PIJPS
ISSN 2456-5180 (ONLINE)
A PEER REVIEWED JOURNAL

# PHONIX INTERNATIONAL JOURNAL FOR PSYCHOLOGY AND SOCIAL SCIENCES

Vol. 2, Issue 2, April 2018


2018

Editor in Chief
Dr. Sunil Kumar Jangir (Ph. D.)

PUBLISHED BY PHONIX INTERVENTION CENTRE, DELHI

http://phonixcentre.in/journal.php
ISSN 2456 - 5180
Mar to April 2018,
Vol. 2 No. 2

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ISSN 2456 - 5180
Mar to April 2018,
Vol. 2 No. 2

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http://phonixcentre.in/journal.php
ISSN 2456 - 5180
Mar to April 2018,
Vol. 2 No. 2

# Academic Self Concept and Emotional Maturity among Students with Learning Disability

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## ABSTRACT

The present study entitled as "Self concept and Emotional maturity among students with learning disability". This study aimed to assess the self concept and emotional maturity among students with learning disability and also to find out the relationship between the variables under the study. Sample consists of 30 students. The present study follows a descriptive research design, survey and interview method were used to collect the data. The instruments used were Academic Self Concept Questionnaire (ASCQ) by Liu and Wang (2005), emotional Maturity Scale by Pal (1984). Carl Pearson correlation and t-test were used for the analysis of data. From the present result it can be concluded that there was found no relationship between academic self concept and emotional maturity among students with learning disability. The students scored low on the variables under the study


***Keywords***: *Academic Self concept, Emotional maturity, Learning disability*

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## INTRODUCTION

Children of today are the citizen of tomorrow and they are going to be the pillars of the country. Hence it is essential to ensure that each pillar is as strong as the other is. There is a possibility that each classroom may have a student with L.D .Learning disabilities refers to a child's or adolescent's deficits in acquiring expected skills in reading, writing, speaking, use of listening, reasoning, or mathematics compared to other children of the same age and intellectual capacity.

Prevalence estimates for learning disability in the general population range between 5 and 9 percent. The rate of incidence of difficulties related to learning can lie between 12 percent and 30 percent of the school population.

Students with learning difficulties have difficulty with reading; writing and/or math are recognizable problems during the school years. Learning disabilities are an "umbrella" term describing a number of other, more specific learning disabilities such as Dyslexia, Dysgraphia, and Dyscalculia.

Dyslexia is a learning disability that affects reading and related language based processing skills. The severity can differ in each individual but can affect reading fluency; decoding, reading comprehension, recall, writing, spelling, and sometimes speech and can exist alone with other related disorders. Dyslexia is sometimes referred to as a language based learning disability.

Dysgraphia is a specific learning disability that affects a person's handwriting ability and fine motor skills. Problems may include illegible hand writing, inconsistent spacing, poor spatial planning on paper, poor spelling and difficulty composing writing as well as thinking and writing at the same time.

Dyscalculia is a specific learning disability that affects a person's ability to understand numbers and to learn math facts. Individuals with this type of LD may also have poor comprehension of math symbols, may struggle with memorizing and organizing numbers, having difficulty telling time, or have trouble with counting.

The symptoms are short attention span, poor memory, difficulty in following directions, inability to discriminate between /or among letters, numerals, or sounds, poorer reading and writing ability, eye hand coordination problems such as poorly coordinated difficulties with sequencing and disorganization and other sensory difficulties.

Other characteristics of learning disabilities are performs differently from day to day, responds inappropriately in many instances, distractible, restless, impulsive, say one thing and means another, difficulty to discipline, doesn't adjust well to change, difficulty in telling time and knowing left and right, difficulty sounding out words, reverse letters, places letters in incorrect sequence, difficulty understanding words and concepts, and /or delayed speech delayed speech development and immature speech. The causes of learning disabilities are not well understood, and sometimes there is no apparent cause for a learning disability. Some causes of neurological impairments are heredity and genetics.

Diagnose a learning disability it is necessary to establish that a student is experiencing an unexpectedly high level of difficulty learning in a particular academic area. It is not really possible to make judgments about academic performance too early because all children make errors and work laboriously when they first start learning to read, spell, unite and calculate. This is only to be expected. It becomes 'unexpected' when students continue to struggle or progress very slowly for a much longer period of time than we would expect.

Learning disability students faces more psychological problems such as feeling of frustration, anger, sadness or shame can lead to psychological difficulties such as anxiety,

depression, or low self- esteem, as well as behavioral problems such as substance abuse or juvenile delinquency. The extreme focus on their disability causes low self concept and emotionally not matured/imbalanced in the minds of the child and will lead to feelings of inferiority in the child. Through this study the research tries to explore the self concept and emotional maturity among students with learning disability.

"Self-concept as a construct has had a long history within psychology and education because it provides a gauge to determine the effects of academic and social functioning on the emotional well-being of the individual" Self-concept is generally viewed as a valued educational outcome. Self-concept is typically defined as a person's general composite or collective view of themselves across multidimensional sets of domain specific- perceptions, based on self-knowledge and evaluation of value or worth of one's own capabilities formed through experiences with and interpretations of the environment.

Academic self concept is the confidence of students' feelings and perceptions about their academic competence and their commitment to and involvement and interest in schoolwork. Emotional maturity refers to your ability to understand, and manage, your emotions. Emotional maturity enables you to create the life you desire. A life filled with happiness and fulfillment. You define success in your own terms, not societies, and you strive to achieve it. Your emotional maturity is observed through your thoughts and behaviours. When you are faced with a difficult situation, your level of emotional maturity is one of the biggest factors in determining your ability to cope.

**Need and Significance of the Study**

Learning disabilities are not fully treated. Children diagnosed with learning and other disabilities can qualify for special educational services. The average LD child it is important to have a clear assessment of their problems and abilities. So that successful treatment can be

implemented. The considerable individual differences in these outcomes and that some adults with LD are able to manage very well. A child with a learning disability may struggle with low self esteem, frustration and other problems. Understanding the level of their academic self confidence and emotional maturity is very crucial in order to help them to maintain physical and psychological equilibrium so that mental health professionals can help the youngster understand these feelings, develop copying tools and build healthy relationship. Thus the present study is significant by all means.

**Statement of the Problem**

The problem can be stated as "A study on self concept and emotional maturity among students with learning disability''

**REVIEW OF LITERATURE**

In a study, Panimalar, Sasikumar and Fathima (2013), conducted a study entitled as "A Study on Emotional Maturity and Self Concept at Higher Secondary Level" This research found the following factors are affecting the emotional maturity and self concept such as hereditary factors, maturation, training, health, intelligence, family relationship, social environment and control over emotions, in other hand self concept are affecting by factors like age, appearance, gender, culture, economical states, environment, and parents education. The Emotional maturity and self concept becomes important in the behaviour of individuals. As the students are the pillars of the future generations their value pattern of Emotional Maturity and self concepts are vital.

In a study, Elbaum and Vaughn (2003), conducted a study entitled "which students with learning disabilities are self concept interventions effective?". The study aimed at enhancing the self concept of students with learning disabilities (L.D). The results indicated that only groups of students with documented low self concept benefited significantly from intervention.

In a study, Coole, Ayres, Black (1974), Conducted a study entitled "The experience of families of children with learning disabilities, parental stress, family functioning and sibling self concept''. The aim of this study was to assess family functioning, parental stress and sibling self concept on the experience of families of children with learning disability. Result of this study was the functioning of the families and the self concept of the siblings were comparable to that in families of nondisabled children, but the parents in the former group experienced greater stress than did parents of non disabled children, despite few problems in sibling relationships', the families experienced adaptation difficulties, especially with regard to the children.

In a study, Margalit and Zak (1984), conducted a study entitled "Anxiety and self concept of learning disabled children". The aim of this study compares anxiety and self concept among learning disabled children and their non disabled peers. Result of this showed the students with learning disability have shown higher anxiety and lower self concept.

In a study, Chapman (1988) conducted a study entitled "learning disabled children's self concepts". The aim of this study is self concept of the learning disabled children. The findings show that LD students have lower self concept than non handicapped students.

**Objectives of the Study**

a) To find out the relationship between self concept and emotional maturity among students with learning disability.
b) To assess the self concept among students with learning disability.
c) To assess emotional maturity among students with learning disability.

**Hypothesis**

H1.There will not be any significant relationship exists between self concept and emotional maturity among students with learning disability.

H2.Theself concept of students with LD will be low.

H3.The emotional maturity of students with LD will be low.

## METHOD

This chapter discussing about method of the present study." Methodology" implies more than simply the methods you intend to use to collect data .It is often necessary to include a consideration of the concepts and theories which underlie the methods.

**Research Design**

This study follows a descriptive research design. Survey and interview method were used to collect the data for the present study.

**Population**

Students with Learning disability

**Sample**

Sample sizes of 30 Learning disability students were selected for the present study.

**Inclusion criteria**

a) Learning disability students of age group 5 to 13 were included in the present study.
b) Only students screened using NIMHANS battery assessment were included in the present study.

c) Students with mild, moderate and severe learning disability were included.

**Exclusion criteria**

Students with multiple disabilities were excluded.

**Sampling Technique**

Purposive technique was used to draw the sample from the population in this study.

**Procedure of the Data collection**

For the collection of data the researcher selected 30 students with Learning disability were selected from different learning disability clinics in Calicut and Malappuram district, Kerala. The Academic self concept questionnaire (ASCQ) by Liu and Wang and Emotional maturity scale by pal were administered to the sample. The researcher read each items of the inventory in order to make them comprehend the meaning. The questionnaires were scored as per the manual of the inventories and the raw score were taken for the analysis.

**Statistical Techniques Used**

Spearman rank correlation Test was used to find the relationship between the variables. Descriptive statistics Method was also used.

**Instruments Used**

**Academic self concept questionnaire (ASCQ) by Liu and Wang**

Academic self concept questionnaire (ASCQ) was developed by Liu and Wang (2005).The original ASCQ consisted of two 10-item sub scales: students academic confidence (AC) subscale assessed students' feelings and perceptions about their academic competence. Example item included "I am good in most of my school subjects" and "Most of

my classmates are smarter than I am" (negatively worded). The academic effort (AE) subscale assessed students commitment to and involvement and interest in school work.

**Reliability and Validity**

Cronbach's alpha coefficients, as a measure of internal consistency for the scales Academic self Concept inventory for the present study were found to be 0.74, 0.78 for Academic self confidence and Academic commitment respectively.

**Scoring**

There are total items for this test. For getting the total row score are the scores of each item. Items 2, 4,7,9,11,13,14,16,17 and 20 were negatively scored. The total score has taken for the analysis.20-60 considered as low and 61-100 as high.

**Academic self concept questionnaire (ASCQ)**

The tool used for assessing emotional maturity was developed and standardized by Pal 1984.It is a five point linkert scale which consists of 40 items.

**Reliability and Validity**

The reliability of the test was measured by split half method and test retest method; it its corresponding reliabilities are 0.74 and 0.77.The validity coefficient of the present scale was found to be .84 and with the adjustment inventory of Srivastava and Tiwari .80 regarding the faulty adjustment area of the present scale.

**Scoring**

There are total 40 items for this test. The maximum score 180 and minimum score is 58.The indicating extremely unstable and the Low score indicating extremely stable. Scores from 40-110 is considered as low score 111-180 as high scores.

The purpose of the data analysis and interpretation phase is to transform the collected data into credible evidence about the development of the intervention and its performance. Data analysis and interpretation of research is the process of assigning meaning to the collect the information and determining the conclusion, significant and implications of the findings. The collected data was analyzed using SPSS

## RESULTS

**Table 1**

*Shows the r-value and level of significant between self concept and emotional maturity among students with learning disability*

| Variable | r-value | Significant |
|---|---|---|
| **Self concept**<br>**Emotional maturity** | -.113 | .553 |

To find out the relationship between self concept and emotional maturity among students with learning disability.

H1.There will not be any significant relationship exists between self concept and emotional maturity among students with learning disability.

The coefficient of correction and the level of significance between the Academic self concept and emotional maturity was found to be -.113 and .553 respectively. From the result it is clear that no correlation exists between the variables. Hence the hypothesis “There will not be any significant relationship exists between self concept and emotional maturity among students with learning disability” was accepted.

Thus the academic self concept and emotional maturity are independent each other as per the present result, which means one variable doesn't have any influence on the other.

To assess the self concept among students with learning disability

*H2. The self concept of students with LD will be low*

**Table 2**

*Shows the men and standard deviation of the self concept score obtained by students with learning disability*

| Variable | Mean | SD |
|---|---|---|
| **Self concept** | 54.90 | 1.780 |

The mean score and the standard deviation obtained by students with learning disability on academic self concept were 54.90 and 1.780 respectively, as per the norm of the scale the mean score can be considered as low .hence the hypothesis "The self concept of students with LD will be low" is accepted.

*To assess emotional maturity among students with learning disability*

*H3. The emotional maturity of students with LD will be low.*

**Table 3**

*Shows the mean and standard deviation of the emotional maturity score obtained by students with learning disability*

| Variable | mean | SD |
|---|---|---|
| **Emotional maturity** | 72.90 | 10.321 |

The mean score and the standard deviation obtained by students with learning disability on emotional maturity were 72.90 and 10.321 respectively, as pr the norm of the scale the mean score can be considered as low .hence the hypothesis "The emotional maturity of students with LD will be low" is accepted.

## DISCUSSION

Education is considered as an essential determinant of an individual's status in a society. Learning disabled students are a group who are adversely affected due to the societies increased status given to the highly educated individuals. Even though they have such problem they may be endured with many other talents. But the focus is only given to their disability and this may affect their self esteem, efficacy and all other psychological realms. This might be the reasons for their low academic self concept and emotional maturity. The extreme focus on their disability causes poor self concept in the minds of the child and will lead to the feelings of inferiority in the child.

Bring up these children at home and teaching them with special aid is undoubtedly very taxing, both for these kinds and the caregivers. What should be understood is that these children may be bestowed with other talents, but because the school education is given almost importance, we often ten to neglect these special talent. The extreme focus on their disability from others around them leads to low self-esteem in these children and causes them to become emotionally immature and will inculcate in them feelings of inferiority

## CONCLUSION

From the present result it can be concluded that there was found no relationship between academic self concept and emotional maturity among students with lerning disability. The students scored low on the variables under the study.

## IMPLICATION

Number of children with learning disabilities is increase day by day. Whereas academic learning is becoming more and more important for the children in this present world of competition. But, these children with learning disability are being neglected, for it would soon lead us in to a healthy society. Therefore helping these children or adults is exceedingly important.

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# Academic Stress and Study Habit among High School Students

Nabeeha M. V.* and Navneetha K.*

**ABSTRACT**

The world is becoming more and more competitive. Quality of performance has become the key factor for personal progress. Parents desire that their children should climb the ladder of performance as high as possible. This desire for high level of achievement puts a lot of pressure on teachers, schools and especially in students resulting in academic stress. Study habits also have a major contribution towards this stress in students. In this study, the author examined the effect produced by academic stress and study habit upon each other using Academic Stress Scale and Study Habit Inventory in 142 high school students (73 males and 69 female) from various schools of Calicut District using quota sampling methods. Correlation and Independent t-test was administered to analyze the data using IBM SPSS Version 22. The findings of this study revealed that academic stress and study habit was strongly negatively correlated and there was no significant difference in males and females for academic stress and study habit. Hence it can be suggested that psycho-education and counseling services can help students to deal with academic stress by shedding light on better and effective study habits so as to have a better academic performance.

***Keywords:*** *Education, Academic stress, Study habit, High school students*

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## INTRODUCTION

### Background

Education is the powerful door of the development and one of the strongest instruments for reducing poverty and improving health, gender equality, peace and stability, and it is the most powerful weapon that we can use to change the world. Generally education is the passport to the future, for tomorrow belongs to those who prepare for it today. On the other hand this empowering system becomes a potential villain leading to significant stress and anxiety among many students. Feelings of stress and anxiety are part of life. Some level of stress can be actually good for us, as the right kind of stress encourages us toward change and growth. However when stress and anxiety exists for an extended period of time, they can become a burden or a health risk. And among students academic stress is the significant source of stress covering not only examinations but also other academically related stressors such as fear of lagging behind in the homework, writing assignment, working on individual and group projects, time pressure, lack of financial support, concern about academic ability, scheduling classes and required motivation to study (Bataineh, 2013)The academic stress faced by most students is attributed to poor study habits, such as poor time management (Macan, Shahani, Dipboye, & Phillips, 1990), studying for exams (Baldwin, Wilkinson, & Barkley, 2000), and coursework (Robotham, 2008), which may eventually lead to poor academic performance (Deb, Strodl& Sun, 2012).

Academic stress among students have long been researched on, and researchers have identified stressors as too many assignments, competitions with other students, failures and poor relationships with other students or lecturers (Fairbrother& Warn, 2003). Academic stressors include the student's perception of the extensive knowledge base required and the perception of an inadequate time to develop it (Carveth et al, 1996). When stress is perceived

negatively or becomes excessive, students experience physical and psychological impairment (Deb, Strodl& Sun, 2015; Prabhu, 2015). Methods to reduce stress by students often include effective time management, social support, positive reappraisal, and engagement in leisure pursuits (Murphy & Archer, 1996). The pressure to perform well in the examination or test and time allocated makes academic environment very stressful (Erkutlu&Chafra, 2006). This is likely to affect the social relations both within the institution and outside which affects the individual person's life in terms of commitment to achieving the goals (Fairbrother& Warn, 2003) while family support plays an important role in reducing academic stress (Ramamalini, 1993).

In order to overcome the pressure from academic stress the students have to employ suitable coping strategies like in any other stressful situation. There are various coping strategies used by students when experiencing academic stress. Some resort to avoidant coping; alcohol/drug abuse, denial and behavioral disengagement; while others cope actively through acceptance, planning, and positive reframing and taking the necessary steps to overcome the academic stress.

Academic performance is mainly a function of student's study habits referring to the student's way of study whether systematic, efficient or inefficient (Abid, 2006). The study habits that influence the academic performance of a student include: time management, setting realistic academic targets, setting rewards on completion of a task, revision, organization of materials, and notes-taking during lectures (Fontana, 1995; Good &Brophy, 1986). Hence, study habits are coping strategies used by students to overcome academic stress so that they can meet the demands imposed on them by the academic environment. This is reaffirmed by studies (Prasida&Kelu, 2014; Aluja& Blanch, 2004; Struthers, Perry &Menec, 2000;) which show that study habits positively correlate with academic performance.

The present study is done in order to analyze to what extent study habit act as a coping strategy in handling academic stress that directly gauges the level of academic performance and achievement and also there were less number of studies on the measured variables among high school students as majority of the literatures were about higher secondary and university students.

**Objectives**

a) To find out whether there exist any relationship between academic stress and study habit among high school students.

b) To find out the difference in academic stress and study habit among male and female high school students.

**Hypothesis**

H1. There will be a significant relationship between academic stress and study habit among high school students.

H2: There will be a significant difference in academic stress among male and female high school students.

H3: There will be a significant difference in study habit among males and females high school students.

## METHOD

**Participants**

The research participants of the study were high school students between the age group of 14 to 16. The participants were bonafide students of different schools across Calicut

district. The total sample was 142 high school students (73 males and 69 females) and the sampling technique employed was quota sampling. All the participants chosen for the study were fluent with English language so as to facilitate easy comprehension of the questionnaire

**Measures**

The measures used in the study were Academic Stress Scale and Study Habit Inventory. Academic stress is a 40 item rating scale which was originally developed by Kim (1970). The scale was adapted to Indian conditions by Rajendranand Kaliappan(1990) each item had five alternatives varying from the response 'No Stress' to 'Extreme Stress'. Academic Stress Scale is assumed that the adopted version is having validity and reliability. The test-retest correlation of 50 students with an interval of 25 days has been found to be 0.82. Study habit inventory was designed and developed by Wren (1941) and later adapted to suit the Indian conditions by Bengalle (1973). The inventory consists of 25 items. There are three response categories 'Never/Rarely', 'sometimes / Often' and 'Always' at the end of the each item. The test-retest correlation of 50 individuals with an interval of 25 days is found to be 0.882.Informed consent was obtained and confidentiality was assured. Personal Demographic data sheet were enclosed along with the questionnaires during data collection. Pearson product moment correlation was used to access the relationship between variables under the study and Independent sample t-test was used to assess the mean difference between male and female participants.

**Procedure**

Informed consent was obtained and confidentiality was assured to the participants before commencement of the test. The data forms were administered manually. The participants were manually identified as per convenience.

**Statistical analysis**

Data obtained from the research participants were analyzed using different statistical techniques by using IBM SPSS version 22. Pearson's product moment correlation was used to assess the relationship between variables under the study and Independent sample t-test was used to assess the mean difference between male and female participants.

## RESULTS

**Preliminary Analysis**

Preliminary analysis includes central tendency measures of psychological variables academic stress and study habit.

**Table 1**

*Mean, SD, skewness and kurtosis of study variables*

| Variables | N | Mean | Standard Deviation | Skewness | Standard Error | Kurtosis | Standard Error |
|---|---|---|---|---|---|---|---|
| **Academic Stress** | 142 | 51.54 | 27.170 | .274 | .203 | -.860 | .404 |
| **Study Habit** | 142 | 57.23 | 7.491 | .275 | .203 | .745 | .404 |

Table 1 shows the mean, standard deviation, skewness and kurtosis of the study variables. It depicted that the mean and SD of academic stress is 51.54 and 27.17 respectively. Also the mean and SD of study habit is 57.23 and 7.491 respectively. Skewness values for all the study variables falls between the acceptable range of +1 and -1 and the kurtosis values for all the study variables falls between the acceptable range of +3 and -3.

**Table 2**

*Frequency table*

| Gender | N | Percentage |
|---|---|---|
| **Males** | 73 | 51.4 |

| | | |
|---|---|---|
| **Females** | 69 | 48.6 |

The table 2 shows the frequency of demographic variable gender. The total sample size was 142 in which 73(51.4%) were males and 69 (48.6%) were females.

