SUMMARY
AND
CONCLUSION
6. **SUMMARY AND CONCLUSION**

**SUMMARY:**

6.1.) The present researcher in this study context ventured out to identify the pertinent psychosocial problems faced by young male trauma victims having undergone one leg amputation trans femorally or transtibially in the metropolis of Kolkata. She also decided to empirically validate some relevant hypotheses about the nature of mental sufferings of them by comparing statistically the findings with that of their normal counterparts in society. In addition she tried to find out the relative contributions of the chosen study variables (Psychosocial barriers) in producing their relatively poorer sense of subjective well-being. Accordingly, the study was conducted in 3 phases:

In the 1\textsuperscript{st} phase the orthopaedically handicapped individuals (leg amputee) were interviewed with a semi-structured open-ended interview schedule.

In the 2\textsuperscript{nd} phase 5 chosen study variables namely Psychiatric Morbidity, Adjustment, Coping, Self-esteem and Sense of subjective well-being were treated as dependant variable and the major independent variable was the incidence of handicap. A comparative account was taken from otherwise matched 100 young normal adults and late adolescents without handicap as such. They formed the control group. 100 handicapped individuals undergoing treatment in Government facilities across Kolkata was the study group.

Finally, (3\textsuperscript{rd} phase) posing sense of subjective well-being as the dependent variable the relative contribution of each of the other 4 psychological variables (as independent variable), statistically, an endeavor was made to find out the relative contribution of these 4 independent variables, leading to reduction in sense of subjective well-being of the orthopaedically handicapped youths (reduction having been empirically supported in the 2\textsuperscript{nd} phase of the study).
PHASE—1:

i) It has been already noted that (vide 2nd chapter) in the developing world trauma is the leading cause of amputation caused by inadequately treated wounds due to accidents in contact with motor vehicles, trains, and other motorized machinery. Also in countries with recent history of warfare or civil unrest trauma can account for up to 80% of all amputations (Esquenazi, 2004). Esquenazi entitled his article most properly in which he intended to say that rehabilitation is a long process started very much from the time of incidence of trauma up to putting back the traumatized victims in the mainstream of society again. Ideally this is a multistage activity, each stage requiring dedicated services of multiple professionals. After prescription and fitting of the prosthetic device, training is indispensable and should include prosthetic management and functional training with the goal of achieving community reintegration. Community reintegration should include recreation activities and sports and when appropriate, work or return to school, as part of the successful rehabilitation program for the person with limb amputation. A well-integrated and experienced team can better achieve the goal of returning the patient to their highest functional level. (Esquenazi et al. 2000; Esquenazi et al. 2001; Traweek et al. 1989).

ii) When approached (with the semi-structured interview schedule 2 months after the trauma and again after another 10 months after they were fitted with prosthetic) the study group members, displayed 2 major negative emotions i.e. grief and despair—grief for loss of body parts and despair for not being able to be the same person when they received the prosthetic. All these they have gone through without having received any training for using the prosthetic and being left to moan within themselves in agony.

iii) Anything that increases mobility and enhances the patient's confidence and self-esteem will facilitate the necessary physical and psychological transitions. But not having received well conducted post operative exercise program to restore confidence in their bodies for which they have longed. Often their fear creates the very situation they dread. Help from a psychiatrist as well as
intervention by a clinical psychologist for allaying the depression and fear aspect by using medicines and proper counseling. (Bishop, 2005) were very much needed by them.

iv) A suddenly acquired loss of body parts frequently lead to a reduced overall quality of life by reducing satisfaction and control in personally important domains. A positive level of quality of life incorporating sense of subjective well-being serve adaptive functions. Bishop (2005) proposed that a positive level of quality of life is vital to adaptation. Such as, Diener and Diener (1995) argued that a positive subjective quality of life baseline is necessary from an evolutionary perspective in that it allows for greater opportunities for social and personal advancement, exploratory behavior and reliable coping resources. The idea that people naturally seek to improve their perceived position with regard to their goals and aspirations is suggested generally in the work of many personalities theorists (Adler, 1956; Rogers, 1961 and Abraham Maslow, 1964). All of them described people as inherently seeking to overcome perceived personal and situational deficits.

