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

PHONIX INTERNATIONAL JOURNAL FOR PSYCHOLOGY AND SOCIAL SCIENCES

Vol. 3, Issue 1, February 2019

2019

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

PUBLISHED BY PHONIX INTERVENTION CENTRE, DELHI

http://phonixcentre.in/journal.php
ISSN 2456 - 5180
Jan to Feb 2019,
Vol. 3 Issue. No. 1

http://phonixcentre.in/journal.php
ISSN 2456 - 5180
Jan to Feb 2019,
Vol. 3 Issue. No. 1

OWNERSHIP

Phonix International Journal for Psychology and Social Sciences is owned by the Phonix Intervention Centre, D-11/384, Sector – 7, Rohini, Delhi - 110085-India, Phone: +91-8527085707. Dr. Sunil Kumar Jangir, Editor-in-Chief, Phonix International Journal for Psychology and Social Sciences, Delhi. Email: editor.pijps@phonixcentre.in. Phonix International Journal for Psychology and Social Sciences purpose is to help to strengthen the research and educational base of psychology.

DISCLAIMER

The statements and opinions in the articles of **Phonix International Journal for Psychology and Social Sciences** are solely those of the individual authors /contributors and not of the publisher or **Phonix Intervention Centre**. No responsibility is assumed by the Publisher, the **Phonix Intervention Centre**, or the Editor for any injury and/or damage to persons or property whether such liability, if any, arises as a matter of products liability, negligence or otherwise, or from any use or operation of any methods, products, instructions or ideas contained in the material herein. The Publisher recommends independent verification should be made.

COPYRIGHT

http://phonixcentre.in/journal.php
ISSN 2456 - 5180
Nov to Dec 2018,
Vol. 2 Issue. No. 6

A Case Study on Childhood Autism Associated With Seizure Disorder

Deva Pramod V B*

ABSTRACT

Autism - Autism spectrum disorder (ASD), defined in DSM V as a heterogeneous neuro developmental disorder with widely varying degrees and manifestations that has both genetic and environmental causes. Usually recognized in early childhood, it continues through to adult life, though the form may be greatly modified by experience and education. Seizures are quite common in autism spectrum disorders, and it is increasingly recognized as an additional clinical problem that must be dealt with. An association between autism and epilepsy has been consistently reported and is included in DSM-V although it is not among the diagnostic criteria. This paper presents a case that is diagnosed as Childhood Autism associated with Seizure disorder.

***Keywords**: Autism, Autism spectrum disorder (ASD), Pervasive Developmental disorder (PDD), Seizure disorder, Intellectual Disability, Epilepsy, Gluten Free Casein Free, Diet, Behaviour Therapy, ABA Therapy*

* Consultant Psychologist, Department of Clinical Psychology, Institute for Communicative & Cognitive Neuro Sciences (ICCONS), Kerala, India,
E-mail: vbdevan.psy@gmail.com, Mob: +91 9947049850 & +91 7591911213

INTRODUCTION

Autism, defined in DSM-IV as a pervasive developmental disorder involving profound deficits in social relatedness, communication impairments, repetitive behaviours, and restricted interests with onset prior to 3 years old, is a behavioural syndrome. An association between autism and epilepsy has been consistently reported and is included in DSM-V although it is not among the diagnostic criteria. Although the prevalence of epilepsy in autism clearly exceeds that of the general population (about .5%–1%), reported prevalence rates of seizures in this condition range from 5% to 40%, and several studies have not reported such an association

This variability has been attributed to the heterogeneity of samples with respect to age, sex, comorbidity, subtype of pervasive developmental disorder (PDD), intellectual disability (ID), or causes. It may also result from the criteria used to diagnose epilepsy. Early childhood and adolescence have been reported to be the peak periods for seizure onset in studies of adolescents and adults presenting the highest rates of prevalence. The risk of epilepsy also varies according to subtype within the autistic spectrum: autism, Asperger syndrome, Rett syndrome, childhood disintegrative disorder (CDD), and PDD not otherwise specified.