**Major analysis**

The major analysis consists of Pearson's product moment correlation and independent t-test.

**Table 3**

*Correlation between Academic stress and Study habit(n=142)*

| | **Academic Stress** | **Study habit** |
|---|---|---|
| **Academic Stress** | **1** | |
| **Study habit** | **.-.376**** | **1** |

**Correlation is significant at the 0.01 level (2-tailed).

Table 3 shows the product moment correlation between study variables. It depicted that academic stress and study habit are strongly negatively correlated (r = -.376, p= .01). Thus, the hypothesis H1 is accepted.

**Table 4**

*Mean, SD and t-value for academic stress and study habit (N=142)*

| **Variables** | **Gender (n)** | **Mean** | **SD** | **Df** | **t- value** | **p- value** |
|---|---|---|---|---|---|---|
| **Academic Stress** | Males (73) | 50.89 | 22.216 | 140 | -.290 | .772 |
| | Females (69) | 52.23 | | | | |
| **Study Habit** | Males (73) | 57.05 | 5.542 | 110.75 | -.286 | .776 |
| | Females (69) | 57.42 | | | | |

Table 3 compares the academic stress and study habit based on gender. It depicted that there was no significant difference between male and female students in terms of academic stress (t=-.290, p=.772) and study habit (t=-.286, p=.776).

Thus, the hypothesis H2 and H3 are rejected.

## DISCUSSION

From the result, it is evident that academic stress and study habit were strongly negatively correlated. It was also evident that both academic stress and study habit negatively predicted each other. In a study by Wittmaier (2015), examined the test anxiety and study habits among students and the findings revealed that test anxiety- a potential source of academic stress is affected by study habits. A similar study was done by Tabassum (2014), examined academic stress relationship on achievement motivation and study habits among higher secondary students and revealed that academic stress and study habit are negatively correlated. The result also depicted that there was no significant difference in academic stress among males and females. This study goes in hand with a study conducted by Kaurand Kaur (2015)examined the academic stress and study habits among adolescents with respect to locale and gender which also revealed that there exists no significant mean difference in academic stress of male and female adolescents at both levels of significance. Another study by Huan, Yeo, Ang and Chong (2006) studied the influence of dipositional optimism and gender on adolescents' perception of academic stress which also revealed the same result. This study also opposes some research findings that there is a significant difference academic stress among males and females. (Ergene, 2011).

It was evident from the results that there was no significant difference in study habit among males and females. The researcher couldn't find any exact study that supports this

finding even then in there was study on learning style of higher secondary students of Tamil Nadu in 160 higher secondary students from private and government schools by Malathi and Malini (2006) The study revealed that there was no significant difference in the learning style of boys and girls studying in higher secondary schools. It also opposed the research finding of Ogan (2015) isn her study of gender influences on study habits of mathematics students' achievement in which males and females had significant difference in study habits.

## CONCLUSION

From this study it can be concluded that Academic stress and study habit are strongly negatively correlated and also there was no significant difference between male and female students in terms of academic stress. So it can be suggested that gender bias should be avoided in academic settings as there is no difference between males and females. It can also be inferred that study habit act as a strong coping strategy in dealing with academic stress so psycho –education and other psychological counseling service can be provided to student's in-order to cope up better with academic stress and to improve study habit.

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# Acquisition of Sign Mand in a Child with Autism Using Differential Reinforcement

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## ABSTRACT

Teaching mands to the children with autism is of significant clinical importance. A 4years11months old boy (AH) with autism was taught to request (Mand) using sign for chips when motivating operations were in effect. The participant was non verbal and requested using inappropriate behaviors like grabbing or sometimes used hand over hand (motoric) communication. The ABA based intervention using the principles of Differential Reinforcement was applied for acquisition of Mand for Tangible. After 6 sessions of intervention the participant was able to independently sign mand for the tangible "Chips" and he was able to generalize it across settings, subjects and stimulus in 10 sessions.


***Keywords:*** *Autism, Reinforcement, Sign Mand*

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## INTRODUCTION

Communication being one of the core deficits in autism, language use and manipulation plays a vital role in its management. Access to tangibles should be reinforced if the motivating operations are in effect. The onus shifts to teaching different signs to these children which can set a starting point for them to explore more and add to the learned mand. The primary goal of behavioral interventions should be verbal behavior and mands training be the first line of intervention. Several studies have provided empirical support for the use of manual sign manding in producing a functional communication repertoire in the absence of effective verbal behavior repertoires for children with developmental disabilities and autism (Benkelman, D. & Miranda, P. (1998).

Skinner defined the mand as, "a verbal operant in which the response is reinforced by a characteristic consequence and is therefore under the functional control of relevant conditions of deprivation or aversive stimulation".

Mands are functionally most important for the early development of language and for the day-to-day verbal interactions of children and adults (Cooper, Heron, and Heard, 2007).

Children with autism frequently present with limited interests and often do not readily learn to emit mands without specific teaching (Shafer, 1994). Furthermore, children with autism do not readily acquire mands as a result of tact or receptive discrimination training alone (Shafer). As a result, program and procedures towards the development of a mand repertoire and its relevance to early language training for children with language delays and disorders, specifically those with autism, have been documented in the behavior analytic literature. The mand is unique because it is the only verbal operant for which a response is directly evoked by a motivating operation.

Many studies have described effective methods of teaching mands for information. In a study by endicot and higbee on three children with autism, echoic prompts were used to

train the "where?" mand for information. All three participants learned to emit the mand for information after the intervention. (Endicot & Higbee, 2007), but only a few studies have documented the use of sign mands.

The aim of the present study is to use differential reinforcement procedures to teach sign mand for chips to a child diagnosed with Autistic Spectrum Disorder.

## METHOD

### Participant

A. H. was referred to the Child Development Clinic with the complaint of speech delay where he was diagnosed with Autism. He is a male child of 4 years 11 months with delayed development in all domains of development. He attends the clinic 3 days a week for 2 hours per day. His total developmental quotient is 64 indicative of mild developmental delay as assessed on Gesell's developmental schedule. He follows selective single instructions. He identifies a few body parts and is able to finish the form board. There are no independent sign mands present when we started the experiment as he used to grab things instead of manding for them.

### Setting and Materials

The mands training was done in one of the therapy rooms of the clinic, which the child attended. The sessions were video recorded. The materials consisted of baskets consisting of different reinforcers (objects, toys and eatables) for A. H. Free Operant Preference assessments were done periodically to assess the value of the items offered in which toys, tangibles and activities were presented to the child. Chips were identified as the most preferred item during preference assessment.

Mand training sessions were conducted 3 days per week and 10 experimental trials were included in every work session.

**Procedure**

**Experimental design**

Single-subject study an AB design was used, where A refers to the baseline phase (non-treatment) and B refers to the intervention phase. The dependent variable consisted of the independent correct mand "Sign for Chips?" The independent variable consisted of the delivery of reinforcer "chips" when motivating operation was in effect.

**Baseline**

During baseline sessions, the child sat in the front of the experimenter and the tangible chips were visible to him. The number of independent sign mands was recorded. It was noted that the child used to grab the item or push the hand of the therapists towards the chips packet. The duration of baseline was for 4 sessions done over 4 days of 10 trials each.

**Intervention**

During the intervention phase the child was taught to mand using the sign for chips and the topography of which was defined and recorded earlier. The experimenter used the procedure of getting the chips out of packet and keeping it within the sight of the child but away from his reach. As soon as the child approached (which signaled the presence of motivating operations) e.g.; eyes moving to the chips packet, hand moving towards the chips packet to grab, the child was helped with full physical prompt to do the sign for chips. This was reinforced with giving him a piece on chips on a continuous reinforcement schedule. Errorless teaching strategies were used with most to least prompts. Gradual prompt fading procedures were then implemented. Differential reinforcement of prompt faded trials led to the acquisition of independent sign mand. The phases of prompt were:

a) Full prompt (FP) - holding child`s both hands,

b) Partial Prompt(PP) – touching child`s both hands,

c) Unprompted correct responses (I) – responses were considered independent if the child emitted the mand sign for chips.

   a. Trial by trial data was recorded in every session. The duration of intervention was 10 sessions each included 10 experimental trials.

After the participant had 3 consecutive sessions with 100% unprompted correct responses, a generalization probe was conducted in different environments (the experimenter repeated the procedure used in the baseline in home setting, he used other materials, e.g. different packets of chips, different color of the packets, other bags and boxes etc.) and with different persons (a second teacher repeated the procedure used in the baseline). Prompted and unprompted responses were recorded for all sessions. In the case of incorrect or non-responses an error correction procedure as described by Sundberg and Partington was used.

**Data Collection**

After each baseline, experimental and generalization trial the experimenter recorded whether the participant did unprompted (I) or prompted response sign for chips when he wanted chips. For prompted response the experimenter further noted that if he used a full (FP) or a partial prompt (PP). All data was noted on data sheets. During the baseline and intervention phase independent correct sign mands were noted (Appendix A and B). In addition trial by trial data sheet was prepared as well.

Percentage Independent Sign mands (% I) were calculated using the formula below:

$$\frac{\text{Independent Sign Mands}}{\text{Total number of teaching trials}} \times \mathbf{100}$$

**Inter-observer Agreement**

A second observer independently viewed the at least 50 % of the records from the each phase of the experiment (100% from baseline sessions, 70% from the intervention sessions and 100% from the generalization sessions) and took data about the apparition of the target behavior. The same observational sheets were completed that were used by the experimenter.

Inter-observer agreement was calculated for each phase by dividing the sum of agreed observations with the sum of the agreed and disagreed observations, all multiplied by 100.

$(\frac{sum\ of\ agreements}{sum\ of\ agreements + sum\ of\ disagreements} \times 100)$. The agreement was:

For Baseline phase, IOA = 100% (4/4*100)

For Intervention phase, IOA = 85% (6/7*100)

For Generalization phase, IOA = 100% (3/3*100)

## RESULTS

The results of the intervention are presented in Figure 1. During baseline A.H. never manded for chips using signs (% independent mands) 0%. In the first intervention session and second session, he was prompted at every trial and percentage of independent mands was 0%. During the third session A.H. did the first correct response without a physical prompt. After 5 sessions of intervention the participant had only independent correct responses (percentage of independent sign mands =100%). Following intervention A.H. was able to independently mand for chips using sign in situations in which the therapist showed the chips packet.

After 3 consecutive sessions only with independent correct responses we probed if the child is able to generalize the ability to sign for chips with other persons and in other environment. A.H. had only correct responses in other environment (home setting) and he generalized also the ability to mand for chips with other persons.

## RESULTS

**Table 1**

| | Sessions | FP | PP | IP | % Independent |
|---|---|---|---|---|---|
| 1 | Baseline | - | - | 0 | 0/10*100= 0% |
| 2 | Baseline | - | - | 0 | 0/10*100= 0% |
| 3 | Baseline | - | - | 0 | 0/10*100= 0% |
| 4 | Baseline | - | - | 0 | 0/10*100= 0% |
| 5 | Intervention | 10 | - | 0 | 0/10*100= 0% |
| 6 | Intervention | 10 | - | 0 | 0/10*100= 0% |
| 7 | Intervention | 3 | 6 | 1 | 1/10*100=10% |
| 8 | Intervention | 1 | 4 | 5 | 5/10*100=50% |
| 9 | Intervention | 0 | 3 | 7 | 7/10*100=70% |
| 10 | Intervention | 0 | 0 | 10 | 10/10*100=100% |
| 11 | Intervention | 0 | 0 | 10 | 10/10*100=100% |
| 12 | Intervention | 0 | 0 | 10 | 10/10*100=100% |
| 13 | Intervention | 0 | 0 | 10 | 10/10*100=100% |
| 14 | Intervention | 0 | 0 | 10 | 10/10*100=100% |
| 15 | Generalization (Across Setting) | 0 | 0 | 10 | 10/10*100=100% |
| 16 | Generalization (Across Stimulus) | 0 | 0 | 10 | 10/10*100=100% |
| 17 | Generalization (Across Subject) | 0 | 0 | 10 | 10/10*100=100% |

**Note**: FP: Full Prompt; PP: Partial Prompt; IP: Independent Prompt

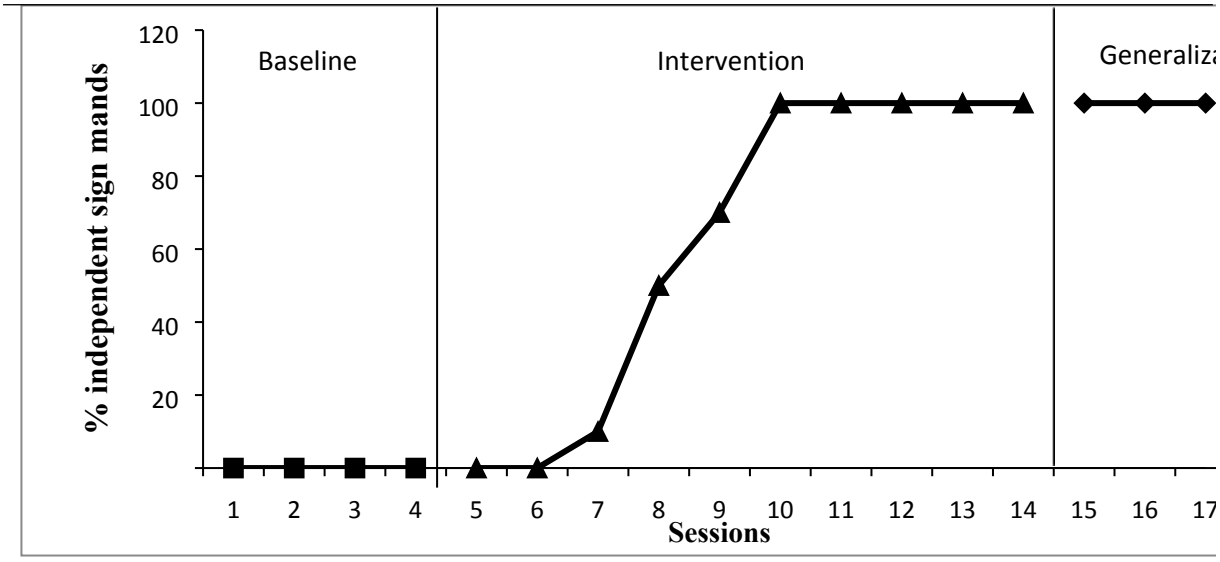


***Figure 1: Graph representing % age Independent Sign Mands***

## DISCUSSION

This study demonstrated an effective procedure to establish and generalize the mand for chips in the case of a 4years11months old boy with autism who never used this mand before.

The results show that the prompt fading procedure and use of differential reinforcement of Independent or prompt faded trials schedule was effective in this study. This calls for more research on teaching mands to children with language delays especially autism. It also makes clear that mands training in children who are non – verbal can help them overcome limitations due to lack of expressive speech. It provides them with an alternative method of interaction other that vocal behavior. As acquisition of mands is under motivation operations the participant needed a relative short-term intervention period of 5sessionsto be able to independently signmand for chips. Generalizations of this repertoire were seen in different settings and across other individuals as well. Principles of applied behavior analysis were instrumental in quickly and effectively teaching the functional mand skill in this non-verbal child.

Future investigations may wish to collect more extensive data about the generalization phase, to collect follow-up data and to investigate other mands for tangibles. The acquisition for discriminated mands for 2 or more tangibles, acquisition of pure mands (or mands out of view) was not studied in this case study or acquisition of vocal verbal behavior was also not done. An AB design is not an ideal experimental design to prove co-relation and multiple baseline design with across behaviors' could have shown a more reliable relationships.

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# Counseling: A tool for adjusting to life with Chronic-illness

Dr. Sharanjit Kaur*

**ABSTRACT**

In today's modern world, individuals are witnessing a steady increase in the incidence and prevalence of chronic illness .Further increases in it is also expected. Chronic illness is defined as an illness which usually cannot be cured and lasts a long time. It has been recognized that living with a chronic illness can be difficult for patients themselves as well as for their family members, often disrupting their daily routines, taxing family resources, and creating various interpersonal and family conflicts. Adjusting to a lifestyle with chronic illness, such as, incorporating new medications, preventative practices, dietary changes, and other behavioral adjustments to properly control the symptoms and persistency of a chronic disease, is often a time-consuming process. In addition, it can be frustrating, both physically and emotionally. While these changes are often difficult and sometimes met with resistance, counseling can help make adjustments easier. Counseling can help them to live effectively with their physical symptoms and to maintain emotional balance. Even if the underlying physical condition does not change, the ability to cope better from an emotional perspective is in itself a significant achievement that should be acknowledged. The present paper focuses on counseling as a tool that can help chronically ill patients cope with the challenges faced by them in their lives.

***Keywords:*** *Counseling, Chronic illness, Behavioral adjustments*

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## INTRODUCTION

Chronic illness is an increasing concern in today's world, where it affects nearly half of the adult population and its prevalence has increased in recent years (Anderson, 2010). The life of someone with a chronic medical condition is impacted in ways that a healthy person cannot begin to comprehend. The personal, emotional, social, recreational and occupational functioning of someone with such illness gets severely affected which can be profoundly overwhelming for him. Anxiety, depression, anger, frustration, irritability, helplessness and hopelessness are some of the psychological impacts experiences by those suffering from such illness. Such pepple need counseling with the help of which they can manage the ill-effects of their disease in their everyday life (Kaakinen, Kääriäinen and Kyngäs, 2012). Counseling can play a very effective role in helping such patients to maintain healthy coping skills in order to deal with their disease and adhere to their medical regimen.

People with chronic disease experience various emotional and mental challenges which require a realistic and positive approach to adapt to such condition which might seem impossible in the beginning, but it can be done. Counseling is one way that can help such patients to build their emotional resilience, so that, they can lead their life in an effective way. According to American Psychological Association (2014), if the psychologist works with the patient's physician and other specialists, appropriate coping strategies can be developed that will not only reinforce the treatment program, but will also help the patient to lead life effectively regardless of any physical limitations.

### Chronic illness

The terms chronic illness and chronic disease are often used interchangeably. Chronic disease is defined on the basis of the biomedical disease classification, and includes diabetes, asthma, and depression (Bentzen, 2003). Martin (2007) has defined *chronic*

*illness* as the personal experience of living with the affliction that often accompanies a chronic disease.

According to World Health Organization (2005), chronic conditions are defined as requiring "ongoing management over a period of years or decades".

According to Bedroussian (2007), "Chronic illnesses are health conditions that either have symptoms on a constant basis or flare up episodically, such as diabetes, heart disease, pulmonary problems, hypertension, mental disorders, stroke, cancer and obesity.

According to a report by the Institute of Medicine (2008), people suffering from a chronic illness need help in the following areas:

- Cope with the intense, sometimes debilitating, emotions related to their illness.
- Change behaviours in order to minimize the impact of their disease and maximize treatment protocol.
- Manage the disruptions their illness may cause their work, social and family life.

**Challenges of Chronic illness**

Some of the challenges faced by people with chronic illness are as follows (Drummond, 2013):

- **Adaptation/Adjustment** - Overcoming the challenges of chronic illness requires cooperation between the patient, family and friends, caregivers and other medical professionals.
- **Physical challenges** – Even chronic illnesses that have few limiting physical effects have been shown to increase fatigue levels and decrease strength and stamina. The frustration experienced as a result of reduced physical or mental abilities can be as debilitating as the illness or condition itself.
- **Financial challenges** - Even with adequate insurance coverage, medical bills and co-pays can easily add up and place a significant financial burden on an individual or

family. Additional financial challenges arise when a chronically ill person is no longer able to work or produce a previously-earned income. This factor, combined with medical bills, can induce massive stress due to financial woes.

- **Emotional challenges** - The physical symptoms, reduced abilities, financial woes and relationship challenges of chronic illness can give rise to strong feelings of self-doubt, worthlessness, decreased self-esteem, feelings of guilt and a tendency toward social isolation. Isolation and guilt, however, further damage a person's self-image, creating a vicious cycle of negativity that can be difficult to break.

**Psychological Complications of chronic illness**

- **Stress -** Individuals with chronic illness normally face an increase in both the frequency and severity of stressful situations. Increased stress is experienced because of the need to cope with daily threats that include threats to (a) one's life and well-being; (b) body integrity; (c) independence and autonomy; (d) fulfillment of familial, social, and vocational roles; (e) future goals and plans; and (f) economic stability (Falvo, 1999).
- **Crisis** - The sudden onset of medical impairment and disabilities and that of life-threatening diagnoses or loss of valued functions (e.g., diabetes, cancer, vision impairment, etc) is highly traumatic. As such, these conditions constitute a psychosocial crisis in the life of the affected person (Livneh and Antonak, 1997).
- **Loss and grief** - The term *chronic sorrow* has often been used to depict the grief experienced by persons with chronic illness and disabilities (Burke, Hainsworth, Eakes, and Lindgren, 1992). Chronic illness and disabilities serve as a constant reminder of the permanency of the condition. Furthermore, daily triggering events act to remind the affected person of the permanent disparity between past and present or future situations (Teel, 1991).

- **Stigma-** The impact of stereotypes and prejudice acts to increase stigma toward people with chronic illness and disabilities. Restrictions imposed lead to deviations from several societal norms and expectations (e.g., utilization of health care services, occupational stability). They are, therefore, viewed negatively by society and result in stigmatizing perceptions and discriminatory practices (Corrigan, 2000).

  In a study conducted by Earnshaw and Quinn (2013), the impact of stigma in healthcare services was explored among individuals suffering from some chronic illness. The results of the study showed that the patients who internalized stigma and experienced stigma from healthcare workers anticipated greater stigma from healthcare workers. Those who anticipated greater stigma from healthcare workers were found to have less access to healthcare services and also experienced a decreased quality of life.

