Chapter XI
CHAPTER XI

CONCLUSIONS

The discussion in the previous chapters now bring forth the conclusions. The chapter is divided into three parts, beginning with the examination of the extent to which the research has been able to achieve the objectives of the study, the emergence of hypotheses that can be tested in future and recommendations for further study.

The following objectives were finalized for the study.

Objectives of the Study

1. To record and analyse case data from the eight settings mentioned.

2. To classify data according to types of intervention viz. crisis intervention, crisis score, time of referral, source of referral, year of intervention, age, gender, problem referral, techniques of intervention etc.

3. To correlate different variables and define the hypothesis as they emerge from statistical data analysis.
The researcher did not make any ambitious research plans as she was not confident of the outcomes of the data available for the study. The main purpose of the research was to test out if the intervention undertaken has a scientific basis or has been only an activity carried out on intuition. The correlations obtained from objective 2 above prove that the intervention does have a scientific base. The intervention has been an outcome of internalisation of the training inputs received by the Researcher during training at Tata Institute of Social Sciences.

Analysis of the 102 cases was done primarily with the use of the qualitative techniques and methods in social work and the qualitative data analysis appears at the end of every case discussed in the study. New variables were constructed in order to interpret the data. Cross-tabulation of the quantified qualitative variables brought very encouraging results and the researcher feels that the modest objectives finalized for the study have been successfully achieved.

The cases were classified primarily for placement within the quota sample and controls. Later, the chapter on socio-demographic characteristics gives varied classification according to the stages in human family life cycle defined by Evelyn Duwall. This classification confirms that the cases are drawn from the highest number of possible age-groups and stages in life cycle. The sample also represents the
various social problems discussed by Dr G.R. Madan’ in his book "Indian Social Problems". The facts within the cases clearly reveal some of the problem areas resolved successfully by social work intervention. Social workers are recognized as agents of change and the analysis proves that the various intervention techniques brought about desirable changes in clients and their social situations.

As the cases are spread over forty years and eight different settings, the nature of social work intervention required by different settings has also become clearer. The variety of settings added to the dimension of this study. The opportunity to work in a variety of settings clarifies the different functions of social workers. Expectations by society from social work practice get more clarity if one social worker gets the opportunity of working in various settings. The insights, methods and skills described in text books are out to test by practice in more than one setting. All the settings are secondary settings of social work. Expectations from social work practice get clear to Industrial settings if practice illustrates effective solutions to human problems that interfere with the process of production. The book written by Pearson and English titled "Problems of emotional living" discussed in detail the problems faced by growing children. Most of the cases in this study reveal problems of young adulthood in sickness or in work situations. Mostly the problems trouble the administrators and superiors in the
workplace. The other side of the coin being the subordinate, social work reveals the reality of the so-called "problem" persons. Placing this fact before the Administrator facilitates correct decision making and in Industry, social work intervention eases out a large number of problems in Industrial relations. Social work thus goes a long way in ensuring Industrial peace. The researcher was able to establish a sound rapport with the Union Leaders by helping workmen and apprentices in their personal, family or health problems. This created an environment of trust when the employees realized that Management have recruited a social worker who visualises and presents the human side of Industry to the administrators. Her intervention eases out the embarrassment of the management before taking any extreme action that may in the long run damage good work relationships. The union leaders appreciated the personal care taken by the social worker during trying situations. The assurance that an aged relative or an infant son or daughter is being given expert medical attention when the social worker refers such cases to the right medical expert, at times she also generates awareness in the workman that it is not worth spending huge amounts of money on cases that have no hope. A person who has the courage needs and support given to withdraw costly medical care for an irrecoverable condition. Timely action and accuracy of diagnosis: both medical and social have saved many situations that could otherwise go out of hands. The preventive areas of intervention have also emerged from this study.
There were a few research questions raised by the researcher in the research proposal. They are-

1. To what extent can these intervention strategies be termed as a professional social work thrust?
   This question is answered by the tables and statistical test results presented in the report.

