many different types of drug rehab facilities. Some specialize in helping patients with a specific drug addiction; others offer a broader range of drug addiction services. Inpatient and outpatient rehab facilities are also available.

Drug rehab treatment centers often carry the stigma that patients are forced to stay. However, this stereotype is untrue. Patients in rehab centers are free to leave anytime they choose to. One reason for this is that drug rehab can only be truly effective when the patient has a desire to be there and to change his or her addictive habits. In instances where individuals are compelled to go to rehab -- such as via a court order -- the rehab process can still be effective, even if they were initially reluctant to go.

Before entering a rehab facility, patients may have to undergo detox treatment. Detox is the process in which a patient rids his or her body of the addictive substance. This process usually takes about a week and is monitored by doctors and nurses. Once a patient completes detox, he or she is ready for rehab.

Drug rehab treatment facilities help patients change their attitudes toward drugs. Many times, drug addicts deny that they have an addiction and sometimes even claim that the drug is not harmful. The first step in rehab is to help patients get past this denial so that they can make an effort to change.

Types of Treatment Programs

Research studies on addiction treatment typically have classified programs into several general types or modalities. They start with detoxification and medically managed withdrawal, often considered the first stage of treatment. Detoxification, the process by which the body clears itself of drugs, is designed to manage the acute and potentially dangerous physiological effects of stopping drug use. Detoxification alone does not address the psychological, social, and behavioural problems associated with addiction and therefore does not typically produce lasting behavioural changes necessary for recovery. Detoxification should thus be followed by a formal assessment and referral to drug addiction treatment.

It is often accompanied by unpleasant and potentially fatal side effects stemming from withdrawal, detoxification is often managed with medications administered by a physician in an inpatient or outpatient setting; therefore, it is referred to as "medically managed withdrawal." Medications are available to assist in the withdrawal from opioids, benzodiazepines, alcohol, nicotine, barbiturates, and other sedatives.

Drug addiction is a complex illness: This addiction is characterized by intense and, at times, uncontrollable drug craving, along with compulsive drug seeking and use that persists even in the face of devastating consequences. It is designed to serve as a resource for healthcare providers, family members, and other stakeholders trying to address the myriad problems faced by patients in need of treatment for drug abuse or addiction.

Addiction affects multiple brain circuits, including those involved in reward and motivation, learning and memory, and inhibitory control over behaviour. That is why addiction is a brain disease. Some individuals are more vulnerable than others to becoming addicted, depending on the interplay between genetic makeup, age of exposure to drugs, and other environmental influences. While a person initially chooses to take drugs, over time the effects of prolonged exposure on brain functioning compromise that ability to choose, and seeking and consuming the drug become compulsive, often eluding a person's self-control or willpower.

But addiction is more than just compulsive drug taking—it can also produce far-reaching health and social consequences. For example, drug abuse and addiction increase a person's risk for a variety of other mental and physical illnesses related to a drug-abusing lifestyle or the toxic effects of the drugs themselves. Additionally, the dysfunctional behaviours that result from drug abuse can interfere with a person's normal functioning in the family, the workplace, and the broader community.

Addiction treatment must help the individual stop using drugs, maintain a drug-free lifestyle, and achieve productive functioning in the family, at work, and in society. Patients typically require long-term or repeated episodes of care to achieve the ultimate goal of sustained abstinence and recovery of their lives.

The influence of genetics and environment on gene function and expression (i.e., epigenetic), which are heralding the development of personalized treatment interventions.

15.6 PRINCIPLES OF EFFECTIVE TREATMENT

1. **Addiction is a complex but treatable disease that affects brain function and behaviour.** Drugs of abuse alter the brain's structure and function, resulting in changes that persist long after drug use has ceased. This may explain why drug abusers are at risk for relapse even after long periods of abstinence and despite the potentially devastating consequences.

2. **No single treatment is appropriate for everyone.** Treatment varies depending on the type of drug and the characteristics of the patients. Matching treatment settings,

interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

3. **Treatment needs to be readily available.** Drug-addicted individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible. The earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes.

4. **Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.** To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture.

5. **Remaining in treatment for an adequate period of time is critical.** The appropriate duration for an individual depends on the type and degree of the patient's problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment. Recovery from drug addiction is a long-term process and frequently requires multiple episodes of treatment. Relapses to drug abuse can occur and should signal a need for treatment to be reinstated or adjusted. Individuals often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

6. **Behavioural therapies—individual, family and group counseling—are the most commonly used forms of drug abuse treatment.** Behavioral therapies vary in their focus and may involve addressing a patient's motivation to change, providing incentives for abstinence, building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problem-solving skills, and facilitating better interpersonal relationships. Also, participation in group therapy and other peer support programs during and following treatment can help maintain abstinence.