In the general population, one of the chief risk factor for seizures is intellectual disability. An overall cognitive deficit is not a defining feature of autism. However, like epilepsy, intellectual disability is still considered to be intrinsically associated with autism, although there is a trend toward reporting less than 50% of ID in autistic subjects in recent studies. Early studies showed that the likelihood of epilepsy was negatively correlated with IQ. More recently, some studies have found a greater rate of seizures in individuals with intellectual disability

DIAGNOSTIC CRITERIA

DSM 5:F84.0 [299.00] Autism Spectrum Disorder

Communication

Despite normal hearing, the speech of patients with ASD may be delayed by as much as several years. Their deficits vary greatly in scope and severity, from what we used to call Asperger's disorder (these people can speak clearly and have normal, even superior, intelligence) to patients so severely affected that they can hardly communicate at all. Others may show unusual speech patterns and idiosyncratic use of phrases. They may speak too loudly or lack the prosody (lilt) that supplies the music of normal speech. They may also fail to use body language or other nonverbal behavior to communicate—for example, the smiles or head nods with which most of us express approval. They may not understand the basis of humor (the concept that the words people use can have multiple or abstract meanings, for instance). Autistic children often have trouble beginning or sustaining

Conversation; rather, they may talk to themselves or hold monologues on subjects that interest them, but not other people. They tend to ask questions over and again, even after they've obtained repeated answers

Socialization

The social maturation of patients with ASD occurs more slowly than for normal children, and developmental phases may occur out of the expected sequence. Parents often become concerned in the second 6 months, when their child doesn't make eye contact, smile reciprocally, or cuddle; instead, the baby will arch away from a parent's embrace and stare into space. Toddlers don't point to objects or play with other children. They may not stretch out their arms to be picked up or show the normal anxiety at separation from parents. Perhaps as a result of frustration at the inability to communicate, ASD often results in tantrums and

aggression in young children. With little apparent requirement for closeness, older children have few friends and seem not to share their joys or sorrows with other people. In adolescence and beyond, this can play out as a nearly absent need for sex

Motor behavior

The motor milestones of patients with ASD usually arrive on time; it's the types of behavior they choose that mark them as different. These include compulsive or ritualistic actions (called *stereotypies*) - twirling, rocking, hand flapping, head banging, and maintaining odd body postures. They suck on toys or spin them rather than using them as symbols for imaginative play. Their restricted interests lead them to be preoccupied with parts of objects. They tend to resist change, preferring to adhere rigidly to routine. They may appear indifferent to pain or extremes of temperature; they may be preoccupied with smelling or touching things. Many such patients injure themselves by head banging, skin picking, or other repetitive motions.

Diagnostic Criteria from International Classification of Diseases (ICD -10)

F84.0 Childhood autism

A pervasive developmental disorder defined by the presence of abnormal and/ or impaired development that is manifest before the age of 3 years, and by the characteristic type of abnormal functioning in all three areas of social interaction, communication, and restricted, repetitive behaviour. The disorder occurs in boys three to four times more often than in girls.

Diagnostic guidelines

Usually there is no prior period of unequivocally normal development but, if there is, abnormalities become apparent before the age of 3 years. There are always qualitative impairments in reciprocal social interaction. These take the form of an inadequate

appreciation of socio-emotional cues, as shown by a lack of responses to other people's emotions and/or a lack of modulation of behaviour according to social context; poor use of social signals and a weak integration of social, emotional, and communicative behaviours; and, especially, a lack of socio-emotional reciprocity. Similarly, qualitative impairments in communications are universal. These take the form of a lack of social usage of whatever language skills are present; impairment in make-believe and social imitative play; poor synchrony and lack of reciprocity in conversational interchange; poor flexibility in language expression and a relative lack of creativity and fantasy in thought processes; lack of emotional response to other people's verbal and nonverbal overtures; impaired use of variations in cadence or emphasis to reflect communicative modulation; and a similar lack of accompanying gesture to provide emphasis or aid meaning in spoken communication.