v) In contrast to persons with congenital disabilities, for whom research suggests that the process of body image and identity development is likely to be similar to that of children without disability. (Grzesiak and Hickok, 1994; Livneh and Antonak, 1997; Wright, 1983), persons who experience later-onset chronic illness or acquired disability (CIAD) may find their sense of self suddenly and dramatically challenged or altered. These persons may be faced with significant changes in their social and familial relationships and life roles while dealing concurrently with psychological distress, physical pain, prolonged medical treatment, and gradually increasing interference in or restriction of the performance of daily activities (Charmaz, 1983; Livneh and Antonak). Understanding how people navigate this process of adapting to CIAD-related changes, and applying this understanding in the form of effective clinical intervention has been an important focus of rehabilitation research for several decades (Elliott, 1994; Wright and Kirby, 1999). This is very much need of the hour here while trying to help trauma victims.
PHASE—2:

In the second section the study variables namely Psychiatric Morbidity, Adjustment, coping, self esteem and sense of subjective well-being were all treated as dependent variable while the incidence of Orthopaedical handicap was treated as the independent variable. Accordingly 5 study hypothesis were formed as given below:

**Research Hypothesis 1:** The sense of subjective well-being of orthopaedically Handicapped youths will be lower in magnitude than that of their normal counterparts.

**Research Hypothesis 2:** The orthopaedically Handicapped youths will be psychiatrically more Morbid than their normal counterparts.

**Research Hypothesis 3:** The Adjustment level will be lower for orthopaedically Handicapped youths than that of their normal counterparts.

**Research Hypothesis 4:** The coping styles adopted by orthopaedically Handicapped youths will be different than from the ones adopted by their normal counterparts.

**Research Hypothesis 5:** The incidence of positive self-esteem will be lesser while negative self-esteem will be more in the orthopaedically Handicapped youths in comparison with that of their normal counterparts in society.

The first Research Hypothesis was accepted with strong confidence and the researcher could conclude that the orthopaedically Handicapped youth showed greater Psychiatric Morbidity than their normal counterparts.

As regards to the second Research Hypothesis the researcher retained it with considerable confidence. According to the findings the normal youths were in a more advantageous position while adjusting to society and satisfying their own needs within societal limits.
Summary and Conclusion

The third Research Hypothesis had seven sub parts as the coping dimension possessed seven sub dimensions.

3.a) The first sub hypothesis concerned about Problem focused coping. Findings clearly indicated acceptance of the hypothesis with strong conviction so that the researcher could say that while normal’s attempted to do something with the problem itself for its solution, the orthopaedically handicapped youths tended to refrain from doing so.

3.b) The second sub hypothesis concerned with positive distraction (of emotion focused coping) could be accepted as true very strongly – the normal’s scoring significantly being higher than that of the Orthopaedically Handicapped Youths.

3.c) The third research Hypothesis was concerned with negative distraction which is an ineffective channel as it induces mood distress in the long run. This Hypothesis was also accepted with considerable confidence indicating strongly that the Orthopaedically Handicapped Youths tended to use negative distraction more than their normal counterparts.

3.d) The fourth sub dimensions --Acceptance or re-definition of the problem -- it was again found that the amputee Youths appeared not to resort to this mode of coping unlike the normal youths.

3.e) Holding on to religion and faith in God (the fifth sub dimension of coping --an effective emotion focused coping styles ).Due to an insignificant difference in respect of this particular approach the concerned research Hypothesis got rejected i.e both the normal as well as the Orthopaedically Handicapped Youths almost equally often believed in God, worshiping, praying etc.