7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** For example, methadone, buprenorphine, and naltrexone (including a new long-acting formulation) are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use. Acamprosate, disulfiram, and naltrexone are medications approved for treating alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (available as patches, gum, lozenges, or nasal spray) or an oral medication (such as bupropion or varenicline) can be an effective component of treatment when part of a comprehensive behavioural treatment program.

8. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation, and/or social and legal services. For many patients, a continuing care approach provides the best results, with the treatment intensity varying according to a person's changing needs.

9. **Many drug-addicted individuals also have other mental disorders.** Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate.

10. **Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.** Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal and can, for some, pave the way for effective long-term addiction treatment, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following detoxification. Motivational enhancement and incentive strategies, begun at initial patient intake, can improve treatment engagement.

11. **Treatment does not need to be voluntary to be effective.** Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.

12. **Drug use during treatment must be monitored continuously, as lapses during treatment do occur.** Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual's treatment plan to better meet his or her needs.

13. **Treatment programs should test patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling, linking patients to treatment if necessary.** Typically, drug abuse treatment addresses some of the drug-related behaviours that put people at risk of infectious diseases. Targeted counseling focused on reducing infectious disease risk can help patients further reduce or avoid substance-related and other high-risk behaviours. Counseling can also help those who are already infected to manage their illness. Moreover, engaging in substance abuse treatment can facilitate adherence to other medical treatments. Substance abuse treatment facilities should provide onsite, rapid HIV testing rather than referrals to offsite testing—research shows that doing so increases the likelihood that patients will be tested and receive their test results. Treatment providers should also inform patients that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among drug-abusing populations, and help link them to HIV treatment if they test positive.

Finding the Right Drug Recovery Centre that Includes the Needs and Wants of the Person: If a person is struggling with drug addiction, it is of vital importance that they receive help for that particular addiction as quickly as possible. However, before you can get someone the help that he or she may need, it is important to understand the basics of recovery. Dependence is a complex physical and mental problem. In order to deal with drug or alcohol addiction in an effective manner, you have to understand that there is no 'one-size-

fits-all' approach. Every person has his or her own assortment of unique issues that have to be taken into consideration. These issues may include:

- The substances they are currently addicted to.
- The length they have been dependent on those substances, empirical studies make it clear that long-term dependence requires a different approach as compared to short-term dependence.
- Are there additional problems that have to be taken into consideration?
- What is their budget for drug rehabilitation programs?

Looking at all these aspects, one may logically conclude that finding the right type of recovery centre is more challenging than picking one out from a list. Before knowing what would be the right fit for the concerned addict, one would need to understand the options.

15.7 THE DIFFERENT REHABILITATION CENTERS

There are countless different types of recovery centers. The major one's are discussed here;

1. **Long-Term Rehabs**

   These programs *begin* at 60 days or longer. These are considered the 'gold' standard for drug rehabilitation because there is so much evidence that suggests they offer better results. This treatment is residential, meaning that the patient actively lives in the recovery centre. This allows the focus to be on getting better without any possible outside distractions. It removes the patient from the current environment that may or may not be conducive to drug abuse. The comprehensive, uninterrupted care received here cannot be compared with anything else.

2. **Short-Term Treatment**

   These are often based on the 28 or 29 day rehabilitation treatment programs. Even though 30 days or less may not be enough to enact long-lasting change for many patients, the residential nature of the program still gets the patient out of his or her current situation.

3. **Outpatient Care**

There are people who like the idea of outpatient care, but it is especially important that the patient have a realistic idea about his or her own determination. Even though it may offer many of the same therapeutic addiction care options that you may find at inpatient recovery programs, it means that patients return home at the end of the day. Though it is possible to drug test patients to ensure the integrity of the program, many patients in recovery find it excessively difficult to remain sober on their own.

4. **Government Funded Program**

They are Government funded (meaning that patients contribute nothing or very little to the overall cost of the rehab). Waiting periods before a patient is able to enter rehabilitation may be quite long as well.

5. **Private Treatment**

Oftentimes patients have to pay for this type of treatment program. Because they are more expensive, they again have added benefits such as smaller waiting lists and a better staff-to-patient ratio. The patient decides to go for this based on his financial condition.

15.8 REHABILITATION PROGRAM FOR HIV/AIDS

A brief introduction: The Human Immunodeficiency Virus (HIV) ultimately led to AIDS. Although there have been great medical advances in suppressing HIV, having the virus requires chronic, intensive treatment, and there is currently no cure. Those with addiction have a higher rate of becoming infected with HIV, and a lower rate of successful suppressive treatment and treatment of opportunistic infections.