The condition is also characterized by restricted, repetitive, and stereotyped patterns of behaviour, interests, and activities. These take the form of a tendency to impose rigidity and routine on a wide range of aspects of day-to-day functioning; this usually applies to novel activities as well as to familiar habits and play patterns. In early childhood particularly, there may be specific attachment to unusual, typically non-soft objects. The children may insist on the performance of particular routines in rituals of a non-functional character; there may be stereotyped preoccupations with interests such as dates, routes or timetables; often there are motor stereotypies; a specific interest in non-functional elements of objects (such as their smell or feel) is common; and there may be resistance to changes in routine or in details of the personal environment (such as the movement of ornaments or furniture in the family home).

In addition to these specific diagnostic features, it is frequent for children with autism to show a range of other nonspecific problems such as fear/phobias, sleeping and eating

disturbances, temper tantrums, and aggression. Self-injury (e.g. by wrist-biting) is fairly common, especially when there is associated severe mental retardation. Most individuals with autism lack spontaneity, initiative, and creativity in the organization of their leisure time and have difficulty applying conceptualizations in decision-making in work (even when the tasks themselves are well within their capacity). The specific manifestation of deficits characteristic of autism change as the children grow older, but the deficits continue into and through adult life with a broadly similar pattern of problems in socialization, communication, and interest patterns. Developmental abnormalities must have been present in the first 3 years for the diagnosis to be made, but the syndrome can be diagnosed in all age groups.

All levels of IQ can occur in association with autism, but there is significant mental retardation in some three-quarters of cases.

Includes:

- Autistic disorder
- Infantile autism
- Infantile psychosis
- Kanner's syndrome

Differential diagnosis

Apart from the other varieties of pervasive developmental disorder it is important to consider: specific developmental disorder of receptive language (F80.2) with secondary socio-emotional problems; reactive attachment disorder (F94.1) or disinhibited attachment disorder (F94.2); mental retardation (F70 - F79) with some associated emotional/behavioural disorder; schizophrenia (F20.-) of unusually early onset; and Rett's syndrome (F84.2).

Excludes: autistic psychopathy (F84.5)

CASE DESCRIPTION

Mr. M. R., 15 year old male, brought with the chief complaints of Age inadequate speech and language, age inadequate social interaction, stubbornness, restlessness, poor eye contact, shyness, inattention, drooling, ADL dependency, Seizure episodes, aggressive behaviour occasionally and age inadequate behaviour. First episode of seizure was at the age of 1 year and undergone proper medications. Now he is seizure free since 1 year. He had difficulty in sucking, chewing and swallowing up to 3 years. He has normal sleep, appetite, bowel and bladder.

Birth and Developmental History

Mr M. R. is the third order child of non-consanguineous union. He comes from a nuclear family were no particular history of seizure, mental retardation, psychiatric illness. Prenatal history reveals that mother conceived at the age of 29yr old, fetal movements were passive and done regular antenatal cheek up.

Natal history reveals that she had a full term normal vaginal delivery; birth weight 3.00 kg and immediate cry after birth; Delayed Motor and Speech & Language milestones. About Social Development, able to recognise his parents and emotionally more attached with mother, poor social smile and name call response. Fine & Gross motor skills – Gait and palmar grasp is present and normal, pincer grasp and eye hand coordination is poor.

Clinical evaluations / Remarks

CT Brain shows sulci absent, suggestive of neuronal migration disorder. Video EEG reveals moderate to severe abnormal, findings suggests multifocal seizures frequently from O_2, T_6 and infrequently from C_4, T_4, F_4 and FP_1. Tesla MRI Brain reveals essentially normal study.

Speech and language evaluation reveals that Mr M.R comprehends near family members, psychological feelings of others, few common objects, few action verbs, some 'Wh' questions, simple one step instructions. Sematic relations are present, poor pragmatic and cognitive skills. Language test results, On Receptive-Expressive Emergent Language Test (REELS), Receptive Language Age (RLA) 3 to 3.5 years scattered upto 3.5 to 4 years, Expressive Language Age (ELA) 30 -33 months.