2. Is the professional community willing to authenticate the innovation and the essential diversion from certain established norms and code of professional ethic?
   1. Is the ethical basis of decisions taken under critical conditions acceptable to the profession of Social Work?
   2. Can the outcome of the arguments for and against some actions and decisions determine a workable modification of the code of professional ethic?

These questions will be best answered during the open defence of this work at which I expect an open discussion on some of the cases and events that appear in the Abstract.
During her service tenure, the researcher had been writing about her experience and cases in professional journals and the House magazine of Thermax. This documented material kept her in touch with analysis and presentations. Not much of social work practice literature has been written or published by practitioners in India. As the researcher had this habit, the evidence of authentic work of this study is supported by the published matter. The material gave information to the workers at Thermax and this resulted in many of them referring their own problems, to her. Articulating the work done keeps the practitioner aware of the outcome of social work practice.

As mentioned earlier this is a qualitative research than a quantitative one, though the researcher has taken the help of statistical interpretations and quantification of qualitative data.

Qualitative researchers attempt to understand meanings that people give to their deeds or to phenomena. In other words, researchers see people from the inside. For example, when you conduct interviews with users of a residential care hospital for people with physical disabilities, you will have pictures of how they feel about lives in the hospital. How do they think of staying or working at the place? What sort or limitations do they notice about it? How do they deal with conflicts with care workers and other patients? What tacit rules cover their human relations? Such
questions would be very interesting for social workers who want to improve their services from the viewpoints of the users.

Quantitative researchers may be able to do surveys without direct contact with research dealt with in this report.

It is essential for qualitative researchers to be aware of the influence of philosophy on strategies of research, because without knowledge of related philosophy, they are apt to be confused when analysing qualitative data. (What we mean by philosophy is) views about how to recognise things that are to be researched. Much has been written regarding the ways in which philosophical positions feed through to influence approaches to qualitative research. Four philosophical paradigms have been identified. They include positivism, post-positivism, critical theory, and constructivism (Guba & Lincoln, 1994).

Medico-social work is regarded as work in a secondary setting. The practice of medicine or Psychiatry is undoubtedly the main activity of hospitals. Yet a secondary setting does not mean a secondary position of the profession in hospital settings. The social worker does not wait for the doctor's orders to carry out her professional responsibility, as a nurse is obliged to do. While the nurse is expected to carry out the
doctor's orders, a Medico-social worker may initiate an action which is subsequently taken over by the doctor.

Table 11.1
Problem at Referral

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Problem</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Poor job performance</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>Behaviour problem</td>
<td>16</td>
<td>15.7</td>
</tr>
<tr>
<td>3</td>
<td>Nuisance to organisation</td>
<td>7</td>
<td>6.9</td>
</tr>
<tr>
<td>4</td>
<td>Treatment</td>
<td>39</td>
<td>38.2</td>
</tr>
<tr>
<td>5</td>
<td>Institutionalisation</td>
<td>21</td>
<td>20.6</td>
</tr>
<tr>
<td>6</td>
<td>Discharge</td>
<td>9</td>
<td>8.8</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>96</strong></td>
<td><strong>93.2</strong></td>
</tr>
</tbody>
</table>

After referring the problem to the social worker, the nature of support from the organisation for further action is not always uniform, as will be seen in the following table:
Thus the required positive support was given by the agency amounts to 55.9 percent. This means that the social worker has to equally develop alternate, support systems. 17.6 is a notable frequency where the organisation does refer a case and thereafter totally withdraw its support. The clients cannot be then left without help because the agency is not extending any support. In the interest of the client the worker must find out other alternatives in the community to prevent clients' total breakdown. Some of these cases are from Thermax where despite giving all possible help the client has not shown any improvement hence the Company has to perforce terminate the services of such a client.

Some research questions raised at the beginning of this report are

1. To what extent can these intervention strategies be termed as a professional social work thrust?
2. Is the professional community willing to authenticate the innovation and the essential diversion from certain established norms and code of professional ethic?

1. Is the ethical basis of decisions taken under critical conditions acceptable to the profession of Social Work?

2. Can the outcome of the arguments for and against some actions and decisions determine a workable modification of the code of professional ethic?