The Human Immunodeficiency Virus (HIV) attacks and destroys certain white blood cells, which are part of the body's immune system needed to fight infections. Acquired Immune Deficiency Syndrome (AIDS) is the end result of HIV. AIDS occurs when the majority of white blood cells have been destroyed by HIV and the immune system no longer functions. Today, there are medications that help manage opportunistic infections such as HIV/AIDS as well as

drugs to slow the progression of HIV. With these new medications, a person can live a long time before the onset of AIDS. Currently, there is no cure for HIV or AIDS.

Occupational therapy & vocational rehabilitation for individuals living with hiv/aids

Occupational therapy can have a crucial role in assisting persons living with HIV/AIDS to re-engage with life, particularly through vocational rehabilitation programmes. The American Occupational Therapy Association states that occupational therapists have both a professional and ethical responsibility to provide services to persons living with HIV/AIDS.

According to Jacobs (1985), occupational therapy can provide the client with a series of learning experiences that will enable the individual to make appropriate vocational choices and develop the necessary work habits for eventual employment.

A four-phase programme was designed which included both individual therapy and group education and support sessions. Phase one of the programme allowed clients to explore and foster the necessary daily habits and work skills to support a vocational role. The second phase allowed further development of skills and habits through various voluntary work placements. These experiences helped the client to determine his or her tolerance for work and how fatigue and the side effects of various medications affected work performance. During the third phase, clients were placed in paid employment or returned to or entered formal education or job-training programmes. The final phase concerned long-term support, follow-up and the availability of the programme's staff to intervene and provide support as necessary.

Braveman (2001) concludes by mentioning that providing such services to the community can bring great reward for both the profession and the individual occupational therapy practitioner.

The benefits of work: A number of authors have outlined the importance of work, indicating the necessity of vocational rehabilitation. Miller (1987) noted that work provides a routine and a distraction away from the traumas of diagnosis or infection. Furthermore, he believes that work is a vital part of learning to live with HIV/AIDS. Creek (2002) identified a number of benefits of work to the individual e.g. giving people a role in society, a means of

earning, giving structure and purpose, providing a source of self-esteem, social interaction, interest and satisfaction. Similarly, Bedell (2000) discovered that participants in his study identified work with giving them a structure, social interaction and stimulation. Other research has found that among individuals with HIV/AIDS, usefulness to others was critical to psychological well-being, while not being a financial burden was important to social well-being. Engagement in work could address both of these issues. Pequegnat and Stover (1999) found that, in relation to research into other chronic illnesses, strong positive correlation exists between returning to work and self-reported quality of life.

Barriers that may exist: However, a number of barriers for persons living with HIV/AIDS returning to work exist. Persons living with HIV/AIDS face "widespread ignorance, fear and prejudice".

Indeed, better quality of life is not guaranteed by returning to work, as discrimination may present a serious source of distress. The occupational therapist, however, can provide psychological support and counselling for the patient with regard to managing and coping at home and in work.

It should be remembered that the client's needs and wishes should always take centre-stage if therapy is to be meaningful. No therapist should ever assume that everyone has a desire to enter into a programme of vocational rehabilitation and return to work.

Advocacy and Empowerment of Self Help Groups

Rehabilitation programs require the support of self help groups to be sustained. **Self-help groups**, also known as mutual **help**, mutual aid, or **support groups**, are **groups** of people who provide mutual **support** for each other. In a **self-help group**, the members share a common problem, often a common disease or addiction.

Their mutual goal is to help each other to deal with, if possible, to heal or to recover from, this problem.

In traditional society, family and friends provided social support. In modern industrial society, however, family and community ties are often disrupted due to mobility and other social changes. Thus, people often choose to join with others who share mutual interests and concerns.

Basic Self-Help Group Models

Self-help groups may exist separately or as part of larger organizations. They may operate informally or according to a format or program. The groups usually meet locally, in members' homes or in community rooms in schools, churches, or other centers.

In self-help groups, specific modes of social support emerge. Through self-disclosure, members share their stories, stresses, feelings, issues, and recoveries. They learn that they are not alone; they are not the only ones facing the problem. This lessens the isolation that many people, especially those with disabilities, experience.

Using the "professional expert" model, many groups have professionals serve as leaders or provide supplementary resources (Gartner and Riessman 1977). Many other groups, using the "peer participatory" model, do not allow professionals to attend meetings unless they share the group problem and attend as members or unless they are invited as speakers (Stewart 1990).

Comparing the self-help peer participatory model with the professional expert model, experiential knowledge is more important than objective, specialized knowledge in the peer model. Services are free and reciprocal rather than commodities. Equality among peers, rather than provider and recipient roles, is practiced. Information and knowledge are open and shared rather than protected and controlled.