Psychological assessment reveals: Behavioural observation shows Attention could be aroused but not sustained, eye contact was maintained and rapport partially established, the client was restlessness, drooling present, follows simple one step instructions and cooperative during assessment. He is oriented to person and place only and inadequate expressive and receptive speech. On VSMS (Vinland Social Maturity Scale), the child obtained the social age SA of 6 years 6 months and a social quotient SQ 46 which indicates the child is having moderate retardation in social & adaptive functioning. On DST (Developmental Screening Test), the child scored developmental age DA of 4 years 1 month indicates, the child is having severe developmental delay.

Diet

The client is recommended for to follow Gluten Free Casein Free (GFCF) Diet, also known as Autistic Diet. Gluten-free casein-free interventions limit food that contains gluten (e.g. breads, pastas, pizza, bagels, crackers, cakes, cookies, oats/ cereals, etc., made from wheat, barley, and rye) and casein (e.g., milk, cheese, cheese products, yogurt, ice creams, dips, sour cream, dressings, etc.)

CASE FORMULATION

Mr. M. R., 15 year old boy, who lives at home with his parents and two younger siblings. He presents to hospital with concern for Age inadequate speech and language, age inadequate social interaction, stubbornness, restlessness, poor eye contact, shyness, inattention, drooling, ADL dependency, Seizure episodes, aggressive behaviour occasionally and age inadequate behaviour. He has history of seizure disorder and undergoing proper medication.

Mr. M. R. meets sufficient DSM-5 and ICD 10 criteria for a provisional diagnosis of Autism Spectrum Disorder; diagnosed as **F84.0 [299.00] Childhood Autism with Seizure Disorder,** requiring moderate support for deficits in social communication, socialisation and mild-moderate support for restricted, repetitive behaviours.

CONCLUSION

Childhood Autism is a pervasive developmental disorder involving profound deficits in social relatedness, communication impairments, repetitive behaviours, and restricted interests with onset prior to 3 years old, is a behavioural syndrome. This case report clearly dictates most varied clinical aspects of the Autism and seizures which helps in the proper diagnosis of the condition. The current understanding of the association between epilepsy and autism is still limited, but from a clinical point of view this association should not be overlooked, and it should be routinely investigated.

REFERENCES

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

American Psychiatric Association (2013). Pervasive developmental disorders, In: Diagnostic and Statistical Manual of Mental Disorders. 5th ed.-text revision (DSM-5). Washington, DC: American Psychiatric Association.

American Psychological Association (2001). *Publication manual of the American Psychological Association* (5th ed.). Washington: APA.

Olsson, I., Steffenburg, S., & Gillberg, C. (1988). Epilepsy in autism and autistic like conditions. A population-based study. Arch Neurol 45:666–668.

Sturmey, P. (2009). *Clinical Case Formulation: Varieties of Approaches* (1st ed.). UK: John Wiley & Sons Ltd.

Tuchman R, & Rapin, I. (2002). Epilepsy in autism. Lancet Neurol 1:352–358. Canitano R (2007): Epilepsy in autism spectrum disorders. Eur Child Adolesc Psychiatry 16:61–66.

World Health Organization (1992). *The ICD -10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva: World Health Organization.

A Quantitative Comparative study on Anxiety and Depression among Good Academic Performers of selected districts of Kerala and Karnataka

Arun Joshy*

ABSTRACT

Anxiety and Depression disorders are the most common mental disturbances in adolescence. During this life. The study focused on the students to assess the level of anxiety and depression during the age boundaries of 13 to 15, the academic class is considering for the study is 8th to 10thwith the comparison of the selected district of Kerala and Karnataka. The sampling of 60 from each. Totally 120 students are included from both the state.

Keywords: Anxiety, Depression, Mental Disturbances

* Student, Dept of Social Work in Research, SDM PG Collage, Ujire, DK,
E-mail ID:arunjoshyed@gmail.com, Mob: +91 918281861480

INTRODUCTION

Depression as well as anxiety disorders are among the most common mental disorders in adolescence. During this life phase, the incidence of these clinical disorders rises dramatically, and even more adolescents suffer from symptoms of depression or anxiety or both that are just below the clinical threshold. Both clinical and subclinical levels of depression or anxiety symptoms are related in decreased functioning of various areas, such as social and academic functioning. Early prevention of depression and anxiety in adolescents is a significant factor.