- **Uncertainty and unpredictability** - The insidious and variable course of chronic conditions is fraught with intermittent periods of exacerbation and remissions, unpredictable complications, experiences of pain and loss of consciousness, and alternating pace of gradual deterioration. Mishel (1981) coined a concept "perceived uncertainty in illness " to depict how uncertainty, or the inability to structure personal meaning, results if an individual is not able to form a cognitive schema of illness-associated events (Livneh and Antonak, 2005).

- **Body image** - Body image can be defined as the unconscious mental representation or schema of one's own body. It evolves gradually and reflects interactive forces exerted by sensory (e.g., visual, auditory, kinesthetic), interpersonal (e.g., attitudinal), environmental (e.g., physical conditions) and temporal factors. Chronic illness, with its impact on physical appearance, functional capabilities, experience of pain, and social

roles, is believed to alter, even distort, one's body image and self-concept (Falvo, 1999).

In a study conducted by Pinquart (2013), the body image of children and adolescents with chronic illness was analyzed. It was found that young people suffering from a chronic illness had less positive body image as compared to health individuals. In addition, it was also found that those suffering from obesity, cystic fibrosis, scoliosis, etc were least satisfied with their bodies.

- **Anxiety** - This reaction is characterized by a panic-like feature on initial sensing of the nature and magnitude of the traumatic event (Livneh and Antonak, 2005). In a study conducted by Peltzer and Pengpid (2016), anxiety was assessed among patients diagnosed with a variety of chronic diseases in three Southeast Asian countries viz. Cambodia, Myanmar and Vietnam. It was found that many patients screened positive for anxiety disorders. Those suffering from cancer had the highest rate of anxiety disorders
- **Denial** - This reaction, also regarded as a defense mechanism mobilized to ward off anxiety and other threatening emotions, involves the minimization and even complete negation of the chronicity, extent, and future implications associated with the condition (Livneh and Antonak, 2005).
- **Depression** - This reaction, commonly observed among people with chronic illness, is considered to reflect the realization of the permanency, magnitude, and future implications associated with the loss of body integrity, chronicity of condition, or impending death. Feelings of despair, helplessness, hopelessness, isolation, and distress are frequently reported during this time (Livneh and Antonak, 2005). Depression is one of the most common complications of chronic illness. According to Fram (2006), upto one-third of those suffering from serious chronic condition

experience clinical symptoms of depression. It was also found that even something as simple as chronic tension headaches decreased work and social functioning in a majority of individuals and made a person three to fifteen times more likely to be diagnosed with a mood or anxiety disorder (American Psychological Association, 2004).

In a study, Peltzer and Pengpid (2016) found that those suffering from obstructive pulmonary disease, kidney disease, Parkinson's disease and cardiovascular disorders had the highest prevalence of depressive features.

## COUNSELING OF PEOPLE WITH CHRONIC – ILLNESS

The Counseling approach for chronically – ill patients is usually patient-centered which takes into consideration the background of the chronically ill, including how much they already know about the disease, lifestyle and emotional health (Harding et al., 2008). According to previous studies, basing counseling on the needs of chronically ill patients improves their satisfaction (Kaakinen, Kääriäinen and Kyngäs, 2012). Such patient-centered counseling enables active participation in treatment and takes account of each individual's background. A study by Lundh, Rosenhall and Tornkvist (2006) found that chronically ill patients want to receive individual patient counseling that relates to their lifestyle, cultural and social background.

The interaction during counseling is encouraged and confidential (Zakrisson and Hagglund, 2010). The confidential environment in which the counseling takes place allows the chronically ill to ask questions and have interactive support to help discuss emotional issues with the counselor (Linnarsson, Bubini and Perseius, 2010). Creating a confidential atmosphere during counseling allows the patient to feel comfortable asking questions (Macdonald, rogersm Blakeman and Bower, 2008), and the provision of social support

through counseling has a positive impact on the daily activities of the chronically ill (Nagelkerk, Reick and Meengs, 2006).

Planned patient counseling takes account of the needs of patient and creates opportunities to receive feedback on how prepared a patient feels to care for themselves. As patient counseling is planned, both the individual needs of the chronically ill and the different ways in which individuals learn are considered. Counseling strategies can then be developed to best suit the patients (Kaariainen and Kyngas, 2010).

In a study conducted by Kaakinen, Kaariainen and Kyngas (2012), it was found that patient counseling had many positive influences on the patients' self-care. Most of the respondents (81%) reported adhering to their medical treatment and also felt that counseling helped them to have better knowledge of healthy living. Their physical activity and responsibility towards managing their disease also increased. The majority of the respondents (68%) felt that patient counseling had influenced their attitudes towards chronic disease.

**NEED FOR COUNSELING OF CHRONICALLY – ILL**

Psychologists play a variety of roles in the management, treatment and study of chronic illness (Stanton, Revenson and Tennen, 2007). These include:

- **Health Service Provider -** Psychologists provide mental and behavioral health services to chronically ill patients (e.g., psychological assessment, intervention and consultation).
- **Teacher -** Psychologists provide education and training regarding the psychosocial influences of chronic illness on health, which helps patients develop better self-care and self-management skills, so that, the impact of disease can be decreased and future health complications can be prevented.
- **Researcher -** Psychologists conduct research and participate in studies on chronic illness that advance knowledge in the area of prevention, treatment and

rehabilitation, which is essential to patients' successful management of their illness.

Following are some tips that will help in making an adjustment to life with chronic illness: (**Yerkes, 2007**)

- Educate yourself about your condition.
- Recognize your limits and learn to say no.
- Accept help from others.
- Build fun into your life.
- Focus your physical and emotional resources on those things that matter most.
- Share your gifts and talents with others.

## COUNSELING STRATEGIES/INTERVENTIONS FOR CHRONICALLY-ILL

The following interventions or strategies are geared toward assisting people with specific chronic illness (e.g., diabetes, cancer, heart disease, etc) in successfully adapting to their condition and its impact on their lives. These interventions equip the client with adaptive coping skills that could be successfully adopted when facing stressful life events and crisis situations. Some of these strategies are as follows (Livneh and Antonak, 2005):

a) ***Assisting clients to explore the personal meaning of the Chronic illness and Disabilities***- These strategies rest heavily on psychodynamic principles and focus on issues of loss, grief, mourning, and suffering. Emphasis is also placed on encouraging clients to vent feelings leading to acceptance of condition permanency, altered body image, and realization of decreased functional capacity.

b) ***Providing clients with relevant medical information*** **-** These strategies emphasize imparting accurate information to clients about their medical condition, including its

present status, prognosis, anticipated future functional limitations, and when applicable, vocational implications (Ganz, 1988).

c) ***Providing clients with supportive family and group experiences*** - These strategies permit clients and their family members or significant others to share common fears, concerns, needs, and wishes. These experiences also allow clients to acquire greater insight and to gain social support and approval from other group participants, family members, and professional helpers.

d) ***Teaching clients adaptive coping skills for successful community functioning*** - These strategies focus on instilling in clients coping skills that will allow them to face a wide range of stressful conditions typically encountered by people with chronic illness in physical, social, educational, and vocational settings. These skills include assertiveness, interpersonal relations, decision making, problem solving, stigma management, and time management skills (Craig, Hancock, Dickson and Chang, 1997).

## CONCLUSION

Assessment of clients' levels of psychosocial adaptation to their condition should pave the way to appropriate selection of intervention strategies (Livneh and Antonak, 2005). It has also been found that chronically ill patient's counseling improves the individual's knowledge of their disease, and this has a positive influence on self-care and quality of life (Kaariainen, 2007). Counseling has many positive effects on disease treatment, such as encouraging patients to take their medication (Carpenter et al. 2010), improved emotional well-being and improvement in their attitudes (Ashe, Taylor and Dubouloz, 2005). Focus should be given to chronically ill patients' counseling because it is necessary to develop new ways to offer more patient-centered counseling in order to address patients' need and fit care

to patients' lifestyle and background, and also help patients to develop coping strategies to overcome the hardships they face in their lives as a result of their chronic physical condition.

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# Effect of Emotional Freedom Technique (EFT) Tapping on Anxiety and Quality of Life

Ambika Warrier*

## ABSTRACT

Emotional Freedom Technique (EFT) as a new therapeutic technique in energy psychology has positive effects on psychological and physiological symptoms, and quality of life. It has deep roots in modern psychology as well as ancient science of acupuncture. It is also called tapping because EFT involves tapping with your fingertips on acupoints on your body. Studies were conducted to understand the effect of EFT Tapping on Anxiety and Quality of Life on adults. Ethical approval was secured. Clients above the age of 20 years and staying in Delhi NCR area were invited to participate in a 2 week long intervention program. At the start and end of their intervention, participants were asked to complete STAT and WHOQOL-BREF questionnaires. 65 participants gave consent, and 61 completed questionnaires and 46 fulfilled the inclusion criteria. . The range of age was 20 - 75 years and numbers of tapping sessions conducted by the researcher were 3 sessions in a time span of 2 weeks. The main presenting conditions were anxiety. STAT and WHO-BREF scores showed both emotionally and statistically significant improvements after the intervention. Statistically there was significant improvement for anxiety and Quality of Life (all $p<0.001$). Mean anxiety scores improved from 8.3250 (high) at start to 6.9750 (average). Mean Quality of Life scores improved from 65.5313 at start to 67.1125 (higher Mean shows better Quality of Life) at end (SD difference=6.81, $p<0.001$). Improvements were seen in all participants. Despite the limited sample size and other limitations, significant improvements were shown. The results support the potential of EFT as a cost-effective intervention to reduce anxiety and thereby help improve quality of life. However, there were few data available comparing EFT to

standard-of-care treatments such as cognitive behavioral therapy, and further research is needed to establish the relative efficacy of EFT to established protocols.

***Keywords:*** *Emotional Freedom, Tapping on Anxiety, Quality of Life*

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## INTRODUCTION

Anxiety is, or at least can be, a normal response to stressful situations and experiencing anxiety is a normal part of being human. Anxiety can become a disorder however, when you experience anxiety repeatedly in situations where it is not productive or rational. Anxiety is remarkably common in our modern world. Studies indicate that 1 out of every 4 people will at some point in their lives experience a diagnosable anxiety disorder. Anxiety disorders are no doubt a part of your life, either because you have a friend or loved one who has, is, or will experience one, or because you personally struggle with an anxiety disorder.

Regardless of how anxiety manifests or what triggers it, there is a common root cause that accounts for all symptoms of anxiety. Experiencing anxiety is a consequence of a blockage within the body's natural energy system. When the body is in a natural state of energy equilibrium, anxiety is rarely experienced. Over time, our body and brain developed a "fight or flight" response. In the modern world, we humans fortunately deal with far fewer life or death situations than our ancient ancestors did. Despite this, the "fight or flight" response remains buried deeply in our DNA, impacting our decision making and influencing our reactions.

Over time, the fight or flight type of situations serve to disrupt the flow of energy, altering our thoughts, feelings, and behaviors, in a way that eventually becomes a diagnosable anxiety disorder. To cure our anxiety we must break through these blockages and restore the

natural equilibrium we are intended to have. When the energy flows through our body we will be free of debilitating anxiety disorders and able to do and achieve the things we want in our lives.

Emotional Freedom Technique (EFT) tapping works by resolving disturbances and blockages that are inhibiting the natural balance and blow in your energy pathways. By resolving and eliminating the disturbances, EFT tapping restores a calm equilibrium to your body and allows your energy pathways to flow uninhibited the way they are meant to.

**Emotional Freedom Technique Tapping**

EFT has deep roots in modern psychology as well as the ancient science of acupuncture. The two approaches from psychotherapy from which EFT draws most are cognitive therapy and exposure therapy. Cognitive therapies address how we see the world through thoughts or "cognitions" that also shape our behavior. Exposure therapies focus on the therapeutic value of remembering traumatic life events. EFT is often called "tapping" because a central feature of EFT involves tapping with your fingertips on acupuncture points (acupoints) on your body. Research has shown that pressure on acupoints, or "acupressure," can be as effective as acupuncture itself (Cherkin, Sherman, & Avins, 2009). Acupuncture theory teaches that energy flows through our body through pathways called meridians. Disease can be caused by a blockage or interruption of that flow, and acupuncture or acupressure can be used to remove those blockages.

In the early 1960s, an American chiropractor named George Goodheart discovered that he could treat physical conditions successfully by tapping on acupuncture points or stimulating them manually, without the use of needles (Adams & Davidson, 2011). He called his method "Applied Kinesiology" (Goodheart, 1991). A breakthrough occurred Roger Callahan combined tapping on acupoints with exposure. Callahan along with other pioneers began to apply acupoint tapping to psychological problems. Callahan first discovered that it

could cure phobias. Later, he applied it to other psychological conditions including anxiety, depression, and PTSD. His method is called Thought Field Therapy or TFT (Callahan, 2000).

One of Callahan's students, named Gary Craig, simplified Callahan's TFT method and called it Emotional Freedom Techniques or simply EFT. While TFT uses elaborate diagnostic methods to determine which acupoints to tap and in which order, EFT simply taps on 12 points in any order.

The way EFT tapping works is by resolving the disturbances in your energy pathways. By resolving and eliminating the disturbances, EFT tapping restores a calm equilibrium as your energy pathways can flow uninhibited the way they are meant to. Since all negative emotions are manifestations of energy blockages and disturbances, EFT tapping can work on all of them.

As EFT became more popular in therapy and coaching circles, many researchers conducted studies of EFT and found that it was extremely effective for mental health problems such as phobias, depression, anxiety, and PTSD (Lane, 2009).

**The Science behind EFT Tapping**

When you're experiencing a negative emotional state - angry or upset or fearful - your brain goes on alert. It prepares your body to enter a full-blown, fight-or-flight response. All the body's defense systems are turned on to support either fighting or fleeing from the danger. The adrenaline pumps, your muscles tense, and your blood pressure, heart rate, and blood sugar all rise to give you extra energy to meet the challenge.

Most of our fight-or-flight responses are triggered internally. For many of us, the internally generated stress response is triggered by a negative memory or thought that has its roots in past trauma or conditioned learning from childhood. The adrenaline flows, the heart races, and so on. What tapping does, with amazing efficiency, is halt this fight-or-flight response and reprogram the brain and body to act and react differently.

The stress response begins in the brain in the amygdala, one of the components of the limbic system, or midbrain. The limbic system is the source of emotions and long-term memory, and it's where negative experiences are encoded. Amygdala signals the brain to mobilize the body in the fight-or-flight response. Tapping on the meridian endpoints helps to deactivate the amygdala's alarm and sends a calming response to the body, and the amygdala recognizes that it's safe.

**How to do EFT Tapping**

The basic technique requires you to focus on the negative emotion at hand: a fear or anxiety, a bad memory, or anything that's bothering you. While maintaining your mental focus on this issue, use your fingertips to tap 5-7 times each on 9 of the body's meridian points. Tapping on these meridian points while concentrating on accepting and resolving the negative emotion will access your body's energy, restoring it to a balanced state.

Tapping is simple and painless. It can be learned by anyone. And you can apply it to yourself, whenever you want, wherever you are. It's less expensive and less time consuming. It can be used with specific emotional intent towards your own unique life challenges and experiences. Most importantly, it gives you the power to heal yourself, putting control over your destiny back into your own hands.

**Process of EFT Tapping**

a) Choose a "Most Pressing Issue" (MPI) and devise a reminder phrase.
b) Rate the intensity the MPI on the 0-to-10 Subjective Units of Distress Scale. A 0 means no distress and 10 would mean the most distress a person can feel.
c) Build a setup statement
d) Tap on the karate chop point while repeating the setup statement three times.
e) Tap eight to ten times through the eight points in the EFT sequence while saying the reminder phrase out loud.

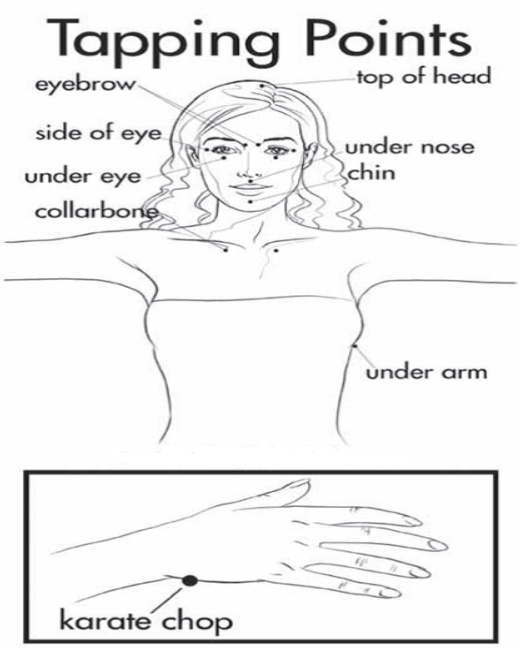
f) Once you have finished tapping the eight points in the sequence (shown below), take a deep breath.

g) Again rate the intensity of your issue using the 0-to-10 scale to check your progress.

h) Repeat as necessary to get the relief you desire.

**The sequence of tapping**

Eyebrow, Side of eye, under eye, Under nose, Chin, Collarbone, Under arm, Top of Head. For the ease of understanding, pictorial representations of the tapping points are given below.




**Anxiety**

**Anxiety** is an emotion characterized by feelings of tension, worried thoughts and physical changes like increased blood pressure. (APA, adapted from Encyclopedia of Psychology).

Anxiety is a general term for several disorders that cause nervousness, fear, apprehension, and worrying. These disorders affect how we feel and behave, and they can

manifest real physical symptoms. Mild anxiety is vague and unsettling, while severe anxiety can be extremely debilitating, having a serious impact on daily life.

People often experience a general state of worry or fear before confronting something challenging such as a test, examination, recital, or interview. These feelings are easily justified and considered normal. Anxiety is considered a problem when symptoms interfere with a person's ability to sleep or otherwise function. Generally speaking, anxiety occurs when a reaction is out of proportion with what might be normally expected in a situation.

**Signs and Symptoms of Anxiety**

There are some common symptoms including:

- **Physical**: panic attacks, hot and cold flushes, racing heart, tightening of the chest, quick breathing, restlessness, or feeling tense, sleeplessness, wound up and edgy
- **Psychological**: excessive fear, worry, catastrophizing, or obsessive thinking
- **Behavioural**: avoidance of situations that make you feel anxious which can impact on study, work or social life

**Methods to overcome anxiety**

It has been seen that when people get anxious, they do try to get away from it by either indulging in leisurely activities like shopping or in vices like smoking, drinking etc. The more serious kind of people may opt for activities like exercising, meditation, yoga, meeting a physician and taking prescribed medicines or even talk therapy.

It has been seen that exercising, praying, meditation are very helpful in overcoming anxiety, but at the same time, time consuming techniques. Hence people tend to lose patience and/or faith in them sooner or later, unless they are very determined. In general, it has also been observed that people are skeptical about using anti-anxiety medicines due to possible side effects.

This is where EFT Tapping has seen to be an excellent technique with immediate and long term (if not permanent) solution.

**Quality of Life**

Quality of life (QOL) is the general well-being of individuals and societies, outlining negative and positive features of life. It observes life satisfaction, including everything from physical health, family, education, employment, wealth, religious beliefs, finance and the environment.

Quality of life should not be confused with the concept of standard of living, which is based primarily on income.

According to World Health Organization (WHO, 1998), Quality of life is the individual's perception of their position in life in the context of the culture and value systems, in which they live and in relation to their goals, expectations, standards and concerns. In this way, it is a personal option to be pursued, defined according to its needs, hopes and possibilities, being subject to constant transformations.

The concept of QOL is subjective. QOL of an individual would be affected by a number of factors, particularly by the significant positive and negative life events. These life events may be related either to his family or society or community where he lives or his own personal life (Khurana, 1996). It is a broad-ranging concept affected by an individual's physical health, psychological state, and level of independence, social relationships, and their relationship to salient features of their environment (WHOQOL Group, 1996; Celle and Bonomi, 1995).

Until recently, quality of life was not considered an issue of psychological importance. For many years, it was measured solely in terms of length of survival and signs of presence of disease, with virtually no consideration of the psychological consequences of illness and treatments (Taylor &Aspinwall, 1990).

In a study, Clond, M. conducted randomized controlled trials in 2016 on individuals with anxiety using EFT. Emotional freedom technique treatment demonstrated a significant decrease in anxiety scores, even when accounting for the effect size of control treatment.

In a study, Gaesser, A. H. examined the anxiety levels of gifted students, as well as the effectiveness of two interventions: Cognitive-Behavioral Therapy (CBT) and Emotional Freedom Technique (EFT) in 2014. EFT participants showed significant reduction in anxiety levels when compared to the control group. CBT participants did not differ significantly from either the EFT or control groups.

In a study, Stewart, A., Boath, E., Carryer, A., Walton, I., Hill, L. conducted a study in 2013 on referrals for any emotional condition (including physical pain.

The main presenting conditions were anxiety, depression and anger and clients revealed up to 4 additional issues. The results support the potential of EFT as a cost-effective treatment to reduce the burden of a range of physical and psychological disorders.

Louis Focused 2 conditions - EFT and a control group- to assess emotional self-report and mindfulness in 2013.

Mixed analysis of variance with paired-sample t tests showed that EFT participants experienced significantly greater increases in enjoyment and hope and significantly greater decrease in anger and shame than did the control group. When data from all emotion-dependent variables were grouped together, analysis showed that EFT participants experienced a significantly greater increase in “positive emotions” and significantly greater decrease in “negative emotions” than did the control group.

Church, in his 2013 research says that EFT has shown efficacy in several RCTs of anxiety. In one study, students with fear of public speaking received a 45-minute EFT session and improved significantly (Jones, Thornton, & Andrews, 2011). In another, high school students with test anxiety were evaluated before their university entrance exams (Sezgin &

Ozcan, 2009). Those who learned EFT improved significantly. A study of fibromyalgia sufferers found significant improvements in anxiety (Brattberg, 2008), as have studies of veterans and hospital patients with PTSD (Church, 2013b; Karatzias et al., 2011). EFT was found to be as efficacious as CBT in reducing symptoms of anxiety, depression, and PTSD.