Peers can model healing for each other. The person who has "already 'been there'" helps the newer member (Mullan 1992). Through peer influence, the newer member is affected (Silverman 1992). Although the newer member learns that the problem can be dealt with and how, the older member who helps also benefits (Riessman 1965).

One possible effect of this peer model is empowerment. Self-help group members are dependent on themselves, each other, the group, perhaps a spiritual power. Together they learn to control the problem in their lives.

Those who share a common shame and stigma can come together, without judging, to provide an "instant identity" and community (Borman 1992). They can give emotional, social, and practical support to each other. They can explore and learn to understand and to combat the shame and stigma together, enhancing their self-esteem and self-efficacy. Through participation,

they can enhance their social skills, promoting their social rehabilitation (Katz 1979).Through "cognitive restructuring" (Katz 1993), members can learn to deal with stress, loss, and personal change (Silverman 1992).

Recovery Programs: The original model self-help group was Alcoholics Anonymous (AA), founded in 1935 by "Bill W."(William Griffith Wilson) and "Dr. Bob" (Robert Holbrook Smith). It is now estimated that 1 million people attend more than 40,000 groups in 100 countries (Borman 1992). AA has come to be known as a "twelve-step group" because its program for sobriety involves twelve steps:

15.9 EMPOWERMENT OF SELF-HELP GROUPS

The elements

Returning to the definition, let us now look at each of the elements:

1. Having decision-making power. Clients of mental health programs are often assumed by professionals to lack the ability to make decisions, or to make "correct" decisions. Many programs limit the number or quality of decisions their clients may make. Clients may not be able to decide not on the overall course of their treatment. Clients are maintained in long-term dependency relationships. No one can become independent unless he or she is given the opportunity to make important decisions about his or her life.
2. Having access to information and resources. Decisions are best made when the individual has sufficient information to weigh the possible consequences of various choices. Many mental health professionals restrict such information, believing restriction to be in the client's "best interest." Since, lacking adequate information; clients may make impulsive choices that confirm professionals' beliefs in their inadequacy.
3. Having a range of options from which to make choices. Meaningful choice is not merely a matter of chance.
4. Assertiveness being able to clearly state one's wishes and to stand up for oneself—helps an individual to get what he or she wants.

5. A person who is hopeful believes in the possibility of future change and improvement; without hope, it can seem pointless to make an effort. Yet mental health professionals who label their clients “incurable” or “chronic” seem at the same time to expect them to be motivated to take action and make changes in their lives, despite the overall hopelessness such labels convey.
6. Learning to think critically; unlearning the conditioning; seeing things differently. The empowerment process includes a reclaiming of one’s sense of competence, and recognition of the often-hidden power relationships inherent in the treatment situation. In the early stages of participation in self-help groups, for example, it is very common for members to tell one another their stories; both the act of telling and that of being listened to are important events for group members.
7. Learning about and expressing anger. Clients who express anger are often considered by professionals to be “decompensating” or “out of control.” The expression of anger has often been so restricted, it is common for clients to fear their own anger and overestimate its destructive power. Clients need opportunities to learn about anger, to express it safely, and to recognize its limits.
8. Not feeling alone; feeling part of a group. An important element is group dimension. We believe that it is necessary to recognize that empowerment does not occur to the individual alone, but has to do with experiencing a sense of connectedness with other people.
9. Understanding that people have rights. The self-help movement among psychiatric survivors is part of a broader movement to establish basic legal rights. Through understanding our rights, we increase our sense of strength and self-confidence.
10. Effecting change in one’s life and one’s community. When a person brings about actual change, he or she increases feelings of mastery and control. This, in turn, leads to further and more effective change.
11. Learning skills that the individual defines as important. (e.g., daily bed making). When clients are given the opportunity to learn things that they want to learn, they often surprise professionals (and sometimes themselves) by being able to learn them well
12. Changing others’ perceptions of one’s competency and capacity to act. As one becomes better able to take control of one’s life, demonstrating one’s essential similarity to so

called “normal” people, this perception should begin to change. And the client who recognizes that he or she is earning the respect of others increases in self-confidence, thus further changing outsiders’ perceptions.

13. People with devalued social statuses who can hide that fact often (quite wisely) choose to do so. However, this decision takes its toll in the form of decreased self-esteem and fear of discovery. Individuals who reach the point where they can reveal their identity are displaying self-confidence.
14. Growth and change that is never ending and self-initiated. Empowerment is not a destination, but a journey; that no one reaches a final stage in which further growth and change is unnecessary.
15. Increasing one’s positive self-image and overcoming stigma. As a person becomes more empowered, he or she begins to feel more confident and capable. This, in turn, leads to increased ability to manage one’s life, resulting in a still more improved self-image.