This quantitative research is focused on anxiety and depression among good academically performers between Kerala and Karnataka students with the primary goal to understanding and preventing depression, anxiety, or both in good academic performance. The selection process yielded 60 students from each state both Kerala and Karnataka. The total sampling of this study was 120 students, 60 from each.

In the day today life we are facing so many problems such as personal, social, environmental, psychological etc…, but in this present scenario we always consider, which happens just because of the low education or insufficient knowledge, if we are considering education is the whole remedy for the all problems? of course not. Because highly intellectual individuals are also having problems in their life. But, those persons may never share such bitter experience with any other persons. That may lead to some psychological problems such as depression, anxiety, phobia, stress, inferiority complex etc., they may under controlled by some pressure and also those pressure leads to stress, likewise the psychological disturbances create.

In the theoretical as well as research literature the term anxiety, fear, nervousness and tension seem to be employed interchangeably. Those psychoanalytic persuasions prefer to reserve the term anxiety for fear that is experienced in the absence of external danger; most learning theorists on the other hand apply this term anxiety to fear learned in the presence of specific harmless stimuli. There is much inconsistency. All these terms interchangeably specifying only the conditions that seems to elicit a given response. Thus, we shall have an occasion to speak of unrealistic anxiety or fear and neurotic anxiety or fear, in contrast with realistic anxiety or fear and objective anxiety.

Depression is considered as a common mental disorder that presents with depressed mood, feelings of guilt or low self-worth, loss of interest or pleasure, decreased energy, disturbed sleep or appetite, and poor concentration. Moreover, depression often comes with the symptoms of anxiety. These problems can become the chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday activities and responsibilities. At its worst, depression can lead to suicide or some social problems. Approximately 1 million lives are lost yearly due to suicide, which translates to 3000 suicide deaths per day. For every person who completes a suicide, 20 or above may attempt to end his or her life (WHO, 2012). Depression may affect people of all ages, about twice as many women and men are diagnosed with clinical depression. The highest rates of depression are those under the age group of 20 years old, with adolescence being the usual age of onset for depression.

It's also an issue for seniors, with those who living in long-term care facilities experiencing depression at a rate of up to 9 in 10. Everyone occasionally feels blue or sad in their life. But these feelings may usually short-lived and pass within couple of days. When

you feel depression, it will interfere with daily life and causes pain for both you and those who care about you. Depression is common but serious illness. Many people with a depressive illness never seek treatment from the trained professionals. But the majority of people even those with the most severe depression, can get better with treatment. The studies proven that, the medications, psychotherapies and other methods can effectively treat people with depression.

In this study, the researcher chose the scale Multiphasic Questionnaire (MPQ) for to understand the anxiety and depression among highly academic performers. It is a comparative study by including two states both Kerala and Karnataka. There are no previous studies were completed on the same topic. In this investigation, the researcher is focusing the factors that may influenced by the student's anxiety and depression with consideration of state, social norms, gender, age and cast, beliefs systems are also an influential factor. It is an investigation for to find out the level of anxiety and depression among the students.

Review of Literature

Depression and anxiety is the most common mental disorders during adolescence with a prevalence of 5.6% for depression and a prevalence of 3–20% for anxiety. Research has shown that, between 13–17-year-old adolescents lifetime prevalence is estimated to be 12.6% for depression and 32.4% for anxiety disorders. Even more, the adolescents suffer from sub-clinical levels of depression or anxiety, 21.4% of the adolescents estimated to suffer from subclinical depression symptom. Unfortunately, the number of adolescents who suffering from subclinical anxiety is unknown.