Working in critical situations will not be free of controversies. The controversy itself is the test of authentic work.

Let us now try and find the answers after a detailed analysis of case data. The conclusions are a product of analysis of empirical qualitative and statistical data. This chapter will include the hypotheses that emerge from statistical analysis and common factors that emerge from the qualitative analysis of case data.

Dehumanisation in medical/clinical practice is very common in a highly populated country ridden by poverty and lack of resistance among poor ignorant and illiterate patients who come for social assistance helplessly.
‘This is not my job’ is a convenient stand of many MPSW’s. Actually they are afraid of exercising their professional authority in interdisciplinary practice. Alertness and memory are essential while working in crowded clinical settings.

In Indian practice the social worker has used herself as resource in 65-70% cases.

Setting does not consider age. However, the nature of intervention has been strongly influenced by the setting (Table 6.3 P. 299, 6.4 P. 300, 6.5 P.301 & 6.6 P. 302 Chapter VI - Process Analysis).

Agencies are so poorly developed from social angle that Indian social workers must develop themselves a mark Emphasis on clinical diagnosis.

The outcome of follow up is presented in the section of adoption. It is more of a positive feedback from an adopted child now into adulthood.

Table 3.18 indicates that social workers must develop the ability of intervention of problems experienced by clients between one and five years. It is either lack of awareness of available service, reluctance to
seek help or significant degree of endurance for physical or social problems affecting individuals.

Expertise in situational analysis is demanded in systems change (Table 6.2 P. 298)

Maximum recurrence of intervention is in work with individuals (86 per cent) and families (70 per cent) in every setting. 18 per cent of cases involved work with significant others, in addition to families. In 71 per cent cases work is done with administration.

One more area of competence demanded from workers is the ability to plan intervention (Table 6.14 P. 316). The maximum demand from clients and settings is for outreach, mobilisation and consultancy.

The researcher has worked with professionals other than social worker in all settings. Use of a combination of different methods is also required in each setting (Table 6.10 P. 309) It is not possible to restrict intervention with any one method of social work in isolation.

The Researcher has played a variety of professional roles as demanded by the clinical situation.
As agents of change, social workers must direct services towards systems and not clients (Table 6.12 P. 313)

Age is an influential variable in client response to intervention. Suicide intervention demands work for behavioural change and direction towards facilitation to live.

Systems change demands direct service. Holistic approach is used in all problems at referral except discharge (Table 6.38 P. 356) Organisational support and working close to legal systems are conducive to effectiveness of social work intervention.

Client’s problem solving ability and nature of intervention are not correlated (Table 6.62 P. 401)

- Services are not rendered according to stage of development
  Table 3.33 P. 3.34
- Systems change takes family systems
- Situations in account
- Client’s education influences his problem solving ability (Table 6.66 P. 407).
- Client response is not related

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Medical Social Service

Standards in Medical Social Service

The primary objective of each medical institution is to give adequate care to each patient. The institution recognizes the dependence of the physician on the personnel and facilitates within the hospital and in the community and seeks to give a rounded kind of service which will help each patient to secure the maximum of benefit from the physician's knowledge and skill and from its resources. Standards of service rendered by medical social service departments may be said, therefore, to be bounded on the east by the quality of the professional medical care, on the west by the adequate social service staff, on the south by the general standards of living and social endeavor within the community, on the north by the adequacy of the programmes and the performance of the social agencies in the community.

To elaborate this a bit, one sees the social service department as a part of the hospital and also of the community. The interdependence of this department and other departments within the hospital is such that unless all are of high quality the social service department is itself handicapped in rendering a service of high quality. If the community is lacking in facilities for various kinds of services to individual patients and families, the social
worker in the hospital is again prevented from helping to meet the need of the patient in a truly adequate way.