This concept is particularly important within psychiatric rehabilitation programs, since these programs often claim that they are promoting independence, autonomy, and other ideas related to empowerment. It would be extremely useful to find out, for example, whether rehabilitation practitioners believed their programs were promoting empowerment in their clients, and whether clients of those programs agreed.

15.10 SUMMARY

This unit has dealt with alcoholism, the individuals suffering from alcoholism and their rehabilitation, the different types of treatment used in rehabilitation. Rehabilitation programs for drug addicts, the different types of treatment programs , the principles adopted for effective treatment, the different rehab centres, rehabilitation programs for HIV/AIDS, the importance of self-help groups, its elements are being discussed here.

15.11 KEYWORDS

Alcoholism

Alcohol dependency

Alcohol detox

Alcohol rehabilitation

Drug addicts

Effective treatment

Occupational therapy

Vocational rehabilitation

Self-help groups

15.12 CHECK YOUR PROGRESS

1. How is Rehabilitation for Alcoholics done?
2. What is Alcohol Rehabilitation?
3. Explain Rehabilitation program for Drug addicts.
4. What are the Principles of Effective Treatment?
5. Explain different Rehab Centres.
6. Explain the Rehabilitation program for HIV/AIDS.
7. Explain the empowerment of Self-help groups.

15.13 ANSWERS TO CHECK YOUR PROGRESS

1. 15.3
2. 15.4
3. 15.5
4. 15.6
5. 15.7
6. 15.8
7. 15.9

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UNIT: 16 - REHABILITATION PROGRAMS

JUVENILE DELINQUENCY AND CRIMINALS

STRUCTURE

16.1 OBJECTIVES

After going through this unit, you will be able to explain

- Causes of Juvenile Crime and Solutions
- Ways of preventing Juvenile Delinquency
- Treatment of offenders
- Rehabilitation programs for criminals

16.2 INTRODUCTION

Juvenile Delinquency is defined as the habitual committing of criminal acts or offences by a young person, especially one below the age at which ordinary criminal prosecution is possible. The difference between a Juvenile Delinquent and a Criminal is that of the age only. Prevention works better and is cheaper than treatment. The fact is that prevention and early intervention hold far more promise than good rehabilitation programs for actually reducing crime.

16.3 MEANING AND DEFINITION OF JUVENILE DELINQUENCY

Juvenile Delinquency is defined as the habitual committing of criminal acts or offences by a young person, especially one below the age at which ordinary criminal prosecution is possible. The difference between a Juvenile Delinquent and a Criminal is that of the age only. When crimes are committed by young people, it is considered juvenile delinquency. It can be any type of crime, kinds that are committed by all ages. Young adolescents and teenagers have less comprehension of the consequences their actions can cause, they are punished differently by the juvenile court system. The punishments juveniles receive when convicted of committing a crime are designed to prevent them from committing another illegal act. Before the establishment of juvenile courts, children under the age of seven were never held responsible for criminal acts. The law considered them incapable of forming the necessary criminal intent. Children between the ages of 7 and 14 were generally thought to be incapable of committing a criminal act, but this belief could be disproved by showing that the youth knew the act was a crime or would cause

harm to another and committed it anyway. Children over the age of 14 could be charged with a crime and handled in the same manner as an adult.

After a debate on 22nd of December 2015, India's upper house, the Rajya Sabha, passed the Juvenile Justice Amendment bill to lower the juvenile delinquency age from **18** to **16 years.**

The juvenile justice system has evolved over the years based on the premise that juveniles are different from adults and juveniles who commit criminal acts generally should be treated differently from adults. Separate courts, detention facilities, rules, procedures, and laws were created for juveniles with the intent to protect their welfare and rehabilitate them, while protecting public safety.

The root causes of crime are many and diverse. Any hope of addressing those causes successfully requires multi-faceted strategies. Any solution to juvenile crime must involve all sectors of society: individuals, families, schools, community groups, governments and businesses. While the scope of effort involved should be as broad as all of society.

16.4 CAUSES OF JUVENILE CRIME AND SOLUTIONS

It has long been a problem why some children steal and not others, why some play truant, or why some set fires and damage property. Theories have been advanced from time to time to explain these things, but only in the last ten or fifteen years have extensive scientific investigation been carried out on these problems. Officers of the juvenile courts, child welfare associations, educational bodies, and mental hygiene clinics have been instrumental in bringing together a vast amount of data concerning juvenile delinquency, from which certain general conclusions may be drawn. Delinquency itself is socially inadequate adjustment on the part of the individual to difficult situations. The factors which go to make up these difficult situations, together with the mental and physical conditions which influence an individual's capacity to adjust, constitute the causes of delinquency.