In a study, Boath, L. Stewart, A., & Carryer, A., conducted a study in 2012 on presentation anxiety which is one of the most common fears that people express. EFT was done on a sample of 25 3rd year Foundation Degree level complementary therapy students undertaking a Research Module. They were guided though one round of EFT focusing on their fear of public speaking. The students were assessed using the Subjective Units of Distress (SUDs) and the Hospital Anxiety and Depression Scale (HADS) pre and post EFT. There was a significant reduction in SUDS HAD and HAD Anxiety Subscale. There was no difference in the HAD Depression Subscale. The results suggest that EFT may be a useful addition to curricula for courses that include oral presentations.

In a study, Jones, S. J., Thornton, J. A., Andrews, H. B. conducted a study on thirty six volunteers with Public Speaking Anxiety (PSA) in 2011. Subjective self-report measures were taken before, during, and after a forty-five minute treatment session with Emotional Freedom Techniques (EFT). A significant reduction in PSA as measured by Subjective Units of Discomfort was demonstrated within the first 15 minutes of treatment with EFT, with further significant reductions also demonstrated at 30 and 45 minutes. EFT was found to be a quick and effective treatment for PSA.

In a study, Church, D., & Brooks, A. J. examined whether self-intervention with Emotional Freedom Techniques (EFT) in 2010, had an effect on healthcare workers' psychological distress symptoms. EFT provided an immediate effect on psychological distress, pain, and cravings that was replicated across multiple conferences and healthcare provider samples.

In a study, Benor, D. J., Ledger, K., Toussaint, L., Hett, G., & Zaccaro, D. (2009): Despite small sample size, significant reductions on the TAI and HSCL-21 were found for WHEE; on the TAI for EFT; and on the HSCL-21 for CBT. There were no significant differences between the scores for the three treatments. In only two sessions WHEE and EFT achieved the equivalent benefits to those achieved by CBT in five sessions. WHEE and EFT show promise as effective treatments for test anxiety.

In a study, Rowe, J. conducted a study in 2005 to measure any changes in psychological functioning that might result from participation in an experiential EFT workshop and to examine the long-term effects.Using a time-series, within-subjects repeated measures design, 102 participants were tested with a short-form of the SCL-90-R (SA-45) 1 month before, at the beginning of the workshop, at the end of the workshop, 1 month after the workshop, and 6 months after the workshop. There was a statistically significant decrease in all measures of psychological distress as measured by the SA-45 from pre-workshop to post-workshop which held up at the 6 month follow-up.

## METHOD

### Research Problem

To study the effect of Emotional Freedom Technique (EFT) Tapping on anxiety and Quality of Life.

### Objectives

- To examine the effect of Emotional Freedom Technique (EFT) tapping on anxiety among urban Indian adults.
- To assess the effect of Emotional Freedom Technique Tapping on Quality of Life among urban Indian adults.
- To see the impact of Anxiety on Quality of Life among urban Indian adults.

**Hypotheses**

- There would be a significant effect of Emotional Freedom Technique (EFT) Tapping on Anxiety among urban Indian adults.
- There would be a significant effect of Emotional Freedom Technique (EFT) Tapping on Quality of Life among urban Indian adults.
- There would be significant effect of Anxiety on Quality of life.

**Research Design**

The study was pretest and posttest study.

| Pre-test | Intervention | Post test |
|---|---|---|
| Anxiety<br>Quality of Life | EFT Tapping | Anxiety<br>Quality of Life |

**Variables**

**Independent variable**

Emotional Freedom Technique (EFT) Tapping

**Dependent variables**

Anxiety and Quality of Life

**Sampling**

Sample size of 40 adults (20 males and 20 females) in the urban area of Delhi and NCR. The tests were administered on a total of 30 males and 35 females. From this, only the subjects who met the following criteria were called for intervention:

- Those who had a score of 7 or above for anxiety; and
- Those who completed both the questionnaires.

**Inclusion**

- People in the age group of 20 years and above
- People willing to participate in both pre-test and post-test
- People who can read and understand basic English (as per Indian standards)

**Exclusion**

- People whose pre-test and/or post-test were incomplete
- People with major physical/mental illness.

**Table 1**

*Tests/tools*

| No. | Tool Used | Variable |
|---|---|---|
| 1. | State Trait Anxiety Test by Psy-Com Services | Anxiety |
| 2. | WHOQOL-BREF by WHO (1996) | Quality of Life |

**Procedure**

**The tapping was done in 3 steps**

- Accepting one-self
- Acknowledging and addressing the issue
- Letting go of the emotion

**Statistical Analysis Techniques**

The data was analysed by computing mean, standard deviation, correlation and applying paired sample t-test using SPSS.

**Results and Discussions**

**RESULTS**

$H_1$: There would be a significant effect of Emotional Freedom Technique (EFT) Tapping on Anxiety among urban Indian adults.

**T able 2**

*Paired t-Test Analysis of Anxiety Pretest and Posttest*

| Variables | N | Mean | Std. Deviation | t | p Value | Significant |
|---|---|---|---|---|---|---|
| **Anxiety** *Pretest* | 40 | 8.3250 | 1.22762 | 11.094 | <0 .001 | **Yes** |
| **Anxiety** *Post test* | 40 | 6.9750 | 1.36790 | | | |

p< .001, significant at two tailed

Low score indicates low levels of anxiety

The Mean score for Anxiety in pretest and posttest are 8.3250 and 6.9750 respectively. The Standard Deviations are 1.22762 and 1.36790 respectively at *df*39 and which is significant at the level of p<.001. Hence, hypothesis 1 is accepted. Therefore, we can say that there is a significant difference in anxiety levels in subjects before and after EFT Tapping.

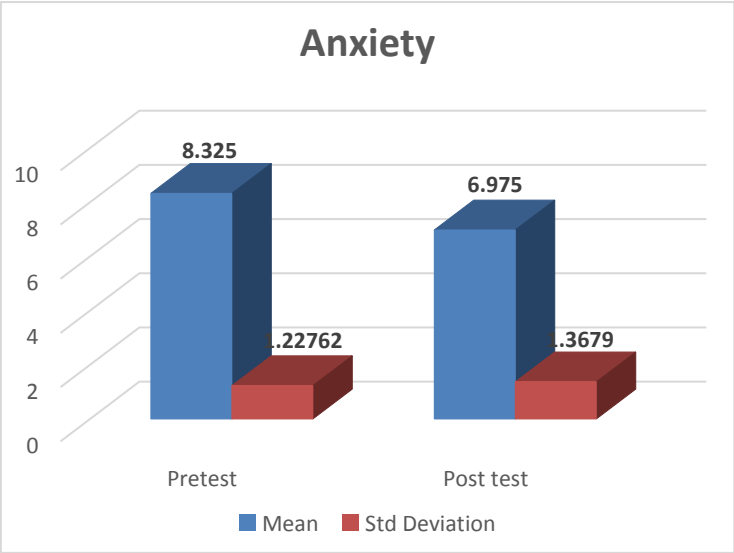



***Figure 1: Analysis of Anxiety Pretest and Posttest***

$H_2$: There would be a significant effect of Emotional Freedom Technique (EFT) Tapping on Quality of Life among urban Indian adults.

**Table 3**

*Paired t-Test Analysis of Quality of Life Pretest and Posttest*

| Variables | N | Mean | Std. Deviation | t | p Value | Significant |
|---|---|---|---|---|---|---|
| **QoL** *Pretest* | 40 | 65.5313 | 10.62731 | -4.585 | <0.001 | **Yes** |
| **QoL** *Post test* | 40 | 67.1125 | 9.88150 | | | |

p< .001, significant at two tailed

High score indicates good Quality of life

The Mean score for Quality of Life in pretest and posttest are 65.5313 and 67.1125 respectively. The Standard Deviations are 10.62731 and 9.88150 respectively at *df*39 and which is significant at the level p<.001.Hence, hypothesis 2 is accepted. Therefore, we can say that there is a significant difference in Quality of Life in subjects before and after EFT Tapping.

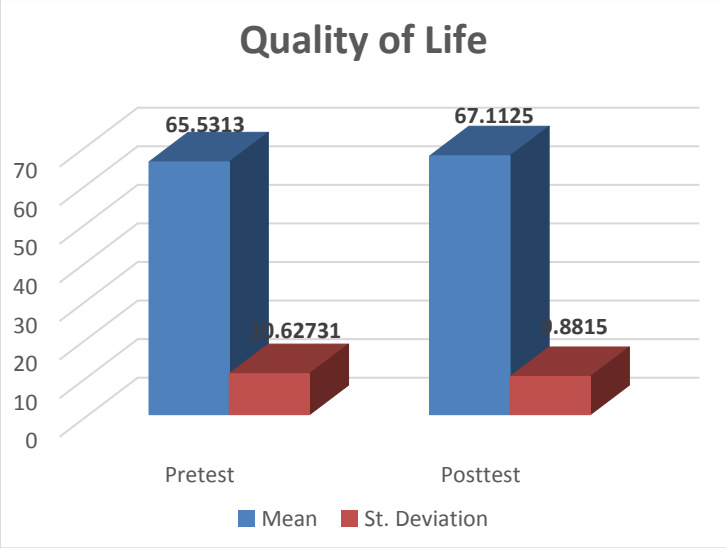



***Figure 2: Analysis of Quality of Life Pretest and Posttest***

$H_3$: There would be significant effect of Anxiety on Quality of life.

**Table 4**

*Correlation of Anxiety and Quality of Life Pretest*

| Variables | N | Mean | Correlation |
|---|---|---|---|
| Anxiety | 40 | 8.3250 | -0.281 |
| Quality of Life | 40 | 65.5313 | |

**Table 5**

*Correlation of Anxiety and Quality of Life Posttest*

| Variables | N | Mean | Correlation |
|---|---|---|---|
| Anxiety | 40 | 6.9750 | -0.460 |
| Quality of Life | 40 | 67.1125 | |

In both the above tables, it is observed that the correlation between anxiety and QoL is negative i.e. when the anxiety levels are high, QoL declines and, when the anxiety levels are low, QoL is improved.

Before tapping, the correlation between anxiety and QoL was -.281 and after tapping, it is -.460. This means after tapping when anxiety levels decrease, as shown in pretest and posttest mean score, the QoL score increases as seen in the mean score of pretest and posttest. Hence, hypothesis 3 is accepted.

## DISCUSSION

The present research is aimed to study the effect of Emotional Freedom Technique on Anxiety and Quality of Life in urban Indian adults. Pretests and posttests were with the sample of the study (N=40).

A significant difference was found in anxiety levels in subjects before intervention and after intervention. The result was obtained with the help of paired t-test.

The present findings support previous research conducted. 'Quantitative findings indicated participants reported significantly less subjective distress and anxiety after using EFT. Qualitative findings indicated three themes whereby participants found EFT calming, relaxing and helpful; considered the transferability of EFT in other settings; and proposed some of the mechanisms of EFT's action.'(Elizabeth Boath, Rachel Good, et al., 2017).

According to the knowledge of investigator, very few studies have been reported exploring the effect of tapping on QoL. The present study however, attempts to examine the effect of tapping on QoL. A significant difference was found in QoL levels in subjects before intervention and after intervention. The result was obtained with the help of paired t-test.

The current study has examined the immediate effect of tapping on anxiety and its relation with Quality of Life. Negative correlation is found between anxiety and Quality of life which means that when anxiety levels increase, Quality of Life decreases and vice versa. Tables 4 and 5 (under Results) of current study shows that EFT tapping has helped in decreasing anxiety levels and increasing Quality of Life respectively.

There are previous studies on how EFT tapping helps release pain and thus enhance Quality of Life. Numerous studies have demonstrated the efficacy of EFT for depression, anxiety, phobias, PTSD, and other psychological conditions.

The current study "Pain, range of motion, and psychological symptoms in a population with frozen shoulder: A randomized controlled dismantling study of Clinical EFT (Emotional Freedom Techniques)" assesses whether acupoint stimulation is an active ingredient or whether treatment effects are due to non-specific factors. Though EFT showed a greater trend for improved Range of motions in most dimensions of movement, changes were non-significant for most measures in all groups. Reductions in psychological distress were associated with reduced pain as well as with improved Range of motions. The results showed that acupoint stimulation is an active ingredient in EFT treatment. The study adds further support to other clinical trials indicating that Clinical EFT is an efficacious evidence-based treatment for pain and psychological conditions (Church, D., &Nelms, J.; 2016).

The above study has relevance because pain is one of the physiological dimensions of Quality of Life. When levels of pain increase, Quality of Life is seen to be low.

## CONCLUSION

Despite the limitations of the study, the results suggest a potential role for EFT as an intervention in reducing anxiety and enhancing quality of life. Also, it takes a very short time to train participants to use EFT, and that once learned, EFT can be very effectively self-administered and can easily be transferred to other aspects of life. The study shows a negative correlation between the two variables i.e. Anxiety and Quality of Life.

### Ethical approval

Ethical approval was obtained from all participants.

**Acknowledgements**

I would like to immensely thank all the individuals who participated in the research and gave their valuable time to be interviewed. I also thank each and every person who guided and supported me in carrying out the research.

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# Emotional intelligence of orphans in relation to their Self Concept

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## ABSTRACT

The study is designed to see the type of relationship between school going orphans students' emotional intelligence and their self concept. The demographic variables are like gender and the home in which they stay and their significance on orphans emotional intelligence. 140 orphan students staying in government and private homes were selected using simple random sampling technique. The tools used for this study is Emotional Quotient Inventory by Bar-on(1997) Self concept Scales by Mukta Rani Rastogi (1979). The result indicates that orphans students' emotional intelligence and self concept are correlated. The other variables like gender and the home in which they stay also influence orphan students' emotional intelligence.


***Keywords***: *Emotional intelligence, Orphans, Self concept*

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## INTRODUCTION

Emotional intelligence is the ability to perceive, understand, and manage emotions as acknowledged by Marques,(2007) Emotions play a great role in school. An orphan child who feels anxious, jealous, hopeless or alienated will have difficulty in learning, making sound decisions, and building healthy relationships. Salovey and Mayer (1990) defined emotional intelligence as, "the subset of social intelligence that involve the ability to monitor one's own and others' feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions." Goleman(1995) recommends the ability to read and be sensitive to others' emotions as a key component of emotional intelligence, Indeed empathy appears to be an established facets of emotional intelligence.

**Sources of Emotional intelligence**

According to Bechara, et al. (2000) emotional intelligence is like most other human characteristics, which reflects both genes and the social environment in which the child develops. The individual's DNA interacts with external stimulation in building the brain, including the limbic system that influences emotion. Perhaps emotional intelligence can be important for regulating and controlling emotion. Reis, et al.(2007) suggests that both frontal and temporal lobes support emotionally intelligent reasoning. In addition the quality of interactions with caregivers and peers, which the child experiences, is known to affect emotional development. Smith and Walden (1999) shows maltreatment and deprivation are known to have various serious adverse effects.

**The concept of emotional intelligence**

According to Thorndike's (1920) use of the term 'Social intelligence' to describe one's ability to relate to other people. Emotional intelligence was conceived by Payne (1985) as one's ability to relate creatively to fear, pain and desire. The concept was thereafter

expanded by Salovey and Mayer (1990) who formulated a model of emotional intelligence based on how people appraise, communicate, and utilize emotions.

In a Study, Salovey and Mayer declared that emotional intelligence is the capacity to both understand emotional information and reason with emotions. And is comprised of four primary abilities (i) the capacity to accurately perceive emotions, (ii) the capacity to use emotions to facilitate thinking (iii) the capacity to understand emotional meanings, (iv) the capacity to manage emotions. Although their linking of emotion and intelligence has been heavily criticized, Mayer and Salovey (1993) argued that many intellectual problems contain emotional information that must also be interpreted and processed. Mayer, et al.(2000) have further demonstrated that the Salovey and Mayer (1990) model of emotional intelligence meets the standard criteria for intelligence. A similar model was proposed by Daniel Goleman (1995) who added the capacity to enter and sustain satisfactory interpersonal relationships.

**The aspect of Emotional intelligence**

Emotional intelligence has two aspects i) understanding oneself, one's own goals, intentions, reposes, behaviour and ii). Understanding others and their feelings, Emotion intelligence doesn't include agreeableness, Optimism, motivation, happiness and calmness as there are only personal qualities and have nothing to do with emotions, intelligence or emotional intelligence.

**Empathy**

In a study, Salovey and Mayer (1990) distinguished the important role of empathy in emotional intelligence, suggesting that empathy was a critical aspect in the appraisal of others' emotions. Although previously regarded as a dispositional tendency, the authors defined empathy as "the ability to comprehend another's feelings and to re-experience them

oneself". Similarly, Goleman (1995) recommended the ability to read and to be sensitive to others' emotions as a key component of emotional intelligence, reflecting Gardner's (1983) suggestion that individuals in the helping professions demonstrate a high level of interpersonal intelligence. Indeed empathy appears to be an established facet of emotional intelligence.

**Branches of Emotional Intelligence**

In a study, Salovey and Mayer (1990) proposed four different factors of emotional intelligence, the perception of emotion, the ability to reason using emotions, the ability to understand emotion and the ability to manage emotions.

**Perceiving Emotions**

The first step in understanding emotions is to accurately perceive them. In many cases, this might involve understanding nonverbal signals such as body language and facial expressions.

**Reasoning with Emotions**

Using emotions to promote thinking and cognitive activity. Emotions help prioritize the attention and react to or respond emotionally to things.

**Understanding emotions**

The emotions that one perceives can carry a wide variety of meanings. If someone is expressing angry emotions, the observer must interpret the cause of their anger and what it might mean.

**Managing Emotions**

The ability to manage emotions effectively is a key part of emotional intelligence. Regulating emotions, responding appropriately and responding to the emotions of others are all important aspect of emotional management.

**Measuring of Emotional Intelligence**

In a study, John D. Mayer (1990) proclaimed that to measure emotional intelligence, the ability testing is the only adequate method to employ. Intelligence is ability, and is directly measured only by having people answer questions and evaluating the correctness of those answers.

**The Domains of Emotional Intelligence**

In a study, Goleman (1990) gazed at the domains of emotional intelligence are i) Self awareness. ii) Managing emotions. iii) Motivating oneself iv) Recognising and understanding other people's emotions, v) Handling relationships.

Emotion drives behaviours, and an individual's ability to consider the potential overwhelming importance of his or her own emotions. Emotional self-awareness is recognizing ones emotions and their effects on oneself and others. This does not mean that the emotionally conscious person has to detach emotions from their actions, but rather that they be understood, and in control.

**Understanding Emotional Intelligence as a process**

In a study, Sternberg (1985) stated that the concept of intelligence is poorly formulated and largely misunderstood. Simply enumerating a person's IQ fails to inform us of how intelligence plays out as an ongoing process in real life contexts. To know how it helps the person adapt to threats and opportunities, this process view is especially important

if emotional intelligence, as claimed is more malleable than IQ. In the absence of understanding processes, interventions are likely to be futile at best perhaps even dangerous.

**Emotional Intelligence (EQ) vs. Intellectual Intelligence (IQ)**

The past, people learned not to trust their emotions and considered being emotional is weak and even childish. On the other hand other abilities are measured or graded. However people who are intellectually brilliant are socially clumsy due to lack of emotional intelligent.

**Emotional development - How to raise ones Emotional intelligence**

Emotional intelligence is learned by winning the emotional parts of the brain in ways that connect us to other senses, perception, olfactory and kinaesthetic.

**Developing emotional Intelligence through five key skills;**

i) The ability to rapidly reduce stress ii) The ability to recognize and manage ones emotions. iii) The ability to connect with others using non-verbal communication. iv) The ability to use humour and play to deal with challenges. v) The ability to resolve conflict positively and with confidence

**Emotion Intelligence action Plan**

Emotional intelligence can be increased by following the four strategies, Self awareness, Self management, Social awareness, and relationship management strategies.

**Emotional intelligence of orphans**

Orphans' emotional intelligence has an impact on their growth and development. Goleman (1995) cites some alarming data stemming from a large survey of parents and teachers, the former revealed that there is a worldwide trend for the present generation of children to be more troubled emotionally than the last more lonely and depressed, more angry

and disruptive, more panicky and prone to be troubled, more impulsive and aggressive. The results show that there is an increasing need to address the emotional health of our children. The challenge in addressing this issue however is learning how to manage orphans in terms of healthy emotional development.

**Orphans** Children who has lost both their parents and, semi orphans are those who have lost one parent through death or other misfortunes.

**Self concept**

According to Myers, David (2009) Self concept is one's perception about oneself; Self concept embodies the answer to "Who am I". This perception is influenced by ones interactions with important people in ones lives. One's self perception is defined by one's self concept, self knowledge, self esteem and social self. One's self concept is made up of self schemas, and ones past, present and future selves. Self concept differs from self- esteem; self concept is a cognitive or descriptive component of one's self, while self esteem is evaluative and opinionated.

As examined by Flook, et al. (2005) self concept is also called as self construction, self identity, self perspective or self structure, a collection of beliefs about oneself which includes elements such as academic performance, gender roles and sexuality. Hoffman, Rose Marieetal (2005), Wade,et al.(1998), Hoffman, et al. (2004) and Aries et al. (1998) expressed that self concept is distinguishable from self awareness which refers to the extent to which self knowledge is defined, consistent, and Ayduk (2009) explained that self concept is currently applicable to one's attitudes and dispositions.

In a study, Berk (2009) accepted that a self concept is the set of attributes, abilities attitudes and values which an individual believes and defines who one is. A changed self

concept may alter the orphan's relationship to the outside world, and may lead to mental disorder.

**Origins' of Self Concept**

Psychologists' Carl Rogers and Abraham Maslow were the first to establish the notion of self concept. According to Rogers, every one strives to reach an ideal self. Rogers also hypothesizes that psychologically healthy people actively move away from roles created by others' expectations, and instead look within themselves for confirmation. On the other hand Aronson, et al. (2007) study shows that neurotic people have "self concept that do not match their experiences, they are afraid to accept their own experiences as valid, so they distort them, either to protect themselves or to win approval from others".