Communities vary in the completeness of their social and health programmes and these affect not only the adequacy of the service rendered by the hospital social worker but in some measures definitely influence his/her practice. Nevertheless with all these variances and with a full awareness that each patient presents a different medical and social situation, which requires an individualized approach, it is possible to define with reasonable clarity the functions of medical social worker. The activities in which the social service department may appropriately engage and which should be developed in close collaboration with the medical staff are the following

1) practice of medical social case work.
2) development of medical social program within the medical institution.
3) participation in the development of social and health programmes in the community.
4) participation in the educational program for professional personnel.
5) medical social research.
The practice of medical social case work is the core of the department's activities, so it is important to consider first what is meant by this phrase. Medical social case work involves the study of the individual patient's social situation, interests and needs in relation to his illness and the medical social treatment of the patient in collaboration with him and his physician when those social needs and interests affect the physical and mental health of the patient.

a) Inquiry into the social situation of hospital patients and the reporting of findings to the responsible physician.

b) Determining, in collaboration with the physician, the factors in the social situation pertinent to the patient's health and stating these as medical social problems or diagnoses.

c) Setting up, in collaboration with the physician, a possible goal or best estate for patient to aim for, given the medical problems and the social situation of patient and distinguishing the role the social worker is to play in plan for helping patient achieve the goal.

d) Executing the social worker's part in the plan for helping patient achieve his best estate.
Putting these points together again we may say that the social worker's job is to help the patient make the best adjustment possible in the face of his situation (medical and social) in order to prevent his being socially disabled.

There are workers who, not thoroughly understanding just where their duties begin and end, failing to learn or regard lines of authority in hospital organisation, get hopelessly in the bad favor of resident physicians and nurses by seeming to meddle aimlessly in the business of getting the patient well. And there is the social worker who typifies the majority of his/her profession - who possess adequate education, tact and native judgment, quietly but efficiently performs the work of her hospital specialty so that all quickly recognize her true worth to her institution. When executives, doctors and social workers labor together a great goal results from intelligent cooperative teamwork. What are the basic causes for the unfortunate and to the patient, most serious lack of mutual understanding?

1. A lack of knowledge on the part of hospital executives of the aims and methods of the modern well-trained social worker; or what is even worse, the presence of a preconceived conviction as to the doubtful value of the practice of social medicine in the hospital.
2. A lack of understanding, or observance on the part of the worker as to the organisation, lines of authority and methods of conducting the daily work of the hospital.

3. Improper organisation of the hospital in so far as the social service department is concerned.

4. Lastly, a lack of on the part of both of certain basic qualities such as tact, administrative ability and pliability, which should be inherent and the absence of which serves to make the executive hasty and arrogant or the social worker restive or insubordinate under the authority of the former.

No wise hospital executive displays any suggestion of arrogance toward any of the hospital's personnel, for the administrator has but coordinating and not in the least kingly prerogatives. Of course the head of any department must expect direction from the institutional head as to general principles and policies. On the other hand, no executive of wisdom and experience would attempt to meddle in so far as the actual work of a specialty such as the social service department is concerned.

If the hospital social service department is to be judged solely on the basis of the actual money, which it returns to the hospital, as compared with its
cost, it is a dead failure. If the hospital superintendent persists in making this balance sheet his only basis for estimating this department's value to his hospital, he is just as dead and equally as great a failure, administratively. But there is no social service department, well staffed and salaried, which is not saving its community and its hospital many times its expense in other ways. The social worker can prove that she is financially worthwhile. The superintendent can do much to make the work of the social service department of most aid to the doctor. He can insist on well-trained workers and pay them living salaries. He can provide dignified quarters for officers and adequate furnishing therefore. He can recommend that this department be properly placed in the hospital organisation and that lines of authority toward and from it are adhered to. He can support the directors in intra-departmental discipline and free her department from duties, which do not rightfully belong there. He can encourage the staff to use and understand this department.

But the unfortunate part is that the authorities do not have the knowledge of the duties and importance of the Medical Social Worker. She not only helps the patients but also helps the administration to keep good public relations. Thus she helps indirectly to maintain the reputation of the Hospital in a positive manner. But her services are not recognized by the Hospital authorities.
There is considerable lack of clarity among social work functionaries about their task, role and functions. Often, every term mentioned above is combined by social work practitioners as the ‘Role of the social worker’. The case illustrations facilitated to bring a clear distinction between each of the above terms. Each of the cases have clarified the task of the social worker in the case and the situational analysis. In fact one of the sub-sections of medico-social diagnosis is the task that is carved out in each case. Task performance highlights the clarity in the worker's thinking and her professional contribution to the client's medico-social situation. The Professional function of the social worker is a much broader term synthesizing the variety of tasks performed, analytical ability exercised in every situation and the use of social diagnosis in execution of every task.