Each juvenile offense is the outcome of a complexity of causes, some of whose origins date back years before the committal of the offense and others whose origins are more obviously and immediately connected with the act of delinquency. It has been shown that a different set of

causes are involved in each individual case. It is impossible therefore to state the group of causes which will invariably result in any particular offense. The factors which operate to turn a child's behaviour in one direction rather than another may be very obscure, many as yet are beyond the detection of expert sociologists, psychologists, physiologists and others. It often appears that quite different offenses are the results of the same group of causes, but further investigation shows that still other factors are present in each case which determines the type of delinquency. For example, a poverty-stricken, unhappy home lack earnings may lead one boy to play truant from school in order to earn more money, may cause another to steal, or may result in another's joining a street gang and gambling. More intensive investigation in each case would bring to light the specific factors responsible for these differences.

In spite of the great complexity and diversity of the causes of delinquency, cases are found to have many factors in common. The different combinations of these factors are largely responsible for the differences in offenses. It should be possible, therefore, to draw up a list of conditioning factors from a study of a large number of cases which would cover most of the possibilities, and from which could be isolated any group or combination of factors applicable to a particular case. Such a list should prove to be a diagnostic aid for all workers in the field of juvenile delinquency. The following outline comprises the factors which have been found to operate in some thousands of cases studied and reported on by various authorities.

These factors are classed under six general headings: Physical factors, Mental factors, Home conditions, School conditions, Neighbourhood conditions, and Occupational conditions. The first two groups include all factors dependent upon the bodily and mental condition of the delinquent. These are the product of both heredity and environment. The other four groups consist of environmental factors: un favourable conditions in the home and the family of the child, unfavourable conditions in the school environment, the neighborhoods. An itemized list is presented below:

I. **Physical Factors.**

1. Malnutrition
2. Lack of sleep
3. Developmental aberrations

4. Sensory defects
5. Speech defects
6. Endocrine disorders
7. Deformities
8. Nervous diseases
9. Other ailments
10. Physical exuberance
11. Drug addiction
12. Effect of weather

II. Mental Factors

1. Mental defect
2. Superior intelligence
3. Psychoses
4. Psychoneuroses
5. Psychopathic constitution (including emotional instability)
6. Abnormalities of instinct and emotion
7. Uneven mental development
8. Obsessive imagery and imagination
9. Mental conflicts
10. Repression and substitution
11. Inferiority complex
12. Introversion and egocentrism
13. Revengefulness (get-even complex)
14. Suggestibility
15. Contra-suggestibility
16. Lethargy and laziness
17. Adolescent emotional instability
18. Sex habits and experiences
19. Habit and association

III. Home Conditions

1. Unsanitary conditions
2. Material deficiencies
3. Excess in material things
4. Poverty and unemployment
5. Broken homes
6. Mental and physical abnormalities of parents, or siblings
7. Immoral and delinquent parents
8. Ill-treatment by foster parents, step-parents, or guardians
9. Stigma of illegitimacy
10. Lack of parental care and affection
11. Lack of confidence and frankness between parents and children
12. Deficient and misdirected discipline
13. Unhappy relationship with siblings
14. Bad example
15. Foreign birth or parentage
16. "Superior" education of children

IV. School Conditions

1. Inadequate school building and equipment
2. Inadequate facilities for recreation
3. Rigid and inelastic school system
4. Poor attendance laws and lax enforcement
5. Wrong grading
6. Unsatisfactory teacher
7. Undesirable attitude of pupil towards teacher
8. Bad school companions and codes of morals

V. Neighbourhood Conditions

1. Lack of recreational facilities
2. Congested neighbourhood and slums

3. Disreputable morals of the district
4. Proximity of luxury and wealth
5. Influence of gangs and gang codes
6. Loneliness, lack of social outlets
7. Over stimulating movies and Shows

16.5 WAYS OF PREVENTING JUVENILE DELINQUENCY

Prevention works better and is cheaper than treatment. The fact is that prevention and early intervention hold far more promise than good rehabilitation programs for actually reducing crime. Children are much harder to "fix" once they have become criminals than they are when they first show signs of deviant or anti-social behaviour.

Personal accountability for actions and decisions is the cornerstone of a civilized society. Children should be taught both at home and in schools informed decision-making processes. And they should learn that, in theory and in practice, there are swift consequences for poor decisions and both tangible and intangible rewards for good decisions. To reinforce these lessons, the juvenile justice system, the policeman, the judge in juvenile court, must strive to make the system work more effectively in providing consequences at all levels of criminal severity.

Academic experts have long recognized that crime is a young man's game. The typical criminal is a male who begins his career at 14 or 15, continues through his mid-20s and then tapers off into retirement.

Furthermore, studies of criminal careers have demonstrated that one of the best predictors of sustained and serious adult criminality is the age of initiation and seriousness of the delinquent career.