Marsh, et al. (2011) endorsed that children and adolescents begin integrating social identity into their own self concept in elementary school by assessing their position among peers. Rubie Davie,s et al. (2006) certified that by the age five acceptances from peers has a significant impact on children's self concept, affecting their behavior and academic success.

**Development of self concept**

Developmental Psychologist assert that gender stereotypes and expectations set by parents for their children impact children's understanding of themselves by approximately age three. Craven, et al. (1991) and others suggest that self concept develops later around age 7 or 8, when children are developmentally prepared to interpret their own feelings and abilities, as well as feedback they receive from parents, teachers, and peers. As stated by Myers, David (2009) despite differing opinions about the onset of self concept development researcher agree on the importance of one's self concept, which influences people's behavior, cognitive and emotional outcomes Marsh, et al. (2011),Swann et al(2012), Markus(1991)

included academic achievement, level of happiness, anxiety, social integration, self esteem, and life satisfaction.

**Component of self concept**

Social identity theory explains that self concept is composed of two key parts: personal identity and social identity. Our personal identity includes such things as personality traits and other characteristics that make each person unique. Social identity includes the groups one belongs to including community, religion, college and other groups.

**Domains related to self concept**

In a study, Bracken (1992) suggested six domains related to self concept i) Social – the ability to interact with others ii) Competence- ability to meet basic needs. iii) Affect- awareness of emotional states. iv) Physical - feelings about looks, health, physical condition and overall appearance. v) Academic – success or failure in school. vi). Family –how well one functions within the family unit.

**Different parts of Self concept**

The humanist Psychologist Carl Rogers assumed that there are three different parts of self concept.

Self image is how one perceives about oneself. Self image does not necessarily coincide with reality. People might have an inflated self image and believe that they are better at things than they really are, on the other hand, people are also prone to have negative self image and perceive or exaggerate flaws or weaknesses. Each individual's self image is probably a jumble of different aspects including physical characteristics, personality traits, and social roles.

Self esteem is evaluation of oneself. A number of different factors can impact self-esteem, including how one compare oneself to others and how others respond to it when people respond positively to their behavior, construct positive self esteem. When people compare themselves to others and find themselves lacking, it can have a negative impact on their self esteem.

Ideal self is a person's conception of how they would ideally like to be. In many cases the way one see oneself and how one would like to see oneself do not quite match up.

**Orphans' academic performance and self concept**

In a study, Marsh, et al. (2011) explained that orpans' academic self concept refers to the personal beliefs, abilities or skills. Carven, et al. (1991) noted that a few studies suggest that development begins from ages 3 to 5 due to influence from parents and early educators. Somech & Anit (2000) stated that by the age of 10 or 11 children assess their academic abilities by comparing themselves to their peers. Cross (1997) contributed that these social comparisons are also referred to as self estimates.

In a study, Gabriel, et al. (1999) proposed that, to raise an academic self concept, parents and teachers need to provide children with specific feedback that focuses on their particular skills or ablates. Marsh, et al. (2011) and Swann, et al. (2012) affirmed that learning opportunities should be conducted in groups that downplay social comparison, as too much of either type of grouping can have adverse effects on children's academic self-concept and the way they view themselves in relation to their peers.

**The orphans and the self concept**

Social withdrawal and social anxiety may, harm the orphans self esteem even more. Boulton & Underwood,(1992), Graham, et al. (2007), Houbre, et al.(2006), Lagerspetz, et al,

(1982), Lodge & Feldman (2007), Olweus (1978), (1984). Yang, et al. (2006) in Houbre, Tarquinio & Lanfranchi,(2010) these researches exposed that orphans tend to have a more negative self concept in comparison with the other schoolchildren. Houbr, et al. (2006) showed those orphans' self concepts about their social competence, physical appearance.

## METHOD

### Objectives

- To understand the type of relationship between orphan's emotional intelligence and their self -concept.
- To find out the significant difference in the emotional intelligence of male and female orphans.
- To see the significant difference in the emotional intelligence of orphans staying in government and private homes.

### Hypothesis

- There is no relationship between orphan's emotional intelligence and self-concept.
- Orphan's staying in the private home and government orphanage do not differ in their emotional intelligence
- Male and female orphans do not differ in their emotional intelligence.
- **Variables:**
- Dependent variable is emotional intelligence
- Independent variables are self-concept, gender and the home in which they stay

**Sampling**

The study was conducted among the male and female orphans staying in Government and Private homes situated in Salem district, using simple random sampling technique.

- Tools Emotional Quotient Inventory by Bar-on(1997)
- Self concept Scales by Mukta Rani Rastogi (1979)

## RESULTS

**Table 1**

*Showing the co-efficient of correlation between orphans' EI and their SC*

| Test | N | r | Significance |
|---|---|---|---|
| **Self regard, self concept** | | 0.43 | 0.01 |
| **Interpersonal relationships, self concept** | | 0.64 | 0.01 |
| **Impulse control, self concept** | | 0.51 | 0.01 |
| **Problem solving, self concept** | | 0.48 | 0.01 |
| **Emotional self awareness, self concept** | | 0.44 | 0.01 |
| **Flexibility, self concept** | 140 | 0.63 | 0.01 |
| **Reality testing, self concept** | | 0.36 | 0.01 |
| **Stress tolerance, self concept** | | 0.59 | 0.01 |
| **Assertiveness, self concept** | | 0.32 | 0.01 |
| **Empathy, self concept** | | 0.13 | Not significant |
| **Emotional intelligence, self concept** | | 0.61 | 0.01 |

Table 1 showing coefficient of correlation between orphan's emotional intelligence and their self concept. There are 140 orphans included in the study and their scores indicate that all the dimensions of orphan's emotional intelligence and their total scores significantly

related to this self concept expect in empathy where the relationship is not statistically related. These indicate that orphan's emotional intelligence depends upon their self-concept. Hence the null hypothesis that there is no relationship between orphans emotional intelligence and their self concept is not accepted.

**Tables 2**

*Showing difference in the emotional intelligence of orphans staying in Government and private homes*

| Dimension | Orphans | N | Mean | SD | t-ratio | Significance |
|---|---|---|---|---|---|---|
| **Self-regard** | **Govt** | 43 | 122.71 | 12.47 | 15.25 | .01 |
| | **Private** | 97 | 154.43 | 10.86 | | |
| **Interpersonal relationship** | **Govt** | 43 | 131.86 | 11.04 | 8.08 | .01 |
| | **Private** | 97 | 148.91 | 12.63 | | |
| **Impulse control** | **Govt** | 43 | 141.04 | 11.39 | 5.56 | .01 |
| | **Private** | 97 | 153.18 | 13.16 | | |
| **Problem solving** | **Govt** | 43 | 151.37 | 12.11 | 2.77 | .01 |
| | **Private** | 97 | 157.43 | 13.04 | | |
| **Emotional self-awareness** | **Govt** | 43 | 124.63 | 11.6 | 7.3 | .01 |
| | **Private** | 97 | 140.55 | 12.74 | | |
| **Flexibility** | **Govt** | 43 | 136.09 | 13.07 | 5.51 | .01 |
| | **Private** | 97 | 149.17 | 12.51 | | |
| **Reality testing** | **Govt** | 43 | 153.36 | 13.06 | 1.33 | NS |
| | **Private** | 97 | 156.48 | 12.44 | | |
| **Stress-tolerance** | **Govt** | 43 | 130.36 | 11.93 | 9.35 | .01 |
| | **Private** | 97 | 151.41 | 13.15 | | |
| **Assertiveness** | **Govt** | 43 | 143.88 | 11.48 | 2.44 | .05 |
| | **Private** | 97 | 149.17 | 12.61 | | |
| **Empathy** | **Govt** | 43 | 149.8 | 13.08 | 1.67 | NS |
| | **Private** | 97 | 153.73 | 12.16 | | |
| **Total Emotional intelligence** | **Govt** | 43 | 139.24 | 11.48 | 7.74 | .01 |
| | **Private** | 97 | 156.13 | 12.81 | | |

**Note:** NS: Not Significant

Table 2 showing difference in the emotional intelligence of orphans staying in the government and private homes. There are 43 orphans staying in the government homes and 97 orphans staying in the non government homes included in the study. In all the areas of emotional intelligence expect in reality testing and empathy, orphans staying in the private homes are better in their emotional intelligence than orphans staying in the government homes. Since the t-ration are statistically significant. In the areas like reality testing and empathy orphans do not differ. The total emotional intelligence also indicates that orphans staying in the private homes are better in their emotional intelligence than orphans staying in the government homes. Hence the null hypothesis that orphans staying in the government and private homes dot not differ in their emotional intelligence is not accepted

**Table 3**

*Showing difference in the emotional intelligence of male and female orphans*

| Dimension | Gender | N | Mean | SD | t-ratio | Significance |
|---|---|---|---|---|---|---|
| **Self-regard** | **Male** | 36 | 132.54 | 11.41 | 12.04 | .01 |
| | **Female** | 104 | 159.51 | 12.36 | | |
| **Interpersonal relationship** | **Male** | 36 | 136.48 | 12.16 | 7.63 | .01 |
| | **Female** | 104 | 154.11 | 11.43 | | |
| **Impulse control** | **Male** | 36 | 141.14 | 11.96 | 1.17 | NS |
| | **Female** | 104 | 143.86 | 12.03 | | |
| **Problem solving** | **Male** | 36 | 154.67 | 11.91 | 5.09 | .01 |
| | **Female** | 104 | 142.8 | 12.46 | | |
| **Emotional self-awareness** | **Male** | 36 | 132.19 | 12.33 | 8.76 | .01 |
| | **Female** | 104 | 152.69 | 11.51 | | |
| **Flexibility** | **Male** | 36 | 128.62 | 12.56 | 8.63 | .01 |
| | **Female** | 104 | 141.62 | 1143 | | |
| **Reality testing** | **Male** | 36 | 142.88 | 12.48 | 0.57 | NS |
| | **Female** | 104 | 142.88 | 12.48 | | |
| **Stress-tolerance** | **Male** | 36 | 128.47 | 12.43 | 8.8 | .01 |
| | **Female** | 104 | 149.15 | 11.51 | | |
| **Assertiveness** | **Male** | 36 | 143.36 | 12.23 | 2.44 | NS |
| | **Female** | 104 | 144.93 | 11.59 | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | **Male** | 36 | 126.42 | 12.59 | | |
| **Empathy** | **Female** | 104 | 148.82 | 11.48 | 9.45 | .01 |
| **Total Emotional intelligence** | **Male** | 36 | 131.17 | 11.83 | | |
| | **Female** | 104 | 149.56 | 12.43 | 7.96 | .01 |

Table 3 showing difference in the Emotional intelligence of male and female orphans. Females are better in their emotional intelligence than males in areas like self-regard, interpersonal relationship, emotional self - awareness, flexibility, stress tolerance, empathy and total emotional intelligence. In problem solving males are better than females. In the other areas like impulse control, reality testing and assertiveness both male and female orphans do not differ in their emotional intelligence. Hence the null hypothesis that male and female orphans do not differ in their emotional intelligence is not accepted.

## CONCLUSIONS

a) There is a significant relationship between orphans emotional intelligence and their self concept.

b) One of the dimensions of emotional intelligence, empathy is not related to self concept.

c) Orphans staying in private homes are better in their emotional intelligence than those staying in Government homes,

d) In the dimensions of emotional intelligence namely reality testing and empathy, orphans staying in private and government homes do not differ.

e) Female orphans are better than male orphans. In the areas like Self regard, interpersonal relationship, emotional self awareness, flexibility, stress tolerance, empathy, total emotional intelligence.

f) Male and female orphans do not differ in impulse control, reality testing and assertiveness dimensions of emotional intelligence

g) Male orphans are better in problem solving dimension of emotional intelligence than female orphans

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# Gender Difference on Emotional maturity

Ramesh D. Waghmare*


## ABSTRACT

Emotional Maturity is a natural and inevitable essential outcome of student growth and development. The Emotional maturity becomes important in the behavior of individuals. As the students are the pillars of the future generations, their value pattern of Emotional Maturity are vital. The purpose research attempted to study the Gender Difference on Emotional maturity. To study by research seared variables in Gender and Emotional maturity sub factor. The sample has 90 college students in each 45 Male college students and 45 Female college students. The scale was used for data collection Emotional Maturity Scale by Singh and Bhargava (1990). Factorial design was used and data were analysis by Mean, SD and 'F' values. Results show that Female Students high Emotional Unstability than Male Students and Male College Students high Emotional regression, Social maladjustment, Personality disintegration, Lack of independence, Emotional maturity than Female College Students.


***Keywords:*** *Emotional Regression, Social Maladjustment, Personality Disintegration, Lack of Independence, Emotional maturity*

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## INTRODUCTION

The tern emotional maturity has been described by experts in many ways-typically as the effective determinate of personality pattern. Second, it also helps us to control the growth of adolescent's development. From a scientific point of view personality is the organization of some traits and emotional maturity is one of them.

The process of maturity emotionally is never complete, for a person in fairly good health mentally continues to grow more “mauler” in his attitude toward life and toward himself as long as he lives. Therefore, when we say that a major aim of a good educational program is to help learners to gain in emotional maturity, what we means are not the achievement of a certain and product that can be graded or rated on graduation day. But rather seeking to help the child in a process of development that continues long after most people leave school.

Emotional maturity that is in keeping with the facts of development and the potentialities involved in the process of development must stress not simply restriction and control but also the positive possibilities inherent in human nature. According to this view, emotional maturity involves the kind of living that most richly and fully expresses what a person has in him at any level of his development.

Emotional maturity constitutes evaluating emotions of oneself and others, identifying and expressing feelings, balancing state of heart and mind, adoptability and flexibility, appreciating’ Others' point of view, helping others, delaying gratification of immediate psychological satisfaction".

Emotional maturity according to Walter D. Smiston (1974) is a process through which the personality continuously strives for greater sense of emotional health, both intro-physically and intropersonality.

**Review of literature**

In a study, Jitender and Mona, (2015) indicated that female students exhibited more emotional maturity than the male students. Mohanty and Devi. L (2010) revealed in their study on gender differences that girls are more optimistic and well aware of their feelings and emotionally mature in comparison to boys. Nelson (2000) and Singh (2002) found the same results showing the significant difference of some variables with emotional maturity of college going students between male and female. Kaur, H. (2004) in her study found No significant difference was found in emotional maturity of boys and girls. Sandra P.T and Margareg.P (2001) this study found that the female adolescents residing in urban area have high level of emotional maturity. Tribhovan B. Makwana, (2015) indicated that there is significance difference between emotional maturity among girls and boys under graduate student. Kumar (2014) observed that there is no significant difference between boys and girls adolescent students in their emotional maturity. Manoharan et al, (2007) and Wani and Masih, (2015) concluded that emotional maturity of P.G. students is influenced by sex, class and group. The level of emotional maturity of female students is higher than that of the male students. Bhanwer (2012) found Adolescent boys were less emotionally mature than girls. Subramanian (2011) found that the high school boys have greater emotional maturity than the high school girls. Sinha (2014) found that boys have better emotional maturity than their girls. Gunde Rajendraand Parit, (2015) indicted that the male and female college students differ significantly in their emotional maturity except the dimensions: Emotional Regression and Lack of Independence. The Males are significantly more mature than females. Kaur (2001) revealed insignificant difference on emotional maturity between boys and girls.

Mukesh Kumar Panth and et. All, (2015) indicated that there are no significant difference found in boys' and girls' Emotional Maturity. Singh, Rashee (2012)- this study found that No significant difference was found between male and female senior secondary school students in relation to emotional maturity. Manoharan, R. John Louis and I. Christie Doss (2007) this study found that their scores on the components namely emotional instable, emotional regression and social maladjustment are on the higher side. Therefore, they are poor in their emotional stability, emotional well-being and social adjustment. Their scores on the last two components namely, personality disintegration and lack of independence are below average. Hence they are moderately sound in their personality integration and independence. The emotional maturity of P.G. students is influenced by sex, class and group. The level of emotional maturity of female students is higher than that of the male students.

**Statement of the problem**

To study of Gender Difference on Emotional maturity

**Objectives**

To examine the Emotional maturity among Male and Female College Students

**Hypotheses**

"There is no significant difference between Male and Female College Students college students with Emotional maturity dimension on Emotional Unstability, Emotional Regression, Social Maladjustment, Personality Disintegration, and Lack of Independence.

## METHOD

**Participants**

The present study sample go was selected from college students of Jalna City in Maharashtra. To select the sample Gender in which students study of College Students were considered as per independent variable taken in this research stratified random sampling method was employed to select the unit of sample. Total sample of present study 90 college students, in which 45 were Male College Students and 45 Female College Students. The subject selected in this sample will be used in the age group of 18 years to 21 years (Mean – 19.16, SD- 2.01.) and Ratio 1:1.

**Research Design**

2 X 2 *factorial* design used in the present study.

**Table 1**

*Variables of the Study*

| Variable | Type of variable | Sub. variable | Name of variable |
|---|---|---|---|
| **Gender** | Independent | 02 | 1) Male<br>2) Female |
| **Emotional maturity** | Dependent | 05 | 1) Emotional Unstability<br>2) Emotional regression<br>3) Social maladjustment<br>4) Personality disintegration<br>5) Lack of independence |

**Table 2**

*Instruments*

| Aspect | Name of the Test | Author |
|---|---|---|
| **Emotional maturity** | Emotional Maturity Scale (1990) | Dr. Yashvir Singh<br>Dr. Mahesh Bhargava |

**Emotional Maturity Scale**

Emotional Maturity Scale is constructed and standardized by Singh and Bhargava (1990). The scale comprised of 48 items and is based on five major areas of emotional maturity i.e. emotional unstability, emotional regression, social maladjustment, personality disintegration and lack of independence. The highest the score on the scale is greater the degree of the emotional immaturity and vice-versa. It is a self -reporting five point scale. Items of the scale are in question form demanding information for each in any of the five options- 'very much', 'much', 'undecided', 'probably', 'never'. The highest score of the Emotional Maturity Scale can be obtained 240 and lowest can be 48. The test-retest reliability of the scale was 0.75 and internal consistency of the scale was checked by calculating the coefficient of correlations between total scores and scores on each of the five areas i.e. emotional unstability (.75), emotional regression (.63), social maladjustment (.58), personality disintegration (.86), lack of independence (.42). The scale was validated against external criteria i.e. the Gha (.64). This scale is meant for adolescents and adults.

**Procedures of data collection**

The following research methodology was used in the present study. The primary information was gathered by giving personal information from to each to each student. The students were called in a small group of 10 to 15 students. To fill the inventories subjects were given general instructions belongs to each scale. The students provided the Emotional maturity Scale.

**Data analysis**

The data were analyzed as follows.

The Mean and SD with graphical representation for Gender (Male and Female College Students) on Emotional maturity was analyzed. A simple design was selected to

adequate of statistical analysis of ANOVA in order to examine the roll of main as well as subsequently on student's Emotional maturity.

## RESULTS AND DISCUSSION

The analysis of data interpretation and discussion of the results are presented below.

**Table 3**

*Show the mean, SD and F value of Gender on Emotional Unstability*

| Gender | Mean | SD | N | DF | Mean Difference | F | Sign |
|---|---|---|---|---|---|---|---|
| **Male Students** | 29.17 | 5.85 | 45 | | 3.13 | 8.09 | 0.01 |
| **Female Students** | 26.04 | 4.94 | 45 | 98 | | | |

(Critical value of "f" with df 89 at 0.01 = 3.94 and at 0.05 = 6.90)

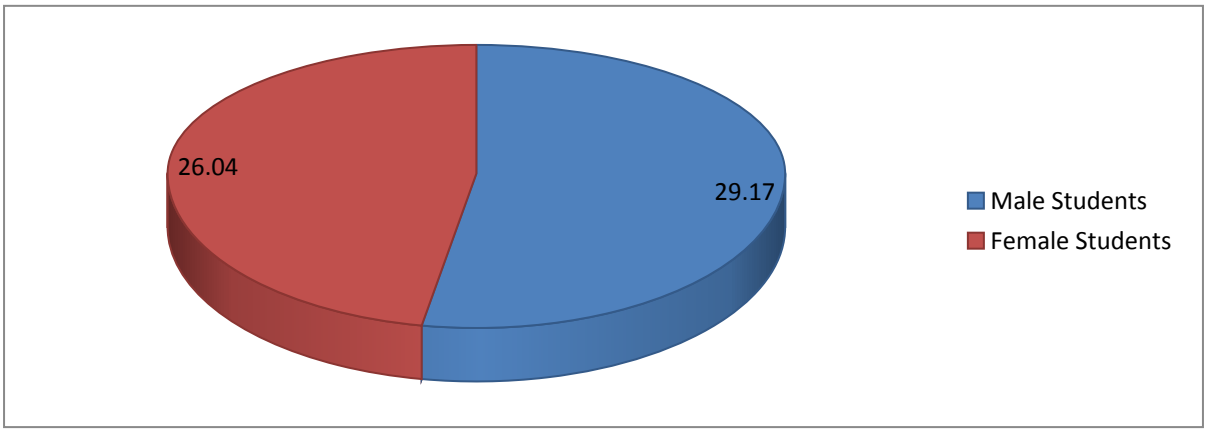


***Figure 1: Shows Mean value of Gender on Emotional Unstability***

Observation of the table 3 and Figure 1 indicated that the mean value of two classified group seems to differ from each other on Emotional Unstability. The mean and SD value obtained by the male college students 29.17, SD 5.85 and Female College students was 26.04, SD 4.94, but on the basis of mean observation it would that mean difference 3.13.

Both group 'F' ratio was 8.09 at a glance those Male college student shows high score than Female college students.