Social Work Functions.

At the beginning of the worker's professional career, Dr Mendonca, the then Dean of BJMC had asked her to record the functions of a Medico-Social worker. The list of social work functions identified in her reply to the Dean's letter are recorded in Appendix III.2, P. 2. The vision of the Head of an Institution contributes a great deal to the clarity related to task and functions. Once such record is created, it gives an official status to social work practice, thereby increasing the authenticity and utility of Medico-Social Work in Government Hospitals. Acceptance of the social
work function by the partners from the medical and paramedical team will give a distinct status to professional social work practice. The visibility of the social worker and the professional functions of the social workers will add the required meaning to the day-to-day work of the social worker. This is not to say that social workers do not contribute to the success of medical practice, but many of them are disappointed that their work is not recognized. A very pessimistic article had appeared in the Illustrated Weekly of India around the year 1970, titled 'the plight of Medico-Social work in India'. While it stated that the profession hardly got any recognition, which is a fact, no one has examined why the profession has not made an impact on the medical setting in India. The visibility of other professions like nursing and physiotherapy increased due to the contribution made by these professions to medical practice. It must be noted that these professions are looked upon by the medical professionals as assisting and supporting professions to medical practice, while Medico-Social Work is still looked upon as an independent profession and that the professional worker is not an assistant to the Doctor but as an independent functionary, as the writing of the renowned medical practitioners have stated in chapter X. It must be noted that these professions are looked important in the Hospital. Without their active role, the patient's care and treatment are not complete.
Case No 22 Page 212 illustrates the part played by social workers as their civic and legal responsibility. We thus have to add two more functions of the social worker to the list.

1. To participate in social advocacy of the clients in family, medical and social settings like voluntary institutions, patients' families and other concerned professionals

2. To appear in courts as witness in critical situations and give evidence in the legal proceedings

3. To prepare material for LAQ's, wherever necessary, bearing in mind the legal obligations and socio-legal and human aspects of the concerned event that invited the LAQ

4. To take part in medical situations involving promotion of the contingent human and economic situations e.g. establishing the futility of blood donation to a terminally sick destitute whose surgery was ordered by a cancer surgeon.

The case illustrations facilitated further clarification of the social work functions. Quite often, social work professionals declare that a certain action is not a social work function. Case Nos. 21 & 22 bring out the
realities of the client world. Realities can go to any limit. If the social worker had not taken the risk even at hazards to herself as a person, the depth of social work function could not have become clear to practitioners. For every profession, the interest of the client is a prime responsibility. The social workers need to develop greater sensitivity and clearer understanding of the worlds of clients. This understanding must be synthesised with mathematical thinking which can only be promoted by research.

**Ethical Battles and Controversies**

The contribution of the social worker in these stormy and delicate situations that involve interdisciplinary elbowing in complex organisations (Ref article by Chales Perrow in Amitai Etzioni ed ‘Complex Organisations’). In such events the professional conviction of the social worker is put to test. If these events are not brought on record, social work professionals will fail in their accountability to the social work profession. The surgeon was sensitive to her perception that the social worker is wrongly stepping into the function of diagnosis of an established profession of surgery. As mentioned earlier, the lines of demarcation between two complimentary professions at times appear hazy. They can be made distinct by such case illustrations.
Expected areas of competence of the Medical & Psychiatric Social Workers

Apart from the task, role and function related concerns, one more area viz. competence needs to be considered in MPSW. (Medical & Psychiatric Social Work)

Medical situations to be raced by the hospital staff demand distinct levels of competence. While patients struggle between life and death, the medical team is struggling with updated knowledge and skill inputs to critical situations. Medical emergencies are charged with crisis situations. Quick and accurate decision making is demanded from every related discipline and social work cannot remain an exception. For the families of patients, critical illness is emotionally charged, at times the intensity leads to a total breakdown. Areas of social competence need to be listed and compiled.