Failure in school: This factor manifests itself at an early age. Failure at school includes poor academic performance, poor attendance, or more likely, expulsion or dropping out of school. This is an important factor for predicting future criminal behaviour. Leaving school early reduces the chance that juveniles will develop the "social" skills that are gained in school, such

as learning to meet deadlines, following instructions, and being able to deal constructively with their peers.

Social Factors: Changes in the Indian social structure may indirectly affect juvenile crime rates. For example, changes in the economy that leads to fewer job opportunities for youth and rising unemployment in general. This factor includes a history of criminal activity in the family. It also includes juveniles who have been subject to sexual or physical abuse, neglect, or abandonment. It is also manifested by a lack of parental control over the child.

Families have also experienced changes with the last 25 years. More families consist of one-parent households or two working parents; consequently, children are likely to have less supervision at home that was common in the traditional family structure. This lack of parental supervision is thought to be an influence on juvenile crime rates. Other identifiable causes of delinquent acts include frustration or failure in school, the increased availability of drugs and alcohol, and the growing incidence of child abuse and child neglect. All these conditions tend to increase the probability of a child committing a criminal act.

Family plays a huge part in the development of an adolescent, both positive and negative. Adolescents learn what is and is not acceptable by the surrounding environments, which is dominated by the family life. For example, if a father disrespects and hits a mother, then a son might consider this as acceptable and copy it later in his life.

Coming from a broken home through abandonment or divorce can profoundly affect a teen's perception of life. Sometimes in these situations, a teen can be neglected, punished too harshly or not regularly disciplined. Any of these conditions can cause juvenile delinquency as the teen has missed out on complete moral development.

Families are important to consider when trying explaining juvenile delinquency. The family unit is crucial to a child’s development and healthy upbringing; in addition, much of what a child learns is through their family or guardians. A criminal parent can teach their child adverse lessons about life when their child views or witnesses their parent’s delinquent behaviour.

Outside influences or other things out of anyone's control can be the causes of juvenile delinquency. Within society, there are several external forces that can lead an adolescent in the wrong direction.

- Drug use is becoming a widespread crime and concern among adolescents. Alcohol and drug abuse can lead to criminal behavior as teens lose control or turn dangerous due to the effects these illegal substances have on mood, cognitive thought and personality.
- Sometimes a teen has faced the hardship of a physical or mental disability. Society can be very judgmental of individuals with handicaps. Because their judgment can be impaired, these adolescents may want to get revenge towards those perceived as against them.
- Peer pressure and influence is a very powerful motivator in a teen's life. Sometimes a boy or girl will commit a crime because their friends have pressured or dared them to do it. At other times, an adolescent may be jealous of a friend who has more and is motivated to steal so he or she can possess the same materialistic items.

Peer can also teach an adolescent or child criminal behavior just as the family member can. Family members and peers can also cause delinquent patterns of behavior by labelling their child as delinquent.

Mass Media and Technology: As much as parents try to protect their children from negative news and non-appropriate media, it is almost impossible. Teens are exposed to everything through social media, computers, etc. Easy access to information through the Internet allows teens to read and view things that are not appropriate for their age. Teenagers are becoming more and more isolated as they depend on technology as their main point of contact with others. As adolescents leave their home and enter society, sometimes they cannot handle the interaction that comes with living on their own, having a job and getting along with others. This can trigger emotions and reactions they have not experienced in the past. These uncontrolled responses are one of the causes for delinquency.

16.6 TREATMENT OF OFFENDERS

The juvenile justice system tries to treat and rehabilitate youngsters who become involved in delinquency. The methods can be categorized as community treatment, and institutionalization. In most instances' community treatment involves placing the child on probation. When the child is not believed to be harmful to others, he or she is placed under the supervision of an officer of the juvenile court and must abide by the specific rules that are worked out between the officer and the child.

There are various factors that cause juvenile delinquency, there is no one single solution or a few solutions for juvenile delinquency. The solution depends on the cause of delinquency, whether it is medical like LD, poor parenting or any other factor. Medical conditions like conduct disorder and attention-deficit hyperactivity disorder can cause youths to be delinquent. Poor parenting like lack of discipline, abuse and setting a bad example can also cause delinquency in juveniles.

Juvenile delinquency Prevention programs positively impact the general public because they stop this crime from happening in the first place. Programs that are more holistic prevent future crime better because they deal with various aspects of a child's life.

The various aspects include poor child-rearing practices, poor parental supervision, criminal parents and siblings, low family income, large family size, poor housing, low intelligence, and low educational attainment. Physical and/or sexual abuse, socio-economic status all leads to antisocial behaviour that occurs later.

The Juvenile Justice System in India has a strong orientation towards rehabilitation of children coming in contact with the system under the provisions and requirements of the Juvenile Justice (Care and Protection of Children) Act, 2000. The institutions, procedures and processes that deliver justice to children within the framework of the JJ system are to be child-friendly, non-adversarial and ensure rehabilitative and restorative objectives.