In the present study was hypothesis related Emotional Unstability and Gender. It was "There is no significant difference between Male and Female college students on Emotional Unstability. Gender effect represent the Emotional Unstability was significant (F- 8.09, 1and 89, P- 0.01 and 0.05). This is significant 0.01 and 0.05 levels because they obtained 'F' value are high than table values at 0.01 and 0.05. In the present study was found that male and female college students differ from Emotional Unstability. The findings of the not supported the first hypothesis, they are first hypothesis rejected the present study. Its means that Female Students high Emotional Unstability than Male Students.

**Table 4**

*Show the mean, SD and F value of Gender on Emotional regression*

| Gender | Mean | SD | N | DF | Mean Difference | F | Sign |
|---|---|---|---|---|---|---|---|
| **Male Students** | 26.35 | 6.74 | 45 | | 3.18 | 7.45 | 0.01 |
| **Female Students** | 23.17 | 4.46 | 45 | 90 | | | |

(Critical value of "f" with df 89 at 0.01 = 3.94and at 0.05 = 6.90)

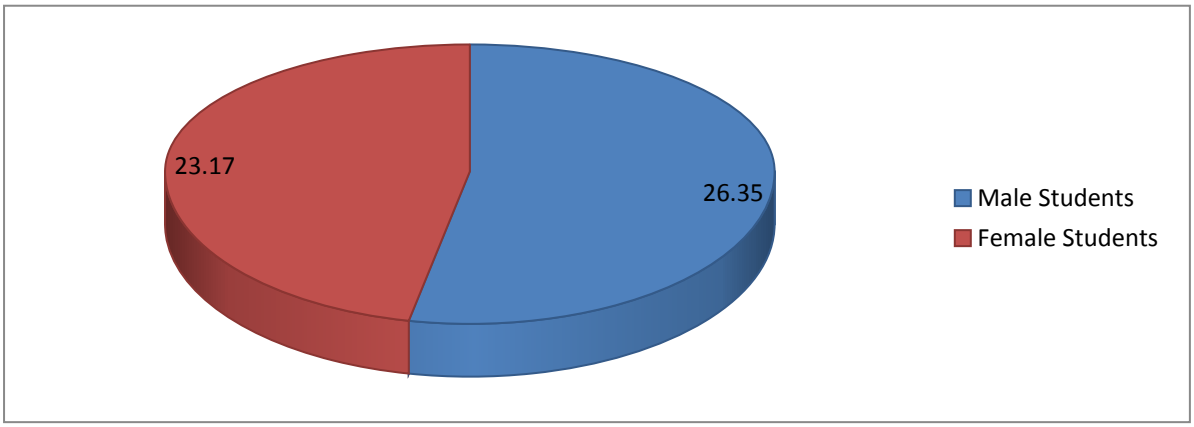


***Figure 2: Show the Mean value of Gender on Emotional regression***

Observation of the table 4 and Figure 2 indicated that the mean value of two classified group seems to differ from each other on Emotional regression. The mean and SD value obtained by the male college students 26.35, SD 6.74 and Female College students was 23.17, SD 4.46, but on the basis of mean observation it would that mean difference 3.18. Both group 'F' ratio was 7.45 at a glance those male college student shows high score than female college students.

In the present study was hypothesis related Emotional regression and Gender. It was "There is no significant difference between Male and Female college students on demotion Emotional regression. Gender effect represent the Emotional regression was significant (F- 7.45, 1and 89, P- 0.01 and 0.05). This is significant 0.01 and 0.05 levels because they obtained 'F' value are high than table values at 0.01 and 0.05. In the present study was found that male and female college students differ from Emotional regression. The findings of the not supported the hypothesis, they are hypothesis rejected the present study. Its means that Male College Students high Emotional regression than Female College Students.

**Table 5**

*Show the mean, SD and F value of Gender on Social maladjustment*

| Gender | Mean | SD | N | DF | Mean Difference | F | Sign |
|---|---|---|---|---|---|---|---|
| **Male Students** | 26.20 | 6.28 | 45 | | 5.72 | 22.98 | 0.01 |
| **Female Students** | 20.48 | 5.61 | 45 | 90 | | | |

(Critical value of "f" with df 89 at 0.01 = 3.94and at 0.05 = 6.90)

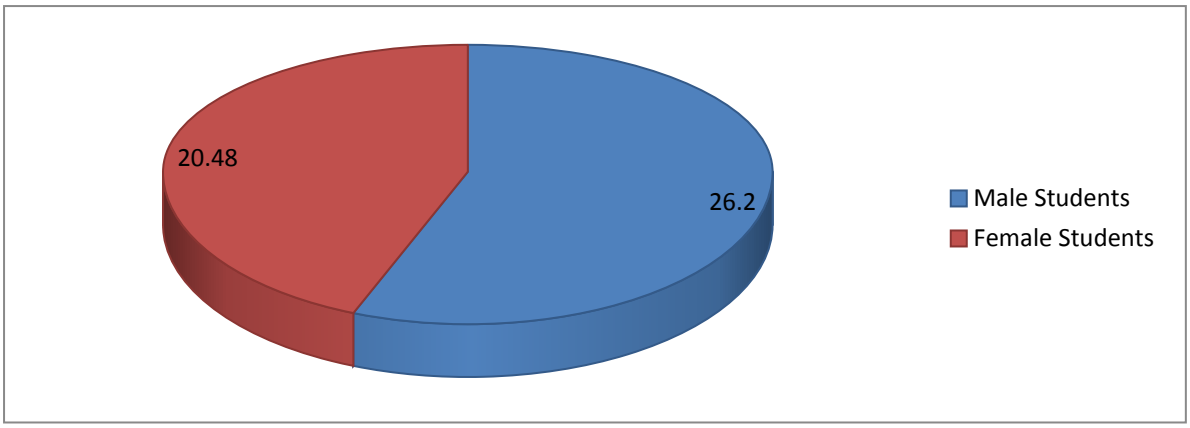


***Figure 3: Show Mean value of Gender on Social maladjustment***

Observation of the table 5 and Figure 3 indicated that the mean value of two classified group seems to differ from each other on Social maladjustment**.** The mean and SD value obtained by the male college students 26.20, SD 6.28 and Female College students was 20.48, SD 5.61, but on the basis of mean observation it would that mean difference 5.72. Both group 'F' ratio was 22.98 at a glance those male college student shows high score than Female college students.

In the present study was hypothesis related Social maladjustment and Gender. It was "There is no significant differences between Male and Female college students on demotion Social maladjustment. Gender effect represent the Satisfaction was significant (F- 22.98, 1and 89, P- 0.01 and 0.05). This is significant 0.01 and 0.05 levels because they obtained 'F' value are high than table values at 0.01 and 0.05. In the present study was found that male and female college students differ from Social maladjustment. The findings of the not supported the hypothesis, they are hypothesis rejected the present study. Its means that Male College Students high Social maladjustment than Female College Students.

**Table 6**

*Show the mean, SD and F value of Gender on Personality disintegration*

| Gender | Mean | SD | N | DF | Mean Difference | F | Sign |
|---|---|---|---|---|---|---|---|
| **Male Students** | 23.88 | 7.99 | 45 | 90 | 4.68 | 11.80 | 0.01 |
| **Female Students** | 19.20 | 6.53 | 45 | | | | |

(Critical value of "f" with df 89 at 0.01 = 3.94and at 0.05 = 6.90)

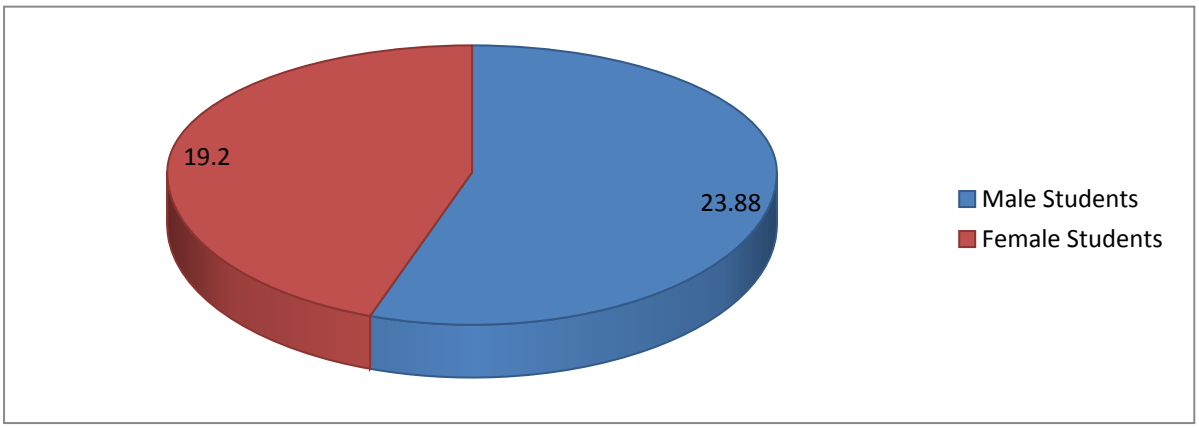


***Figure 4: Show Mean value of Gender on Personality disintegration***

Observation of the table 6 and Figure 4 indicated that the mean value of two classified group seems to differ from each other on Personality disintegration. The mean and SD value obtained by the male college students 23.88, SD 7.99 and Female College students was 19.20, SD 6.53, but on the basis of mean observation it would that mean difference 4.68. Both group 'F' ratio was 11.80 at a glance those female college student shows high score than male college students.

In the present study was hypothesis related Personality disintegration and Gender. It was "There is no significant differences between Male and Female college students on demotion Personality disintegration. Gender effect represent the Personality disintegration was significant (F- 11.80, 1and 89, P- 0.01 and 0.05). This is significant 0.01 and 0.05 levels because they obtained 'F' value are high than table values at 0.01 and 0.05. In the present

study was found that male and female college students differ from Personality disintegration. The findings of the not supported the hypothesis, they are hypothesis rejected the present study. Its means that Male College Students high Personality disintegration than Female College Students.

**Table 7**

*Show the mean, SD and F value of Gender on Lack of independence*

| Gender | Mean | SD | N | DF | Mean Difference | F | Sign |
|---|---|---|---|---|---|---|---|
| **Male Students** | 21.62 | 5.62 | 45 | | 4.51 | 21.38 | 0.01 |
| **Female Students** | 17.11 | 4.71 | 45 | 90 | | | |

(Critical value of "f" with df 89at 0.01 = 3.94and at 0.05 = 6.90)

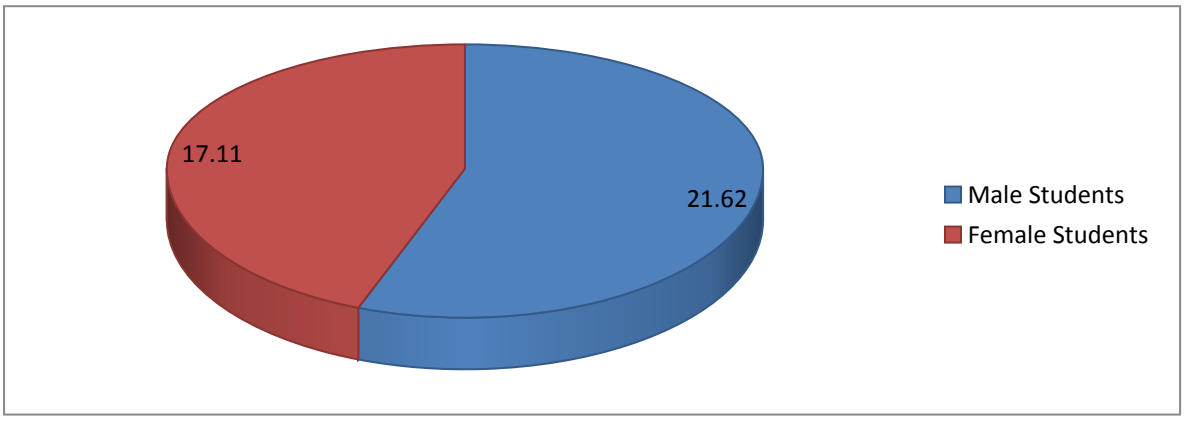


***Figure 5 Show the Mean value of Gender on Lack of independence***

Observation of the table 7 and Figure 5 indicated that the mean value of two classified group seems to differ from each other on Lack of independence. The mean and SD value obtained by the male college students 21.62, SD 5.62 and Female College students was 17.11, SD 4.71, but on the basis of mean observation it would that mean difference 4.51. Both group 'F' ratio was 21.38 at a glance those male college student shows high score than female college students.

In the present study was hypothesis related Lack of independence and Gender. It was "There are no significant differences between Male and Female college students on demotion Lack of independence. Gender effect represent the Lack of independence was significant (F- 21.38, 1and 99, P- 0.01 and 0.05). This is significant 0.01 and 0.05 levels because they obtained 'F' value are high than table values at 0.01 and 0.05. In the present study was found that male and female college students differ from Lack of independence. The findings of the not supported the hypothesis, they are hypothesis rejected the present study. It means that Male College Students high Lack of independence than Female College Students.

**Table 8**

***Show the mean, SD and F value of Gender on Emotional maturity***

| Gender | Mean | SD | N | DF | Mean Difference | F | Sign |
|---|---|---|---|---|---|---|---|
| **Male Students** | 127.29 | 26.30 | 45 | | 20.6 | 17.30 | 0.01 |
| **Female Students** | 106.69 | 21.88 | 45 | 90 | | | |

(Critical value of "f" with df 89 at 0.01 = 3.94and at 0.05 = 6.90)

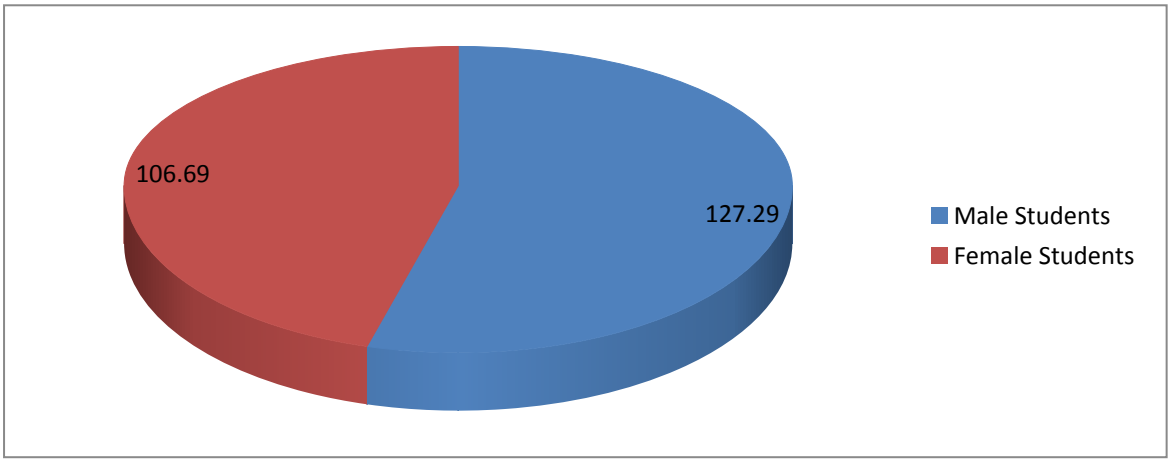


***Figure 6 Show Mean value of Gender on Emotional maturity***

Observation of the table 8 and Figure 6 indicated that the mean value of two classified group seems to differ from each other on Emotional maturity. The mean and SD value

obtained by the male college students 127.29, SD 26.30 and Female College students was 106.69, SD 21.88, but on the basis of mean observation it would that mean difference 20.6. Both group 'F' ratio was 17.30 at a glance those female college student shows miner high score than male college students.

In the present study was hypothesis related Emotional maturity and Gender. It was "There are no significant differences between Male and Female college students on demotion Emotional maturity. Gender effect represent the Emotional maturity was not significant ((F- 21.38, 1and 99, P- 0.01 and 0.05). This is significant 0.01 and 0.05 levels because they obtained 'F' value are high than table values at 0.01 and 0.05. In the present study was found that male and female college students differ from Emotional maturity. The findings of the not supported the hypothesis, they are hypothesis rejected the present study. It means that Male College Students high Emotional maturity than Female College Students.

A similar finding was found that Sinha (2014) found that boys have better emotional maturity than their girls. An Opposite finding was found that Kumar (2014), Singh, Rashee (2012), Kaur, H. (2004) in her study found No significant difference was found in emotional maturity of boys and girls.

**Delimitations of the study**

1) The finding of the study is based on very sample.
2) The sample was restricted to Jalna Dist. in Maharashrta.
3) The study was restricted to only B.A. arts college students (arts facility) only.
4) The study was restricted students are only 18-21 years only.

## CONLCUSION

a) Female Students high Emotional Unstability than Male Students.
b) Male College Students high Emotional regression than Female College Students.

c) Male College Students high Social maladjustment than Female College Students.

d) Male College Students high Personality disintegration than Female College Students.

e) Male College Students high Lack of independence than Female College Students.

f) Male College Students high Emotional maturity than Female College Students.

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# The Quality Of Life among Cancer Survivor's Receiving Chemotherapy

Penumaka Sirisha* and Jasmine Debora**


## ABSTRACT

Cancer is a group of diseases involving abnormal cell growth potential to invade or spread to other parts of the body. Chemotherapy is often used to treat patients with cancer that has spread from the place in the body where it started (metastasized), but it may also be used to keep the cancer from coming back (adjuvant therapy). The quality of life decreases in cancer survivor's receiving chemotherapy. **Materials and Methods:** A descriptive survey design was used to assess the Quality of life among cancer survivor's receiving chemotherapy. One fifty cancer subjects were selected by using purposive sampling technique by using hand pick method .The data were gathered by using EORTC QLQ C-30 scale and analyzed by using descriptive and inferential statistics. **Results:** The results showed that, Concerned with functional scales, out of 150 respondents 12(8%) had low functional inability, 83 (55.33%) had medium functional inability, 55 (36.67%) had high functional inability. As far as symptom scale is Concerned, 125(83.33%) had low symptoms, 23 (15.33%) had medium symptoms, 2 (1.34%) had high symptoms. In relation with global health status, 105(70%) had low global health status, 37 (24.67%) had medium global health status, 8 (5.33%) had high global health status. The chi-square showed association with the variables like age, stage of cancer in functional scale, family income, and type of family, duration of disease in symptom scale, and age, family income and duration of chemotherapy in global health status. **Conclusion:** The study concluded that, most of them are having medium physical inability with medium number of symptoms and low global health status.


***Keywords:*** *Quality of life, Cancer survivors, functional scale, symptom scale, global health status.*

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## INTRODUCTION

Cancer is characterized by uncontrolled growth and spread of abnormal cells. Cancer is caused by both external factors (tobacco, chemicals, radiation, and infectious organisms) and internal factors (inherited mutations, hormones, immune conditions, and mutations that occur from metabolism).

According to estimates from the International Agency for Research on Cancer (IARC), in 2012 there were 14.1 million new cancer cases and 8.2 million cancer deaths worldwide. By 2030, the global burden is expected to grow to 21.7 million new cancer cases and 13 million cancer deaths.

The main purpose of chemotherapy is to kill cancer cells. It can be used as the primary form of treatment or as a supplement to other treatments. Chemotherapy is often used to treat patients with cancer that has spread from the place in the body where it started (metastasized) [5]. It is also helpful in reducing the tumor size prior to surgery (primary [neo adjuvant] chemotherapy). Chemotherapy can ease the symptoms of cancer (palliate), helping to have a better quality of life.

Cancer patients on chemotherapy face some psychological problems (stress, anxiety, and depression), some physiological side effects (hair loss, pain, tiredness, nausea, vomiting), some social problems (social isolation, role and function loss) which eventually, worsen the Quality of life.

**Objectives**

a) To assess the Quality of life among cancer survivors receiving chemotherapy.

b) To determine the association between Quality of life among cancer survivors receiving chemotherapy with their selected variables.

**Hypotheses**

1. **$H_1$** _ Significant association will be there between the functional scale score (Quality of life) among cancer survivors receiving chemotherapy with their selected variables.
2. **$H_2$** - Significant association will be there between the Symptom scale score (Quality of life) among cancer survivors receiving chemotherapy with their selected variables.
3. **$H_3$**- Significant association will be there between the Global Health Status score (Quality of life) among cancer survivors receiving chemotherapy with their selected variables.

**VARIABLES OF THE STUDY**

**Dependent variable:** Quality of life among cancer survivors receiving chemotherapy.

**Extraneous variable:** Age, Gender, Education, Occupation, Family income, Type of family, Duration of disease, Stage of cancer and duration of chemotherapy.

## METHOD

**Study design**

The study was hospital based Non experimental descriptive survey design.

**Setting of the study**

The study was conducted in Chemotherapy wards and daycare at NRI Cancer Hospital, chinakakani, Guntur, Andhra Pradesh, India. These areas have an average daily attendance of about 30 clients.

**Ethical consideration**

Ethical consideration was obtained from the institutional ethical committee; permission was obtained from Medical director cum Medical Oncologist, and Nursing superintendent of NRI cancer hospital. Informed consent was obtained from cancer survivors receiving chemotherapy.

**Criteria for selection of sample:** Characteristics are essential for inclusion or exclusion.

**Inclusion criteria**

The study included cancer survivors who are:

a) Between the age 21 to 80 years.

b) Receiving chemotherapy at NRI Cancer Hospital.

c) Males and females.

d) Willing to participate in the study.

e) Able to read, write and speak telugu or English.

f) Available at the time of data collection.

**Exclusion criteria**

The study excluded cancer survivors who are:

a) With age below 21 and above 80 years.

b) Transgender.

c) Receiving chemotherapy in other than NRI cancer hospital.

d) Receiving radiation therapy in combination with chemotherapy.

e) Receiving other modalities of cancer treatment.

f) Not willing to participate in the study.

g) Not able to read, write and speak telugu or English.

h) Not available at the time of data collection.