3.f) The sixth sub dimension of coping styles Denial displayed retention of the research hypothesis with high confidence i.e. the Orthopaedically Handicapped subjects were more likely to resort to this inadequate coping styles to reduce their distress unlike the normal individuals.

3.g) This last hypothesis stating that Orthopaedically Handicapped subjects would resort to seeking social support more than their normal counterparts-------- an Emotion cum problem focused coping. Here, the concerned sub-hypothesis had to be rejected. The sub-hypothesis stated that the Orthopaedically
Handicapped Youths will seek more social support than their normal counterparts. But scanning the reality led the researcher to reject it indicating that probably the Orthopaedically Handicapped Youths in the present study, although needing it very much, failed inhibited to seek explicit social support from others.

The **Fourth Major Hypothesis** stated that the incidence of positive self esteem will be lesser and negative self esteem will be higher in the Orthopaedically Handicapped Subjects, in comparison with that of their normal counterparts in society. This Hypothesis was retained with strong conviction i.e the two groups did differ in reality in respect of their self esteem as observably enough percentage of individuals with negative self esteem was much higher in their Orthopaedically Handicapped Group than in the normal group.

The **Fifth Major Research Hypothesis** stated that normal will report a higher sense of subjective well being than the Orthopaedically Handicapped Youths. The result strongly indicated that the content of the Hypothesis were highly supported by findings of the present study.

**PHASE—3:**
In this section sense of subjective well being was treated as a dependent variable, the other four study variables remaining as the Independent variable and contributing to variance of the dependent variable.

Firstly, correlations were computed between each independent variable and dependent variable. As the measure of the 4th independent variable (self-esteem) yielded frequencies of scores instead of conventional scores. In the preceeding chapter the researcher already mentioned that this particular variable had to be dropped in the third phase of study. The first Independent Variable (psychiatric morbidity) bore a negative yet highly significant correlation with sense of subjective well being —the dependent variable in this section i.e to say higher one has psychiatric morbidity lesser will be his sense of subjective well being. Therefore the orthopedically handicapped youths could not experience a sense of subjective well-being like the normal counterparts in society.
In case of the 2nd independent variable (adjustment) a highly significant and positive correlation was found with sense of subjective well being, which clearly pointed out that better is one’s adjustment more is his sense of subjective well being.

In respect of Denial the variable (3.g) a less significant and negative correlation was found with sense of subjective well being. The implication was that more one tries to deny the reality while coping with the problem less was his sense of subjective well being. (Vide table 5.3.i)

While applying SMRA to the data the beta coefficient yielded important information (Vide .5.3.ii). Thus psychiatric morbidity contributed negatively to the sense of subjective well being of Orthopaedically Handicapped Subjects.

The beta coefficient for adjustment was positive revealing that adjustment contributed positively to sense of subjective well being of orthopaedically handicapped subjects. No sub dimension of coping contributed significantly to sense of subjective well being.

Psychiatric morbidity and adjustment together contributed to 43.4% variance of sense of subjective well being. The remaining variance might have been caused by other factors not included in the present study.
CONCLUSION:

In order to comprehensibly assess the impact of and response to disability, it is important to understand not only the level of impact experienced in different areas of life, but the importance placed upon these areas by the individual.

Rehabilitation counselors should explore the clients’ experience in the domains of mental health, physical health, family relations, social relations, relationship with partner or spouse, economic situation, leisure activity, and the religious or spiritual domain. Information about the client’s experiences in each of these domains needs to be frequently discussed as a part of the intake (in any rehabilitation program) interview, such information must be organized in a way that allows for the prioritizing of interventions. For e.g if work is discovered to be highly central for a client and is also highly affected by the disability or illness, counselors may prioritize addressing work related problems over concerns in less central areas. If however, family relations are of primary importance and are currently being significantly impacted, it is important that this area receive counseling attention. Indeed, until these more important issues are addressed it is less likely that vocational planning will be successful. However, the process is not so simple, complications being inducted into it by experience of phantom pain (Geertzen et.al. 2005) and disturbed charm of family life (Singhi et. al, 1990; Mukherjee, 2005).