Medical information must be obtained in detail. The terms used by doctors must be quickly grasped by the social worker. The complementality of functions needs to be interwoven.

This study is confined only to secondary settings of social work practice. It is likely that presentations of case data from primary settings like

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family counseling centers, adoption agencies, etc. may make an altogether different presentation of the characteristics of clients and types of interventions.

The demand from every setting is for the function of planning for intervention. This emerges from the analysis of table No. 6.8 P. 306, 6.12 P. 313, 6.13 P. 315, 6.14 P. 316 'Roles of Social Worker in a variety of settings.'

The study has made an effort at classifying the role, task and function of social workers in mutually exclusive categories. Post facto evaluation gives a prediction for future professional intervention. Most of the cross-tabulation with statistical tests of correlations have led to very conclusive findings.

While Medical settings demand situational analysis to a large extent, the settings caring for chronic conditions like leprosy and mental challenge do not seem to involve any situational analysis. It is surprising that while situational analysis was indicated at the mental hospital, the two cases at MIMH (Table No. 6.9 P. 308), Chapter 'Intervention' did not invite this need. Possibly two cases is too small a sample to determine the need of this form of intervention.

1. Table No. 3.26
2. Intervention by gender - Table 3.25
   Intervention did not have any gender bias.

3. Gradually the acceptance of human rights philosophy is definitely present.

4. Table 3.31 - There is a strong correlation between settings and organisational problems.

5. Table 3.32 - Social problems are correctly referred to the various settings.

While the human rights philosophy is gradually accepted by organisations there is no evidence of human rights in the social institutions of family marriage caste etc. as observed in the case studies (Chapter IV).

The researcher now makes an effort to examine the established definitions of social work. The following definition of social work was downloaded from the internet in 2004.

**Social Work**, professional activity aimed generally at enriching and enhancing individual and group development or at alleviating adverse social and economic conditions. Its practitioners work to provide care for abused or neglected children; rehabilitate the physically, mentally, or emotionally handicapped; and extend financial aid to the poor and the
aged. Social workers also carry out treatment, counseling, and direct-service activities to help those individuals with mental and emotional disorders, to help rehabilitate those with disabilities, or to provide preventive services.

Formerly, all forms of philanthropic and charitable activities, including those of untrained, civic-minded individuals/ were regarded as social work. Such activities focused primarily on solving the immediate problems of the indigent and did little to change the conditions that caused those problems. More recently, however, a vast amount of new social research has made possible analyses of the social and economic maladjustments of modern society, and the activities of social workers have been coordinated in an effort to achieve the maximum possible benefit both for those individuals who are in need and for the entire community.

Types of Social Workers

Social workers may be employed in varied settings. Social caseworkers deal directly with the individual or the family. They work in family-service agencies, medical and psychiatric hospitals and clinics, public agencies, substance-abuse clinics, and industrial settings. In the last two decades, there has been a trend toward professionals working in private practice rather than in the nonprofit or public sector. After determining the nature of
The client's problem, the clinical social worker tries to help the person overcome these difficulties or obtain appropriate assistance. In recent years the areas of specialisation within social work have increased greatly.

The social group worker is usually concerned with planning or leading activities of large groups of persons. This type of social work is often carried out in recreation centers such as those maintained by the American Red Cross and the Young Men's Christian Association, and in hospitals and other therapeutic settings.

Social planners are social workers who conduct research and help develop social welfare policies, frequently acting as proponents of social legislation. Community organizers act as area-wide coordinators of all the programs of different agencies so as best to meet community needs for health and welfare services. They also facilitate self-help programs initiated by local common-interest groups, for example, by training local leaders to analyze and solve the problems of a community. Community organizers work actively, as do other types of social workers, in community councils of social agencies and in community-action groups. At times the role of community organizers overlaps that of the social planners.