**Sample and data collection**

One hundred and fifty cancer survivors receiving chemotherapy were sampled at NRI cancer hospital. A non randomized purposive sampling was used to select the subjects**.** The data was gathered by using the following tool.

**Description of tool**

**Part A**

Consists of structured questionnaire to collect the socio-demographic data

**Part B**

Consists of standardized tool i.e., EORTC QLQ C-30 to assess the Quality of life of cancer survivors receiving chemotherapy. The reliability of the tool is 0.80 – 0.89. A scoring system includes the overall score of each item in the scale and scores are categorized into 3 levels for the statistical convenience by the investigator. Such as low Quality of life: 1 – 50, medium Quality of life: 51 – 75 and high Quality of life: above 75.

**Collection of data**

The investigator collected the data from 150 cancer survivors receiving chemotherapy within 45 days by administering EORTC QLQ C-30 to assess the Quality of life from 16/01/2017 to 01/03/2017 between 1.30 pm to 4.30 pm according to the sample availability and convenience.

## RESULTS

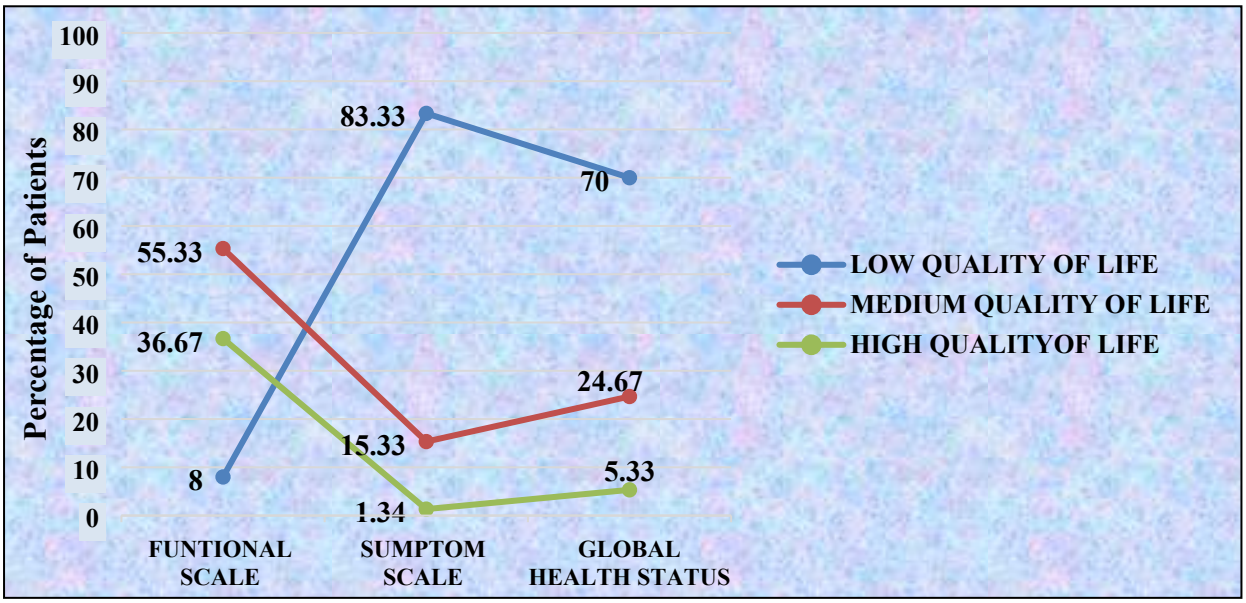
**Table 1**

*Frequency and percentage distribution of socio demographic characteristics of cancer survivors receiving chemotherapy*

N=150

| S.no | Sample characteristics | Frequency (f) | | | Percentage (%) | |
|---|---|---|---|---|---|---|
| **1.** | **Age** | | | | | |
| | a. 21-35 years | 17 | 55 | 62 | 11.33 | 36.67 |
| | b. 36-50 years | | 16 | | 41.33 | 10.67 |
| | c. 51-65 years | | | | | |
| | d. 66-80 years | | | | | |
| **2.** | **Gender** | | | | | |
| | a. Male | 69 | 81 | | 46 | 54 |
| | b. Female | | | | | |
| **3.** | **Education** | | | | | |
| | a. Knows to read and write | 30 | 36 | 29 | 20 | 24 |
| | b. Primary school | 21 | 19 | 13 | 19.33 | 14 |
| | c. Middle school | | 2 | | 12.67 | 8.67 |
| | d. High school | | | | 1.33 | |
| | e. Intermediate | | | | | |
| | f. Graduate | | | | | |
| | g. Post graduate and above | | | | | |
| **4.** | **Occupation** | | | | | |
| | a. Government employee | 9 | 35 | 11 | 6 | 23.33 |
| | b. Private employee | 18 | 70 | 7 | 7.33 | 12 |
| | c. Shop owner | | | | 46.67 | 4.67 |
| | d. Farmer | | | | | |
| | e. House wife | | | | | |
| | f. Unemployed | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **5.** | **Family Income** | | | | |
| | a. Rs. less than 5000/- | 39 | 64 | 26 | 42.67 |
| | b. Rs. 5001/- to Rs. 10,000/- | 40 | 7 | - | 26.66 4.67 |
| | c. Rs. 10,001/- to Rs. 20,000/- | | | | - |
| | d. Rs. 20,001/- to Rs. 30,000/- | | | | |
| | e. Rs.30,001/- and above | | | | |
| **6.** | **Type of Family** | | | | |
| | a. Nuclear family | 131 | 19 | 87.33 | |
| | b. Joint family | | | 12.67 | |
| **7.** | **Duration of Disease** | | | | |
| | a. Less than 1 year | 110 | | 73.33 | 20 |
| | b. 1-2 years | 30 | 7 | 4.67 | 2 |
| | c. 2-3 years | 3 | | | |
| | d. More than 3 years | | | | |
| **8.** | **Stage of Cancer** | | | | |
| | a. Stage 0 | 4 | | 2.67 | |
| | b. Stage I | 21 | 41 | 14 | 27.33 |
| | c. Stage II | 48 | 36 | 32 | 24 |
| | d. Stage III | | | | |
| | e. Stage IV | | | | |
| **9.** | **Duration of Chemotherapy** | | | | |
| | a. 1 week | 3 | 18 | 2 | 12 |
| | b. 2 weeks | 96 | 26 | 7 | 64 17.33 |
| | c. 3 weeks | | | | 4.67 |
| | d. 4 weeks | | | | |
| | e. More than 4 weeks | | | | |




Concerned with functional scales, out of 150 respondents 12(8%) had low functional inability, 83 (55.33%) had medium functional inability, 55 (36.67%) had high functional

inability.As far as symptom scale is Concerned, 125(83.33%) had low symptoms, 23 (15.33%) had medium symptoms, 2 (1.34%) had high symptoms. In relation with global health status, 105(70%) had low global health status, 37 (24.67%) had medium global health status, 8 (5.33%) had high global health status.

**Table 2**

*Mean and standard deviation of the quality of life among cancer survivors receiving chemotherapy*

N=150

| S. no. | Scales assessed | Mean | | | Standard deviation | | |
|---|---|---|---|---|---|---|---|
| | | Low QOL | Medium QOL | High QOL | Low QOL | Medium QOL | High QOL |
| 1. | Functional Scales | 38.25 | 67.24 | 84.32 | 10.26 | 10.87 | 5.54 |
| 2. | Symptom Scales | 34.13 | 59.30 | 77.5 | 9.60 | 7.73 | 1.5 |
| 3. | Global health Status | 42.17 | 64.94 | 82.5 | 8.95 | 3.38 | 0.5 |

Mean and standard deviation in functional scales, for low QOL 38.25± 10.26, medium QOL 67.24 ± 10.87 and high QOL 84.32 ± 5.54, in symptom scales the mean and standard deviation for low QOL 34.13± 9.60, medium QOL 59.30 ± 7.73 and high QOL 77.5 ± 1.5 and in global health status the mean and standard deviation for low QOL 42.17± 8.95, medium QOL 64.94 ± 3.38 and high QOL 82.5 ± 0.5.

Chi square showing association between Functional scale, Symptom scale and Global health status (Quality Of Life) among cancer survivors receiving chemotherapy with their selected variables.

In relation with functional scale, the chi square showing association between functional scale score with their age ($\chi 2=28.3$) and stage of cancer ($\chi 2=17.7$), concerned with symptom scales the chi square showing association between symptom scale score with their family income ($\chi 2=15.5$), type of family ($\chi 2=15.5$) and duration of disease ($\chi 2=34.4$) and regarding global health status the chi square showing association between global health status with their age ($\chi 2=20.1$) family income ($\chi 2=16.3$), and duration of chemotherapy ($\chi 2=38.2$).

## DISCUSSION

An important concern in cancer care and research is Quality of Life (QoL). The Quality of life refers to "global well-being," including physical, emotional, mental, social, and behavioral components. In the last few years, a number of informative and valid QoL tools have become available to measure health-related QoL. The most widely applicable instrument to measure the QoL in cancer survivors receiving chemotherapy is the EORTC QLQ-C30. Using this method, the current study assessed the QoL in cancer survivors undergoing cancer treatment. Several studies support our findings on the influence of treatment on good or adequate QoL among the cancer survivors receiving chemotherapy. The diagnosis and treatment of cancer often has an impact on health-related quality of life (HRQoL) and cause multiple concerns and needs of care and support. HRQoL is typically measured with standardized instruments such as the EORTC QLQ-C30.

Currently, QoL has been introduced as an endpoint for treatment comparisons in many cancer types, particularly in advanced stages. QoL also, is an early indicator of disease progression which could help the physician in daily practice to closely monitor the patients.

QoL may be considered to be the effect of an illness and its treatment as perceived by patients and is modified by factors such as impairments, functional stress, perceptions and social opportunities.

In this study the socio demographic characteristics of cancer survivors receiving chemotherapy revealed that out of 150cancer survivors the majority 62 (41.33%) respondents were between the ages 51-65 years. Juan Ignacio arraras, Berta Hernandez et al; states that age was not a predictive factor where as other studies state (Arrieta et al; Ediebah et al); age is found to be a predictive factor in non small cell lung carcinoma patients at a variety of stages. The present study findings were consistent with the findings of Thais de olivesra, Gozzo et al; and national study.

In the study 81(54%) respondents were females, Adel N. Abdullah, Khalidah A. Mansour, et al says that higher percentage (62.5%) of the chronic myeloid leukemia patients were males, the age group (31-40) and (41-50) years of males affected which is inconsistent.

In a study, Radha Achrya Pandey Govinda, Prasad Dhungana et al; study revealed that female exceeded male patients by 8 %. This finding is consistent with the present study and findings of a study done by Maryam et.al also states that breast cancer among the malay females are higher in Malaysia. This finding were consistent even with the findings of annual report of B. P. Koirala Memorial Cancer Hospital, as cancer of cervix was found to be the most common cancer among all followed by breast cancer.

In a study, **Khalidah A. Mansour et al; states that the majority of study samples (41.6%) were had primary school. The findings of the present study supported by even** Noens, colleagues who reported that the educated level was lower and it is consistent.

In this study 70 (46.67%) were house wives. Adel N. Abdullah, Khalidah A. Mansour, et al revealed high percentage of the chronic myeloid patients were employees which is inconsistent with present study values.

In a study, Adel N Abdellah, khalidah A. Mansour et al, stated that the majority of the study sample (50.5) were (>3years) consistent with the findings of present studyresults i.e., 110 (73.33%) respondents reported having less than 1 year. LM Wintner, J M Giesinger et al study revealed the majority of patients in the research were with stage III and IV of non small cell lung cancer which is consistent with the findings of the present study i.e., 48 (32%) respondents were with stage III, 41 (27.33%) were with stage II, 36 (24%) were with stage IV, 21 (14%) respondents were with stage I and 4 (2.67%) were with Stage 0 cancers.

The present study, showed the association with the age and QOL which is inconsistent with the findings of Yao xie fang –huj, Si-han Lu, et al study i.e., no association between patient age and QOL, which was consistent with the results reported by Greimel *et al*. Chi square ($\chi^2$) value was computed to find the association between Quality of life among cancer survivors with their age.

Many studies have reported that educational level has an effect on quality of life (Akin et al; Cui et al;), these findings were inconsistent with findings of present study but it consistent with findings of sema ustundag et al; revealed education did not affect the quality of life of the patients.

In a study, Fakhriya Jaber Study revealed that the chemotherapy had medium impairment of Quality of life. These findings were consistent with the present study findings. Quality of life of female was better than those of male. The results on the relation between socio-demographic variables and quality of life of cancer patients, has been reported in various studies. Guner et al; had done a study to determine whether a relationship existed between QoL and socio-demographic characteristics of gender, marital status, educational level, occupation and level of income in patients with cancer in Turkey. The findings of the study concluded that men, older adults, widowed spouses, patients with lower level of education, housewives and those with lower income had lower QoL scores.

In a study on factors affecting the quality of life to cancer patients at the community level in Shanghai, China, some socio-demographic factors were certified to have significant relationship with QoL of cancer patients, such as family income, education and occupation. Some factors like age and marital status however, affected only certain aspects of the QoL. In conclusion, patients who had divorced or lost spouse, and those with lower educational level, poor income and old age would tend to have a poor QoL outcome.

Similarly, in another study done in China, involving lung cancer patients, the young, male and married patient groups were found to have better QoL. Patients with lower education or income had worse QoL. As, the other study done among newly diagnosed cancer patients in Norway concluded that those cohabitating had significantly higher QoL compared to those living alone.

In contrast to the above findings, in relation to the marital status, the American scientists found that when battling esophageal cancer, married patients did not fare as well as their single counterparts in certain aspects of their QoL. In same way, when quality of life was studied among the patients with gynecological cancer in US, the results showed that QoL scores were reported to be poorest by the youngest women with cervical cancer and was opposite in case of women with ovarian and endometrial cancer, where age was negatively correlated with QoL. Hence, there are contradictory results concerning the effect of various socio-demographic characteristics on quality of life of cancer patients. The lesser significance level also might be due to the fact that not all the groups had equal number of sample size and the respondents varied according to tumor types. Perhaps a large scale study involving specific group of cancer patients would be needed to find out the actual results for the association of socio-demographic characteristics and quality of life.

## CONCLUSION

Majority of respondents were between the age group of 51-65 years, females reported highest number, with primary school education, house wives were affected more, earning between Rs5001-10000/-, belong to Nuclear family, With less than 1 year of duration of disease, had stage III cancer and had 3 weeks of duration of chemotherapy.

The majority frequency and percentage distribution of cancer survivors receiving chemotherapy at functional scale, symptom scale and global health status were concerned with functional scales (55.33%) had medium functional ability, symptom scale shows (83.33%) had low number of symptoms and global health status revealed (70%) low global health status.

The majority obtained mean ($\bar{x}$) and standard deviation (SD) score of functional scale for the medium quality of life among cancer survivors receiving chemotherapy was found to be 67.24 ± 10.87, the obtained mean ($\bar{x}$) and standard deviation (SD) of the symptom scale for the high number of symptoms among cancer survivors receiving chemotherapy was found to be 77.5 ± 1.5 and the obtained mean ($\bar{x}$) value and standard deviation (SD) of the global health status for the high quality of life among cancer survivors receiving chemotherapy was found to be 82.5 ± 0.5.

The chi-square showed association with the variables like age, stage of cancer in functional scale; family income, type of family, and duration of disease in symptom scale; age, family income and duration of chemotherapy in global health status. Hence the results of the study concluded that there is a need to bring awareness among cancer survivors receiving chemotherapy regarding the quality of life. The study concluded that, most of them are having medium physical inability with medium number of symptoms and low global health status.

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# The role of Personality on Stress and Coping among Prisoners

Shishir Gupta* and Sonali Jakar**


## ABSTRACT

"Prisoner" was a legal term for a person prosecuted for felony. It was not applicable to a person prosecuted for misdemeanour. The idea of prison as a comprehensive method for reformation of the inmates. In general, the effect of imprisonment are the nature of the progressive weakening of mental powers and of a deterioration of the character in a way which renders the prisoners life fit for useful social life and in consequence more liable to reconviction. Personality is made up of the characteristic patterns of thoughts, feelings and behaviours that make a person unique in their social and personal life. In addition to this, personality arises from within the individual and remains fairly consistent throughout life. Personality is usually broken into components called the Big Five, which are: openness to experience, conscientiousness, extroversion, agreeableness, and neuroticism (or emotionality). These components are generally stable over time and appear to be attributable to a person's genetics rather than the effects of one's environment. It is requiring a significant adjustment in a person's life; this Life without stress cannot be imagined. Psychological stresses form an inescapable part of life and up to a degree might be requires for adequate personality development. However if these stresses become too severe or two numerous, they may be affect the physical equilibrium, producing maladaptive patterns and possibly mental disorder. The present study was aimed to see the effect of personality on stress and their effective coping strategies among prisoners. Sample of the study comprised 40 prisoners of open jail, age 30 to 50 year, 2 year minimum punishment, literate including crime such as robbery, murder, rape, kidnapping etc. The data was collected with the help of Eyesenck Personality Questionnaire (for adult) EPQ-DBTR developed by Dr. B. Dey and Dr. R. Thakur and Distressful Life Events Scale (DLES) constructed by Dr. Kiran Bala Verma

and Dr. Madhu Asthana. The sampling was purpose in nature and included only those who were interested to participate. It followed Mean and one sample t test to analysis the data. From the result of this study certain conclusion may be derived. The study highlights the findings that personality variable such as neuroticism and introvert has significant effect on stress rather than extrovert has insignificant effect on stress.

***Keywords***: *Personality, Stress, Prisoners*

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## INTRODUCTION

"Society has not yet made the choices that will be necessary to resolve the problems. Do we want the prisons only to punish? Or do we want prisons to educate and train offenders to aid their adjustment in society? Are we going to continue to ignore the problems in prisons until mass riots, with their extensive destruction of property and human life, force us to look at our institutions? **-Sue Titus Reid**

The oldest penal institution is actually the "JAIL" which is also commonly called a "PRISON" in many countries. In the early stage jail functioned as a place for detaining prisoners awaiting trail and execution of sentence. Getting-off a slow start in the sixteenth century imprisonment as a form of punishment became the major form of punishment of the nineteenth century. From nineteenth century onward and following in twentieth century, certain individualized measures of offenders are introduces in to prison sentence. Thus began concept of institution correction. The idea of prison as a comprehensive method for reformation of the inmates. The penal policy in post-revolutionary America was resolved on the question, "How prison could be organized to reduce the chance that offenders would

repeat their criminal activity. This approach expressed a definite towards human beings that they are modifiable for the better if given the proper opportunity"? In general, the effect of imprisonment are the nature of the progressive weakening of mental powers and of a deterioration of the character in a way which renders the prisoners life fit for useful social life and in consequence more liable to reconviction. Our enormous investment of time, energy, and money for reformative and rehabilitative prison model has been demonstratively successful in preventing and controlling recidivism among prisoners. But many criminologist and sociologist believe that the ways in which inmates adopt to prison life have simplification not only for the institution and of society but also for the future of the inmates. Justice Thurgood Marshall observed in regard to prison life the following: "When the prison gets slum behind an inmate, it does not lose his human quality; his mind does not become close to ideas, his intellect does not cease to feed on a free and open interchange of opinions, his yearning for self-respect does not end; nor is his quest for self-realization concluded."

But the present state of affairs of prison administration almost ignored the possibility of reformation of prisoners. To sum up, Tihar prison is an arena of tension trauma, tantrums and crimes of violence, vulgarity and corruption. And to cap it all, there occur the contamination of pee-trial or accused with habitual and injurious prisoners of international gang. The crowing peace is that the jail official themselves are allegedly in league with the criminals, officials and non-officials, smuggling, violence, theft, unconstitutional punishment by the way of solitary cellular life and transfer to other jail, are not uncommon. One reputed journalist Kuldip Nayer expressed in his book "In Jail": "…..one could get as much money as one wanted from outside again at a price. There was a money-order and mail service that perhaps was more dependable than what the postal department could offer."

**Goals of imprisonment**

There are four main functions that prisons serve:

- Incapacitation
- Rehabilitation
- Punishment
- Deterrence

**The psychological effects of imprisonment**

Bartol comment that clinical case studies on the effect of prison life have often concluded that, for many individuals, imprisonment can be brutal, demeaning and generally devastating". It is, however, very difficult to generalize about the effect that imprisonment may have on psychological functioning. Firstly, there are considerable individual differences in the way people adjust. Secondly, few control longitudinal studies have been conducted. Thirdly, different presents have very different regimes so there is bound to be a wide variation in effect. Fourthly both the different length of sentence and the reason for incarceration are likely to have an effect of individual reaction.

One aspect of prison life with some inmate has to endure and which can cause particular problem is crowing. It can result in physical illness, socially disruptive behaviour and emotional distress, especially in women's prisons. Psychological studies in everyday situations have shown that in crowded condition it is like to privacy and control that are liable to produce dissatisfaction, not necessarily the amount of space available. If you can put around your bad shield yourself from the gaze of others then the psychological effect of being „cooped up" are not so bad. The same applies in prison. When inmates are provided with the means of obtaining some privacy and a place to put personal possession than some of the negative effects of crowding diminished. This, of course, does not ameliorate all of the

unpleasant effect of crowding, which include lack of control over social interaction and too much stimulation in terms of activity, noise, smelliness and violation of personal space.

**Personality**

The normal criminal personality: Most theories using the concept of normal criminal personality assume that individual possess definable and dominant set of rules which determine how they will behave in virtually any situation. This is often called the central or core personality. Psychologist and psychiatrist believe that criminals tend toward certain well-defined personalities, and their criminal tendencies can be overcome by controlling or alerting those core personalities. The line between normality and abnormality is impossible to draw exactly. Normality itself is elusive and difficult to define in any positive sense. It is usually negatively described as the state of mind or personality that cannot be classified as having a mental abnormality, examples which cannot be classed as mentally defective, psychopathic, neurotic, psychotic, and compulsive. The mere factors that something is numerically common does not make it normal, and similarly the bare fact that something is uncommon does not make it abnormal. An event is not made normal or healthy because it frequently occurs and will certainly re-occur. For example, there will always be murder but this does not make it a normal are socially acceptable activity. Neither does the fact that an activity is socially unacceptable mean that those who take part in it are necessarily psychologically abnormal. If it did, it would follow that all criminals of mentally abnormal and this is patently not the case.