Bearing in mind that “handicap” is the limitation imposed by social and psychological reaction to the disabled condition, it maybe reported that a disability does not necessarily imply a handicap (Craighead and Nemeroff, 2001). Besides, it may be pointed out after Mac Millan (2003) that an Orthopaedically Handicapped condition is primarily concerned with medical problems which inhibits or restrict the normal physical capability to manipulate limbs and body parts to perform gracefully. The findings have revealed that the Orthopaedically disabled person have acquired further handicapped ness secondarily — which are rooted in socio-cultural and psychological matrices of life. This is specially manifested in Maguire and Parkes (1998) writings. They wrote that loss of body parts and grief caused by the death of a loved person is only too apparent. People with either of these losses were pre-occupied with this feeling of loved: bereaved people were missing the lost person and
the amputees were missing the loss of physical attractiveness (loss of body image) or the occupational and other physical functions that could no longer be carried out (loss of function) or both of these. Both groups reported having clear visual memories of the lost person or part and may had a strong sense of their persistence presence. This was most pronounced in the amputees as the “phantom limb”. As time passed both the phantom limb and the phantom spouse tended to dwindle in significance. In the case of amputee the phantom limb seem to merge with the prosthesis. Both before and after amputation, impairment of mobility give rise to anxiety or depression which, in turn, delayed rehabilitation.

The hard truth which surfaced from the very beginning of the study is that there remains an all pervading sense of hopelessness, despair, pain and agony in the trauma victims which get enhanced after amputation by the absence of any formal psychological help structure in the government hospitals where such victims were brought from the accident sites and get admitted in the hospitals. The Decade of the Disabled Persons in Asia and the Pacific (1993-2002) has ended (immediately after which the presence study was designed). Most unfortunately decade has ended but with little impression in the minds of the people concerned with rehabilitation in this part of the country and little improvement in the plight of the trauma victims. Another point which surfaced there must be some formal psychological help being made available to them so that besides their physical pain and discomfort their mental agony must be handled properly since their injury had occurred only after that it might be possible to create an urge within the leg amputees to be useful and effective for themselves as well as for the society.

Thus, it is a high time to remove the psycho-social barriers (Mukherjee, 2005; Mukherjee et.al. 2008; Gray, 2008).

Rehabilitation here encompasses those medical and occupational activities which enable disabled or handicapped persons to live independently and gain or regain the necessary skills for employment. But occupational rehabilitation must proceed together with medical and psychological rehabilitation as part of the same reahabilitational approach to render it holistic.
SUGGESTIONS:

In Kolkata or in West Bengal effort is essentially needed to build up a group of Occupational physicians and a group of clinical psychologists who have unrivalled opportunities to provide co-ordination between medical, social and vocational rehabilitation schemes and to facilitate the entry or return of those orthopaedically disabled or handicapped into the work environment. Government have to take necessary steps to make their services easily available (at low cost), the disabled or handicapped to get pertinent information (to prevent their harassment).

The said medical rehabilitation team has to incorporate the skills of various health care workers, for e.g Doctors, nurses, physiotherapists along with techniques like reconstructive surgery and the use of prosthetic and other electronic aids—appropriate to the physical and mental capacities of the disabled / handicapped concerned. To restore self image, self confidence, self esteem and mental health of the vocationally trained orthopaedically handicapped / disabled worker the need for occupational counseling has been advocated by several experts. The local authorities need to focus their attention upon creating occupational counseling network in the city and the state under the directive of the authorities of the Employment Bureau for the Handicapped and of the Sheltered Workshop (meant for the training).