The above definitions appear quite inadequate in terms of the complex nature of interventions described in this study. These definitions will
appear an understatement of the nature of required intervention described in this study.

The above definitions include a discussion on “social work agencies” thereby indicating that social work needs a setting for practice. The description does not do any justice to social work in open settings like village and slum communities as well as work with the varied social systems.

Hence we attempt here to define social work afresh, on the basis of available theories in social sciences.

Theories Related to Social Work

This chapter deals with the relevance of theory to this research. The pioneering book that gave theoretical perspectives to Social Work was published in 1897. Mary Richmond's book ‘Social Diagnosis’ is the first work that pointed to client centeredness. The book ‘Client centered Therapy’ by Carl Rogers was published much later in 1905, Soon afterwards we see the development of Psychometry and sociometry. Richmond spoke of the client centered approach and a holistic view of the client's world in the first book of social casework. While Rogers concentrates on Psychological insights into the operations of the human mind, Richmond gave insights into the ‘Friendly visitors’ responsibility...
of understanding the totality of clients' world. Dora Goldstein in her work of Medical Social Work emphasizes the situation of the clients in various disease conditions, retaining the agency environment at the center of the discussion. Therapeutics in clinical settings have been a recurrent concern of several theorists. The later works of Gordon Hamilton clarify the supportive and modificatory techniques of intervention, articulating the thrust of social casework practice with the incorporation of psychoanalytical methods in social casework. Around the same time the principles of social casework and social Group Work have been articulated by way of recurrence of outcomes of the practice of the two methods. Social Work started incorporating the development of Psychology, sociology, social pathology and Medical sciences in its arena of practice. The adoption of the study-diagnosis-treatment procedures in clinical social work is a definite evidence of the incorporation of the medical model in social work. In 1949, Florence Hollis gave a decisive mathematical form to the classification of methods of social work treatment. She classifies the methods of treatment as sustaining procedures, procedures of direct influence, catharsis and reflective procedures in casework treatment.

The main difference between Social Work theory and other theories is that Social Work profession concentrates on the technologies of intervention. The theories relate to change in any undesired situation or
behavioral changes in individual or change in oppressive social systems. 

Intervention is the essence of social work theory. A well known criticism of social work profession is that social workers tend to generalize on the basis of a limited number of case illustrations. Many find the social work methods abstract and difficult to put into action. What is required of social workers is the ability to internalize formal training and develop effective thrusts specially designed for every unique individual, group or psychosocial situation.

Social work theory must facilitate study, social diagnosis, situational analysis and the treatment thrust in any unpredictable person-situation configuration.

The developments in the social sciences offer a more sound base to social work practice, adding to the holistic approach and integrated models of practice. Psychometry, sociometry have been auxiliary techniques offering greater possibility of measurement and accuracy. While Psychology, Psychiatry, Psychoanalysis, Psychometry and sociometry offer possibilities of more sophisticated measurement to practice, most of these practices are more or less restricted to clinical and laboratory settings. The practice of professional social work in the West almost assumes practices within well defined and sophisticated clinical settings. While organisations developed well in the westernized practice bases, the
third world scenario makes distinctly different demand on the practice skills of social workers. The ethos of the third world, challenged by poverty, ignorance, illiteracy, over-population and gender discrimination is a different challenge to the agents of change. Social activism has demonstrated yet another ideology and an economical model of practice, making the environment itself a huge laboratory, with little sophisticated equipment and no boundary of work.

Integrated social work methodology became a need of the third world clientele, with its complex and imperceptible human situations, a majority of client population not capable of accessing secure and sophisticated laboratory facility. Increased need for workable models of practice in open settings creates a fresh demand for innovative intervention

Techniques from social work practitioners. Table No. 6.11 P. 311 proves that integration of methods and techniques of intervention is more effective in Indian settings. The social worker in India has very limited facility for referrals to appropriate agencies delivering required specific services. Our service delivery systems are not equipped to attend to a huge clientele with multiple needs and almost no means to recruit services. More than this, they do not possess the competence to use or order the service they need. The client covered by social insurance is
aware of his needs and can clearly articulate his demand, while the poor ignorant and baffled Indian clientele cannot access even available service for want of social and economic resource to say nothing of its total lack of awareness of any form of help available within the social assistance net. Often the culture gap between the client and the service provider makes the client drop out of organised treatment centers. Developments in the social sciences have provided good insights to social workers and explain the social phenomena rationally.