Black burn has taken the theory further. In 1971 he carried out dour MMPI test on 56 murderers who had been detained in mental hospitals, and claimed that they could be analyzed into four groups. Two of the groups were under control and two were over-controlled.

**The under controlled were**

- Psychopathic- poor self-control, High extraversion, hostility towards others and low anxiety.
- Paranoid aggressive- poor self-control, hostility towards others and psychotic symptoms.

**Macho personality and dangerousness**

The final personality difference which in present years has been closely related to violence, and therefore possibly to dangerousness, is the macho personality as measured by the hyper masculinity inventory. The macho personality views violence as manly, danger as intrinsically exciting, callous sexual activity aimed at women as acceptable, and interprets being tough as a form of self-control. Zaitchick and Moscher connected this personality element with inter-male violence, callousness, violence and sexual attack on women, gang violence and abuse of children. The utility of this test in predicting dangerousness could therefore be very strong but more scientific testing of the inventory is necessary before it can be reliably used to remove an individual's freedom.

**Life event Stress**

Life events refer to events that require a significant adjustment in a person's life, for instance divorce, moving house etc. Life Events are those times when significant change has come upon the family or home or in society. Examples of Live Events include:

- Marriage or other consolidation of multiple households.
- Birth of a child.
- Moving to a new home, including downsizing to a smaller home.
- Transition to a telecommuting arrangement.

- Children transitioning out of the home.
- Parents transitioning into the home.
- Death of a family member.

Each of these events carries its own level of stress without the added worry of how to modify the home to accommodate them. Consider using a professional organizer to navigate through these events to reach peaceful, manageable solutions. At Stanford, we know things change, and we want to help you prepare for whatever comes your way - good, bad or just different. A change in your personal or work life can change your benefits. When a "life event" takes place, you may make mid-year changes to some or all of your benefit elections.

This section includes information on the following life events: Marriage/Partnership- Whether embarking on a new commitment or ending an existing one, find out what can change for you and your spouse/partner's benefits. Children- A new child changes everything, even your benefits. Learn about what you need to do with your benefits when you have a new child, or when your child gains or loses coverage. Also find out about Stanford's maternity, adoption and child care benefits. Leave- Before you take time off - whether for family leave, disability or otherwise - make sure your benefits are covered. Employment- A job change for you or your spouse/domestic partner can affect your benefit eligibility. Keep up with your benefits coverage when you start a new job, go from part-time to full-time (and back again), retire or leave your job. Other- Other life events - such as an unanticipated injury, death or even a name or address change - may impact your benefits.

**Coping Resources**

The characteristics of a person, group, or environment that is helpful in assist ing individuals in adapting to stress. Coping refers to the thoughts and actions we use to deal with stress. In large part, feeling stressed or not depends on whether we believe we have the

coping resources to deal with the challenges facing us. Most coping strategies fall into one of two broad categories: Problem-focused coping strategies are used to tackle the problem directly. Emotion-focused coping strategies are used to handle feelings of distress, rather than the actual problem.

In general, research has shown that problem-focused coping strategies are the most effective way for dealing with stress. In psychology, coping is expending conscious effort to solve personal and interpersonal problems, and seeking to master, minimize or tolerate stress or conflict. The effectiveness of the coping efforts depends on the type of stress and/or conflict, the particular individual, and the circumstances.

Coping Responses are partly controlled by personality (habitual traits), but also partly by the social environment, particularly the nature of the stressful environment.  In INDIA Sinha Sudhinta (2010) studied was to investigate the adjustment and the mental health problem and its relation in the prisoners. Vipassanna Research Institute (June, 2000) studied to see the effect of Vipassana Meditation on Quality of life, Subjective well-being, and Criminal Propensity among inmates of Tihar jail, Delhi.

**Purpose of the study**

The prisoners; A person legally committed to prison as a punishment for a crime or while awaiting trial. They also have known as an inmate or detainee. In India, At Rajasthan district prison establishment comprise of 2 categories of jail- Central jail and Open jail. The most common feature observed throughout of India is that prisoners sentenced to imprisonment for a long period (more than 2 year) and are bounded to go outside of jail. But open jail are minimum security prison, in there prisoners are engaged in agricultural and other activities. Personality is a dynamic and organized set of characteristics possessed by a person that influence his or her cognition, emotion, motivation and behaviour in various

situations. It is usually broken in big 5 dimension, which are openness to experience, conscientiousness, extroversion, agreeableness, and neuroticism (or emotionality). They are generally effect a person's environment. Through the personality, measure the main dimension, which are the reasons of behaviour modification in prisoners and compelled him for doing a crime and also explore their criminal propensity? The personality of a prisoner is directly influenced by the events of their life, which may be positive or negative. In life event, there are so many major change in person's circumstances, eg:- divorce, death of spouses, less of job etc., that effect leisure or recreational activities and inter-personal relationship. Through this study wants to explore retrospectively the relationship of the accumulation of life event as it relate to a prison incarceration. We also want to opt out the reasons of a prisoner's environmental changes which are the result of overt behaviour for a crime. In life event, we can also discuss the both positive and negative events such as happiness, promotion, stress, anxiety, and frustration etc., which can be cause of a crime. These positive and negative events of life either increase or decrease a person's confidence level, decision making power.At last when a prisoner has done crime, and got the punishment for a fix time period to live in jail then he/she suffer from many problems and either they feel guilt or not. If they feel guilt and realize their fault, they want to cope-up their stress and also promote their health. They use so many coping skills for readjustment in society, family and peer group. Through this study, also explore and discuss the different strategies have been used by them for readjustment. After doing this, provide the best suggestion to improve their life and council them to reduce their stress and promote their health.

## METHOD

### Objectives

The present study was aim to study the effect ofpersonality on stress among prisoners.

**Hypothesis**

- **H1-**There will be no significant effect of personality on stress among prisoners.
- **H2-**There will be significant effectof personality on stress among prisoners.

**Sample**

This study comprised of 40prisoners of open jail including crime such as robbery, rape, murder, kidnapping etc. Age: - 30 to 50 yrs. Minimum punishment of 2 yrs. Education level must be literate.

**Tools to be used**

The data was collected with the help of

- Eyesenck Personality Questionnaire (for adult) EPQ-DBTR developed by Dr. B. Dey and Dr. R. Thakur.
- Distressful Life Events Scale (DLES) constructed by Dr. Kiran BalaVerma and Dr. Madhu Asthana.

**Procedure**

The sample will be selected from Open jail of Jaipur city. After the tools to be used for the research purpose, the conduction will be carried out with permission of jail department. The subjects will be made aware of the purpose of the study and will be assured of confidentiality of response. A mutual report will be established there after a set of the Questionnaire comprising of Life Event, Personality and interview techniques for Coping Resources will be filled one by one to each subject. Each scale will be administered separately and independently. Instructions will be given to the subject and each of them was

asked to reach them carefully. Any clarifications sought by the subjects will be provided. Few case studies will be taken and analysed.

**Statistical analysis**

- Mean and one sample t test were used to analyse the data.

**One sample t test-**

$$t = x-u/sx$$

Where

$$sx = s/\sqrt{n}$$

u= proposed mean

x= sampled mean

n= sample size

s= standard deviation

sx= estimated standard error of the mean

## RESULTS

**Table 1**

**Life event stress**

| No. | Variable | Mean | t value | Significant |
|---|---|---|---|---|
| 1 | **stress** | 18.42 | 6.75 | Significant at 0.1 |

**Table 2**

| Personality | | | | |
|---|---|---|---|---|
| No. | **Variable** | **Mean** | **t value** | **Significant** |
| 1 | **Psychoticism** | 10.67 | 10.64 | Significant at 0.1 |
| 2 | **Extraversion** | 10.65 | -2.96 | Insignificant |
| 3 | **Neuroticism** | 12.12 | 10.58 | Significant at 0.1 |
| 4 | **Lie** | 8.72 | -17.3 | Insignificant |

## RESULTS

The present study aimed at finding out the effect of personality on stress and their effective coping skills among prisoners of open jail. Here the result is being discussed under the following sections for the sake of convenience:

Researches in the personality characteristics as a modifier of the response to stress focus mainly on differentiating individual characteristics between high and low stress individuals. This may examine the relationship between psychometric measures through EPQ and response to stress or stress related illness. One can make crude distinction between that personality variable that affects the amount of stress a person experience and those promote effective coping (Wheaton, 1983).

Traits are simply described as the group of correlated behaviour act or action tendencies. The extraverts are seen as sociable, cheerful, talkative, lively and outgoing, whereas the introvert is quitter, shy, more withdrawn and unsociable. The majority of population is at midpoint of extraversion dimension. Arousal theory explains the differences in preference for social contact between introvert and extrovert. Social interaction and interpersonal intimacy increase arousal level, thus, the stimulus seeking extravert will be positively influence by social contact. observation of interview and group discussion situation

indicates that extravert are engaged in gaze behaviours, maintain less interpersonal distance and show a higher rate of verbal interaction than introvert. Degree of extraversion is a modifier of response to stress. The extraverts are seen as geared to respond and will attempt a response when given the opportunity. Introverts react more negatively and suffered greater tension than extroverts. However the extroverts are more likely to participate in behaviour that may both intensify the response to stress and constitute an additional source of stress. Extroverts drink more alcohol than introverts and seek stimulation by cigarettes smoking and also consume more spicy food. The problems of lung cancer and cardiac heart disease are medical but the epidemiological aspects of these problems are related to constitutional difference in personality. Alcohol consumption is related to disease of heart and lever. It also renders the individual more vulnerable to accident involvement. The extroverts are at risk because he is more likely to consume alcohol and is also less tolerant of the effect of it than introvert. According to Eyesenck, alcohol is a depressant drug, which has extroverting effect: thus the extravert is directed to the point of no return more quickly by the effect of alcohol consumption. Personality disposition therefore has an impact of behaviour and ultimately and indirectly increases accident risk.

Eysenck identifies Neuroticism in the structural of personality. It predisposes a person to respond to stress with neurotic symptom. There is no doubt to accept neuroticism as a major structure of personality. Although it is to be determined whether anxiety and neuroticism dimension may or may not be the same disposition. In the discussion, the term Neuroticism and anxiety are used with meaning although the trait anxiety refers to the individual's susceptibility to anxiety. Thus the difference in state anxiety between groups high and low in trait anxiety should be enhanced as the degree of situation stress increases. It is found that neurotic individual tend to avoid stimulating, active and unusual situation more than stable individuals. In intimate interpersonal situation, attempts are made to reduce the

level of intimacy by gaze avoidance. Shyness is associated with an anxious behaviour. There are two types of social shyness stems from the preference to be alone, although introverts are capable of a functioning effectively in company. Neurotic shyness develops because of worries of inadequacy and fear to face others, although they have a desire to company others. In the work environment neurotic and neurotic-introvert are the most susceptible to stressful situation, thus the introvert and extrovert and neuroticism stability dimension maybe postulated to mediate the response to stress that determine vulnerability to diseases and illness.

Once we experience an event as stressful, we usually begin to make efforts to cope with those events. Coping is the process of attempting to manage demands that are viewed as taxing or exceeding our resources (Lazarus & Folkman, 1984).

Coping with a stressful life event is a dynamic process. It begins with the appraisal people make of the situation with which they must cope (Major, Richards, Cooper et. al., 1997). These appraisals are central to subsequent efforts to manage the stressful situation. As raising a potentially stressful event as a challenge can lead to confident coping, little sense of these and positive emotions, whereas assessing a potential stressor as threatening on lower confidence in one's coping abilities and increase negative emotions (Skinner and Brewer, 2002). For example, the impending breakup of a relationship can produce a variety of responses, including efforts at reconciliation or attempt to find, activities that will district us from emotions such as sadness or indignation.

Generally researchers distinguish between two types of coping efforts: problem solving efforts and efforts of emotional regulation (Lazaruz & Folkman, 1984). Problem solving efforts are attempts to do something constructive to change the stressful circumstances. Emotional focused coping involves efforts to regulate or work through one's

emotional reaction to the stressful events (Stanton, Kirk and Cameron 2000). These two types of coping can occur simultaneously. For e.g. who romantic partners break up, both people try to cope by cheering themselves up and by taking steps to meet new people. Generally speaking, the ability to be flexible in the use of one's coping strategies is associated with more stressful coping (Cheng, 2001). Psychologist also study more specific coping strategies (Taylor, 2003, for a review) including active coping method, such as seeking information, planning, or attempting to get help from others, and emotion focused coping methods which include positive reinterpretation, acceptance, or turning to religion. Active coping is used more often and is more adaptive in situation that is changeable (Park, Armeli, &Tennen, 2004). Whereas emotional-focused coping may be more appropriate in situation that cannot be changed. Psychologist also study avoidant coping methods, which involve disengaging behaviourally or mentally from a stressful event, as through substance abuse or distancing. These "coping" strategies are maladaptive for the health and mental health. The important distinction between individualist or independent cultural orientation and collectivist or interdependent cultural orientation. Not surprisingly, cultural orientation is associated with different types of coping strategies. A study of pregnant women in Japan and the United States (Morling, 2003) assessed whether women coped with the stresses of pregnancy by exerting personal influence, practicing acceptance, or obtaining social assurance. For, women in US, acceptance predictor better outcome (less distress over time, better pre-natal cares, less weight gain), whereas for Japan women, social assurance predictor a better outcome (a positive maternal relationship). This is surprisingly finding because personal influence or confluence is usually an adaptive, successful coping strategies. It may be that the time-limited nature of pregnancy conductive to this form of active coping.

**Conclusion**

It can be concluded that personality variable such as neuroticism and introvert has significant effect on stress rather than extrovert has insignificant effect on stress.

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# The study on Self efficacy and Machiavellianism among Malayalee Community in USA

Sannet Thomas*


## ABSTRACT

**Aim:** Self-efficacy is defined as a personal judgement of "how well one can execute courses of action required dealing with prospective situations". Machiavellianism in psychology refers to a personality trait which sees a person so focused on their own interests they will manipulate, deceive, and exploit others to achieve their goals. The present study aimed to investigate the Self-efficacy and Machiavellianism among Malayalee community in USA. **Methods:** This study was done on 60 people (30 males and 30 females) through purposive sampling technique. Self-efficacy Scale, Mech- iv were used to collect data. Data were analysed by using Mean, S.D, t-test, and Pearson product moment correlation. **Result:** Result proves it there is no significant difference in the Self-efficacy and Machiavellianism among Malayalee community in USA and also there is a negative correlation between Self-efficacy and Machiavellianism as well as there is no significant correlation between Self-efficacy and Machiavellianism among Malayalee community in USA.


***Keywords:*** *Self efficacy, Machiavellianism*

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## INTRODUCTION

Self-efficacy is defined as a personal judgement of " how well one can execute courses of action required dealing with prospective situations". Expectations of self-efficacy determine whether an individual will be able to exhibit coping behaviour and how long effort will be sustained in the face of obstacles. Individuals who have high self-efficacy will exert sufficient effort that, if well executed, leads to successful outcomes, whereas those with low self-efficacy are likely to cease effort early and fail. Psychologists have studied self-efficacy from several perspectives, noting various paths in the development of self-efficacy; the dynamics of self-efficacy, and lack thereof, in many different settings; interactions between self-efficacy and self-concept; and habits of attribution that contribute to, or detract from, self-efficacy.

Self-efficacy affects every area of human endeavour by determining the beliefs a person holds regarding his or her power to affect situations, it strongly influences both the power a person actually has to face challenges competently and the choices a person is most likely to make. These effects are particularly apparent, and compelling, with regard to behaviours affecting health.

Machiavellianism in psychology refers to a personality trait which sees a person so focused on their own interests they will manipulate, deceive, and exploit others to achieve their goals. Machiavellianism is one of the traits in what is called the 'Dark Triad', the other two being narcissism and psychopath.

The term itself derives from a reference to the infamous Niccolò Machiavelli, a diplomat and philosopher in the Renaissance whose most well-known work became 'The Prince" (Il Principe). This notorious book espoused his views that strong

rulers should be harsh with their subjects and enemies, and that glory and survival justified any means, even ones that were considered immoral and brutal.

By the late 16th century "Machiavellianism" became a popular word to describe the art of being deceptive to get ahead. But it wasn't a psychological term until the 1970s, when two social psychologists, Richard Christie and Florence L. Geis, developed what they called "the Machiavellianism Scale". A personality inventory that is still used as the main assessment tool for Machiavellianism, this scale is now called 'the Mach-IV test". Machiavellianism has been found to be more common in men than women. It can, however, occur in anyone - even children.

The Malayali people or Keralite people (also spelt Malayalee,) are an Indian ethnic group originating from the present- day state of Kerala, located in South India.[21] They are identified as native speakers of the Malayalam language, which is classified as part of the Dravidian family of languages. As they primarily live in Kerala, the word Keralite is used as an alternative to Malayali.

This present study is mainly focused on to identify self esteem and Machiavellianism of malayelee community in United States of America

**Statement of the Problem**

"The Study on Self efficacy and Machiavellianism among Malayalee Community in USA"

**Review of Previous Researchers**

In a study, David, et al. (2009) conducted study to develop and validate a measure of perceived bicultural self-efficacy and to explore its relationships with indices of mental health and psychological well-being. In the study exploratory (n=268) and confirmatory (n=164) factor analyses was done on the theoretically derived Bicultural Self-Efficacy Scale (BSES), items support a measurement model

that taps into the six dimensions of bicultural competence proposed by Fromboise, Coleman and Gerton (1993). Furthermore, initial evidence for internal consistency (for all three studies) and test-retest reliability (n=51 Asian Americans) for each of the six subscales were computed. Finally, perceived bicultural self-efficacy was found to be related to college student's mental health status and psychological well-being.

In a study, Gable and Dangello (1994) examined the moderating effect of locus of control on the relationship between Machiavellianism and job performance. The sample was comprised of 48 male store managers in a retail setting. Results revealed no relationship between locus of control and managerial job performance; however, there was a significant moderating effect in the relationship between Machiavellianism and job performance. Managers high in Machiavellianism traits who perceived themselves as being subject to external control were more effective than managers with internal locus of control.

## METHOD

### Objectives

1. To study self-efficacy and Machiavellianism among Malayalee community in USA based on gender
2. To know the correlation between Self-efficacy and Machiavellianism among Malayalee community in USA

### Hypotheses

1. There is no significant difference in the self-efficacy among Malayalee community in USA based on gender.
2. There is no significant difference in the Machiavellianism among Malayalee community in USA based on gender

3. There is no significant correlation between Self-efficacy and Machiavellianism among Malayalee community in USA

**Variables**

IV- Gender

DV- Self-efficacy, Machiavellianism

**Sample and Data**

The sample for the present study consisted of 60 people, (30 males and 30 Females) selected through purposive sampling technique from United States of America.

**Data collection tools**

1. Self-efficacy Scale developed by Albert Bandura
2. Mech- iv developed by Richard Christie and Florence L. Geis

**Statistical Treatment**

The data collected was analysed by Mean and S.D., t-test and correlation coefficient was used for hypotheses testing. Statistics were done using SPSS.

## RESULTS

**Data Analysis and its Interpretation**

The main purpose of the present study was investigating the Self-efficacy and Machiavellianism among Malayalee community in USA. For this purpose investigator formulated three different hypotheses. Results are shown in below given tables.

**Table 1**

*Shows t-ratio for male and female on Self-efficacy and Machiavellianism*

| Variable | Gender | N | Mean | SD | t | df | Sig. |
|---|---|---|---|---|---|---|---|

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Self-efficacy | Male | 30 | 96.07 | 10.628 | -.037 | 58 | .784 |
| | Female | 30 | 96.17 | 10.386 | | | |
| Machiave- | Male | 30 | 65.60 | 8.190 | -1.760 | 58 | .199 |
| llianism | Female | 30 | 68.90 | 6.200 | | | |

The above table shows that there is no significant difference in the self-efficacy and Machiavellianism among Malayalee community in USA. Hence the two null hypotheses are accepted.

**Table 2**

*Shows Correlation between the variables*

| | | Self-efficacy | Machiavellianism |
|---|---|---|---|
| Self-Efficacy | Pearson correlation | 1 | -.061 |
| | Sig. (2-tailed) | | .644 |
| | N | 60 | 60 |
| Machiavellianism | Pearson Correlation | -.061 | 1 |
| | Sig. (2-tailed) | .644 | |
| | N | 60 | 60 |

Table 2 shows that there is no significant correlation between Self-efficacy and Machiavellianism among malayalee community in USA. Hence the 3rd null hypothesis accepted and there is a negative correlation between self efficacy and Machiavellianism.

## DISCUSSION

### Discussion

The present study focuses on Self efficacy and Machiavellianism in malayalee community in USA. In the present investigation, self-efficacy is measured by using self-efficacy scale developed by Bandura and Machiavellianism is measured by using Mech iv developed by Richard Christie and Florence L. Geis.

Table 1 show that there is no significant difference in the self-efficacy and Machiavellianism among Malayalee community in USA. When means compare females have higher self-efficacy and Machiavellianism than males.

A table 2 show that there is no significant correlation between self-efficacy and Machiavellianism and it is a negative correlation.

### Conclusion

To sum up, we might conclude that, there is no significant difference in the self-efficacy and Machiavellianism among Malayalee community in USA. There is no significant correlation between self-efficacy and Machiavellianism

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https://www.harleytherapy.co.uk/counselling/machiavellianism-psychology.htm

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The manuscript must be written in following the style outline of the **Publication Manual of the American Psychological Association** shortly instructed below:

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