Depression and anxiety during the age of adolescence are associated with decreased psychosocial functioning that is, malfunctioning in social relations, poor academic

performance or school drop-out, increased risk for substance abuse, other mental health problems, and suicide. Adolescents with depression or anxiety disorder are at considerable risk for developing recurrent depression and anxiety disorders later in life. These negative consequences may can comparable in between adolescents who meet the criteria for depression or anxiety disorder and adolescents with subclinical depression and other anxiety symptoms. Therefore, it is imperative to reduce the incidence of depression and anxiety in the society, but also to prevent further development of depression and anxiety symptoms. Because in the present scenario, the depression and anxiety symptoms rise dramatically during adolescence, this seems to be the appropriate age to implement prevention, because the risk for depression and anxiety may rises during this phase. Further, adolescents are, better than younger children, they can able to understand the concepts that are being taught in the prevention programs due to their improved reasoning ability.

Several prevention programs have been developed for to prevent the depression and anxiety during adolescence. Such programs utilize different kinds of prevention strategies and focus on populations with different risks of developing depression or anxiety. Universal prevention programs are intended for all individuals in a population, regardless of their level of risk, such programs have shown mixed results in decreasing and preventing depression and anxiety symptoms. Selective prevention programs are developed to target such populations with high risk factors, which are known to be related to the onset of depression as well as anxiety. Selective prevention programs can be focused at children of parents with psychopathology or children from lower socio-economical environments. Indicated prevention programs are developed to target adolescents who already have elevated symptoms of depression or anxiety problems, but the symptoms do not qualify for a clinical

diagnosis. The results of selective and indicated prevention programs are together called targeted prevention, have shown to be more promising than universal prevention

Selective as well as indicated prevention programs are both aimed to populations with risk factors for depression or anxiety. An important risk factor is in parental psychopathology, as children are three times more likely to develop the major depressive disorder and two to seven times more likely to develop an anxiety disorder when their parents suffer from the same, respectively. And another risk factor for the development of adolescent is depression and anxiety is the experience of stressful life events during adolescence. The studies shown that, increased depressive and anxiety symptoms are often preceded by stress, and particularly in girls. Stress and depression are closely associated during adolescence. The existence of subclinical symptoms of depression and anxiety, or undiagnosed clinical levels of these disorders, is a risk factor for the development of clinical disorders.

Prevention in high risk populations are aims to decrease the likelihood of the onset of a depressive or anxiety disorder or decrease in symptoms, treatment focus to reduce existing symptoms. In targeting symptoms, prevention seems to parallel treatment in behalf of these goals. As we know the reviews of meta-analyses, cognitive behavioral therapy demonstrated to be an effective treatment for the wide range of psychological problems, including depression and anxiety. On the overlap in goals (i.e., decreasing symptoms) between treatment and prevention, techniques of the cognitive behavioral approach seem to be suitable techniques can use in the prevention of depression and anxiety in high-risk adolescents. Although, such several prevention programs for the depression and anxiety are based on cognitive behavioral theories, to our knowledge, the effects of depression and anxiety prevention programs are with the same theoretical background on high-risk adolescents were never reviewed or studied in a meta-analysis. On this meta-analysis, research team examined

whether prevention programs based on the cognitive behavioral approach are effective in preventing depression and anxiety in high-risk adolescents.

Several reviews and meta-analyses have been conducted to evaluate and understand the effectiveness of depression prevention programs and anxiety prevention programs for adolescents. These meta-analyses were focused on either depression or anxiety, and on prevention in general and not on high risk of populations. This review intended to identify and describe school-based as well as community-based prevention programs based on cognitive behavioral therapy (CBT) with a primary goal of preventing depression and anxiety, or both in adolescents at risk for may developing these disorders

Evidence from the 1990's

Compared with the literature base we reviewed for our 1991 synthesis, we found relatively few studies focusing on change or gains in general cognitive skills and intellectual growth during high school. The literature we did find focused largely in two broad areas that we term critical thinking and post formal reasoning.

Identity development

Many of the studies of identity formation in our earlier review used models with theoretical roots in Erik Erikson's conceptions of psychosocial developments. For Erikson developmental tasks or crisis were A central dynamic in identity formation. He theorized eight stages of periods of life cycle when biological and psychological changes with interact act eristic of that particular stage. For Erickson a, crisis is not a physical or psychological emergency but rather period requiring serious consideration of an choice among possible course of action.