Outcomes of Field Data

Some important gender issues emerge from the study.

1. **Social Work Intervention:**

   1. Men prove to be less amenable to change and are unwilling to respond to interventions all by themselves in isolation, while women are willing to accept counseling individually (see Table 6.2, P. 298)

   2. The researcher had to take recourse to institutional placement in only 12.7 per cent cases (Table 6.1 P. 297). This social work intervention has succeeded in rehabilitation in the community rather than permanent institutional placement. Thus professional intervention has effectively reduced the burden on closed institutions.
3. The Researcher has used holistic approach in problem solving in 54 or 53.5 per cent cases analysed in this study. Thus the holistic approach proves more effective than focused problem solving discussed by Perlman.

4. The nature of intervention is significantly influenced by the setting of social work practice (Table 6.3, P. 299).

5. It is not possible to entirely use any organised resource for effective intervention. In Indian settings, the worker is compelled to make conscious use of self as resource as the organisations are not sensitive to clients’ needs to a desired result (Table No. 6.4 P.300).

6. Age and gender are not correlated to social work intervention.

7. Table 6.20 proves that the social worker has had no gender bias or preference.

8. Table 6.21 indicates that the social worker has followed the principle of resource utilisation throughout, over four decades of her practice.

9. The function of planning intervention has been put in practice in 87.3 per cent cases.

10. The variable of age significantly influences response to social work intervention.

(570)
11. while the problem at referral does not influence the duration of social work intervention (Table 6.27 P. 338), the "place" or agency at which the intervention was carried out (Table 6.33, P.347)

12. One term that social workers seem to use quite frequently is the term 'Role'. We often see that this creates vagaries and confusion in the operational area and clarity of role perception of professional social workers. The term ‘Role’ must be strictly used to define/describe the professional role. This will go a long way in making an assessment of the contribution made to service to clientele in any situation or agency.

The question of evaluation of profession competence and effectiveness of social work practice must be an essential factor to the performance appraisal of a social worker employed in any organisation, whether it is a primary or a secondary setting for social work practice.

In tact this entire research is devoted to a professional evaluation of forty years practice in various settings.

13. There is no correlation between intervention with help of co-laterals and the agency setting (Table 6.12, P. 313 )

14. While agencies recognise the human rights of clients quite objectively (Table 3.31 )
15. The clients make misuse of this right in a glaring proportion of 62.7 per cent cases. The subjective orientation of clients to their problems is obvious.

The Client and Intervention

Suffering a personal problem without seeking any external help is a personal value nurtured by Indians. This makes problem resolution prolonged and complex. The client gets conditioned to a form of unsuccessful repression of a certain problem. Intervention is directed towards first deconditioning the client and then offering a realistic problem resolution. A client who is used to faulty adaptation over very long takes much longer time for deconditioning and fresh adaptation to realistic problem solving. Suffering not only becomes a value but also enjoyed by the person for personal gratification or attention seeking.

Review of utility of MPSW in clinical setting

Hypothesis: Organisational support through the decades shows a positive correlation to social work practice.
### Chart – III
Emerging Hypotheses

<table>
<thead>
<tr>
<th>No</th>
<th>Variable 1</th>
<th>Variable II</th>
<th>Chi Square DF Pearson</th>
<th>Significance</th>
<th>ch.sq DF</th>
<th>Likelihood ratio</th>
<th>Significance</th>
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<td>client corruption</td>
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<td>14</td>
<td>do</td>
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<td>(linear association)</td>
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The above table is compiled in order to record the emerging hypotheses and to examine if there were any stereotypes in the professional practice by the Researcher and to examine if she was biased by any of the variables. The result indicates that the professional effort has been carried out without any bias.

(573 A)
# References

<table>
<thead>
<tr>
<th>Reference</th>
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