In fine it has to be borne in mind that in the decade of the Disabled Persons in Asia and the Pacific (1993-2002) funds have been released and obligations to implement the Agenda for Action for the Asian and Pacific Decade of Disabled Persons – Integration of the handicapped with equal rights in the community. For the aforesaid purpose, all efforts be given to make them useful and effective for themselves and their society. To achieve the said target, local Government have not only to develop skilled man-power (Human resource) for the vocational training in sheltered workshops and in usual establishments and work with not-disabled people for restoring their self-esteem, mental health and quality of work life but at the same time should strive for letting the trauma victims feel that they are not alone in their plight—they have someone to lean upon and lend a patient and supportive listening to them.
Without defending the lapses in a true program for their rehabilitation by the plea of "high cost" or "no money", local authorities have to encourage local experts to accelerate information exchange on the production of low cost, high quality and culturally appropriate assistive devices to facilitate the participation of people with disabilities or handicaps in economic and social activities--where the beneficiaries may get an advantage to get employment or receive education, as priority.

Therefore, another suggestion which automatically surfaced itself was that enough number of clinical psychologist be trained for counseling trauma victims and be present within the hospitals set up right from the very beginning where the victims are brought to emergency wards up to the moment they are reunited with the community life and become independent. Such counselors can assist clients in their adaptation process by

i) helping clients to experience increase control over their own feelings and life.

ii) by exploring avenues for increasing satisfaction in various domains of life, the domains being different from the earlier ones prior to the trauma.

In order to effectively manage an acquired disability one must become knowledgeable about, and a participant in one’s own care. Self management means that the amputee is an active and informed participant in the relationship with health care provider, adheres to and understands treatment regiments, and communicate adverse effects and questions. From the counselors perspective this involves helping the client:

a) To actively monitor and evaluate physical and psychological well being and

b) To be knowledgeable about their condition and its treatment.

Counselors may also increase the amputees sense of control by helping him to first clarify and then reach domain- specific goals such as if the client experiences little control over social relationship the counselor may imply social skills training to increase his confidence and competence in social skill besides helping to identify opportunities for social interactions. Also it involves promoting success by initially developing measurable and achievable sub goals and encouraging the client for
successful efforts. The process of adaptation can be further helped by identifying functional and environmental accommodation at work or at home as well as evaluate the range and form of their participations in life domains i.e by assisting the client to develop new interest, new social outlets and new ways of engagements with life, thereby increasing the importance of or satisfaction within peripheral domains.

Lastly, while helping the amputee to return to main stream of life in a new way the present researcher thought that it will be better to remember at every stage of the helping process that acquired disability is so pervasive, powerful and all encompassing that coping with, challenging and overcoming it cannot be left to chance. The reasons are as follows: Unlike persons with congenital disabilities persons who experience acquired disability finds the sense of self suddenly and dramatically challenged or altered. As such they face significant changes in their social and familial relationships and life roles while dealing concurrently with psychological distress, physical pain, prolonged medical treatment and gradually increasing interference in or restriction of the performance of the daily activities. Applying this understanding of how people navigate this process of adapting to acquired disability related changes and applying this understanding in the form of effective clinical interventions is an important focus of counseling in the rehabilitation process. (Bishop, 2000).

**Limitations of the study**

1) Because of enormous difficulty in approaching leg amputee in hospitals and other facilities the researcher had to restrict herself to purposive sampling which is a non probability sampling technique.

2) Due to the fact that leg amputees had to be interviewed as they arrive in the indoor facility of hospitals no control could be exercised on the level of amputation (Some were Trans femoral while others were transtibial amputees). Also no control could be exercised over site of limb amputation some were right leg amputees while some were left leg amputees.

3) The study was conducted upon the urban population only.
4) Both sexes were not included within the sample. Only male amputees were taken into considerations.

5) The study is internally valid only.

Lastly, a few thoughts arose in mind of the present researcher: she fondly hoped that including both males and females in rural as well as urban settings, using a probabilistic sampling procedure and extending the scope of the study to other major parts of India would undoubtedly enhance the external validity of the study (Zaltman and Burger, 1975).