16.7 REHABILITATION PROGRAMS FOR CRIMINALS

Criminals mean someone who breaks the law. A person who has committed a crime or has been legally convicted of a crime.

Rehabilitation is the re-integration into society of a convicted person

A successful rehabilitation of a prisoner is also helped if convicted persons:

- are not placed in health-threateningly bad conditions, enjoy access to medical care and are protected from other forms of serious ill-treatment,
- are able to maintain ties to the outside world,
- learn new skills to assist them with working life on the outside

Rehabilitation for criminals should have all these above said aspects. It was not so long ago that prisoners were fed bread and water and chained up together during the day to perform hard labour. Nowadays prisons are very different and a variety of programs (some rather strange) have been implemented as jail time moves away from punishment to rehabilitation. The goal of prison is to both punish and rehabilitate the inmates, with the intent that upon release an inmate has a higher chance of re-entering society and functioning without criminal activity. Although not all inmates participate in rehabilitation programs, some rehabilitation programs include educational, spiritual, work and transitional programs.

Educational: Educational programs within the prison environment include classes to help with obtaining a skill based Diploma, college degree etc. Learning languages that could aid in finding work or a job later too is encouraged. Inmates who increase their skills in these areas often have a higher chance of re-entering society and being more successful at not repeating criminal behaviour. Working within these educational settings provides inmates something else to do with their time.

Spiritual: Prisons supervise and manage the spiritual needs of an inmate population. Inmates are free to practice any religion of their choosing, including no religion at all. Community leaders and organizations often volunteer their time to provide study over sacred texts, worship services, meditation sessions and other times of spiritual practice in accordance with prison rules

and safety requirements. Self-help programs are also provided, such as life-building and communication skill-building classes.

Work Programs: Working within the prison gives inmates several benefits, including a structured work day, the ability to practice positive team-building skills and receiving pay that helps them fund incidental living expenses behind bars. Work programs include inmates working as part of day-labour crews that are hired to do things like carpentry, construction work around etc. After release, this work experience can help inmates obtain jobs or help in providing paperwork to the court for receiving custody of children from foster care.

Transitional Program: Transitional rehabilitation programs help the inmate prepare for release and then guide the inmate back to successful re-entry to society. These take the form of counseling to help with anxieties about being released, and sessions that provide information on local resources that help with free clothing, housing assistance and more. Some inmates may be required to stay at a halfway house for a temporary period, where he is provided assistance in finding employment, required to save money, abide by a curfew and abstain from alcohol and drug usage. These rules vary depending on the type and purpose each halfway house.

When society locks an individual away and doesn't provide some means by which the offender can understand why he/she committed crimes in the first place, then there will be no corrective behaviour. That being said, it has been found that the success to rehabilitation begins with education. When one begins to occupy or focus one's attention on acquiring knowledge, information or even a skill, one begins to discover some things about oneself. Vocational training provides confidence that one does not have to depend on crime to support oneself. When a person is educated, he/she is introduced to new ways of thinking.

16.8 SUMMARY

The successful rehabilitation of prisoners, has three components. These components, healing, treatment and education, that crime is linked to a problem riddled society. That is, there is a circular pattern linking abuse, neglect, and ignorance to criminality. The first step, which must be voluntary, to rehabilitation is healing. Offenders who were abused, neglected and/or

addicted to drugs as children or adults must begin a meaningful healing process (i.e. through spirituality, addiction recovery…) to understand the dynamics in their lives which lead them down the wrong path. In addition healing will help offenders gain understanding the damage that their actions have caused to their victims, themselves and the community. The second step is treatment. Nobody starts life telling themselves that they wish to be a drug addict or a criminal. Once a person reaches the point of deviating from acceptable behaviour there should be therapy and intensive training to repair the damage and to change the mindset of the offender. Finally, education, education, education! Without the tools to communicate, gain employment and flourish in society, men will do whatever they have to do to survive even if it means deviating from their moral compass to commit additional crimes. Education opens doors to healthy, meaningful, clean lives.

16.9 KEYWORDS

Juvenile delinquency

Offenders

Juvenile courts

Mass media

16.10 CHECK YOUR PROGRESS

1. Explain the meaning and definition of Juvenile Delinquency.
2. Explain the causes of Juvenile Crime and Solutions.
3. What are the ways of preventing Juvenile Delinquency?
4. How is the treatment of offenders done?
5. Discuss the Rehabilitation programs for criminals.

16.11 ANSWERS TO CHECK YOUR PROGRESS

1. 16.3
2. 16.4
3. 16.5
4. 16.6
5. 16.6

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