Significance of the Study

In this study I'm focusing about the anxiety and depression among high school students who are highly intellectual. Because the some highly intellectual students may not have the proper relationship between societies, after their completion of education that person wanted to work in society and also mingle with the people who is belongs to them. At that time that person may find some difficulty in it, but he/she is well qualified in terms of academics. That person may develop inferiority complex and also have a kind of social anxiety. These social anxiety and inferiority complex may lead depression in that person's future life.

Aim and Objective

- To study the level of anxiety among adolescents of Karnataka and Kerala
- To study the level of depression among adolescents of Karnataka and Kerala

Hypothesis

- There is no significant difference in the level of depression and anxiety of the students studying in Kerala and Karnataka states.

METHOD

Methodology is the systematic application of the scientific procedure to conduct the research various procedures are to be followed in the course of investigation. The present chapter gives a detailed description of research method followed in the study. It includes the detail of sample, statistics applied, tools, procedure, scoring and analysis of the collected data.

Criteria

- Inclusion-(age from 13 to 15, class from 8^{th} to 10^{th}.
- Exclusion-Below 6^{th} class and above 11^{th} class

Sample

The sample for the study consisted of 120 students out of which 60 students from Kerala and 60 students from Karnataka between the age group of 12 to 16 years.

Statistical application

Independent Sample t-test

Tool

- Multiphasic Questionnaire developed by Anisha Shah, Deepa Sarugunraj and V.G kaliyaperumal in the department of clinical psychology and biostatistics National Institute of Mental Health and Neuroscience Bangalore India and Department of psychiatry and behavioral sciences Anxiety prevention and treatment research center Medical University of south Carolina Charleston, South Carolina,U.S.A.

Procedure

All the samples selected for the study are from High school students including boys and girls with age group of 12 to 16 years. The purpose of the study was explained to each of the subjects because the lie scores (K Scale) is also considered in the experiment. Seat the subject comfortably and establish a good rapport with them. Then give the questionnaire to all the students and instruct as follows "This is a questionnaire to find out certain psychological areas which is related to your day to day life, there are 100 questions, read each

question carefully and mark a tick (✓)or round (O)against the answer you feel appropriate (true or false). There is no right or wrong answer. All your answers will be kept confidential. Answer all the questions."After the administration all the subjects are thanked and the questionnaire was collected for scoring and analysis.

Scoring

The scoring pattern showed that many of the items were overlapping on the scales. Twenty-three items were not used for interpretation on any of the 9 scales. The remaining 77 items were used many times in interpretation of different scales. Many of these items had same direction of scoring on more than one scale. The maximum score on each of the scale ranged from 8 to 34. Only three of the nine scales have mutually exclusive items (psychopathic deviate:12 items; schizophrenia 5 items; and mania:3 items). In the process of item content examination, the researcher felt that item one (I often get red spot on my neck) should be deleted from the tool. It is one of the items not used for interpretation on any of the MPQ scales. Clinical experience also suggested clients are often not able to comprehend this item.

Each True or False response to the remaining 99 items was entered into the Statistical Package for the Social Sciences (SPSS version 7.0, 1995), for the data reduction. A 'true' response was coded as 1 and 'false' response as 2. There was missing data on one or more items across subjects. Three options were explored to handle the missing data:

1) To include only those subjects with complete data on all items (with this criteria , only 110 subjects were available for analysis),

2) To substitute the mean values in place of the missing data (with approach the derived correlation may deviate from the original as the missing value may be different from available data, or
3) To calculate a correlation coefficient matrix using each pair of items for which information was available. The third option was judged to be the most useful method as there was no loss of subjects from the sample and no artifact was introduced into the analysis.

RESULTS

Table No 1

shows mean, SD and t-value of anxiety between Karnataka and Kerala students

	Group	N	Mean	Std. Deviation	t-value
Anx_t_Score	**Karnataka**	60	50.89	9.03	.977 NS
	Kerala	60	49.10	10.88	

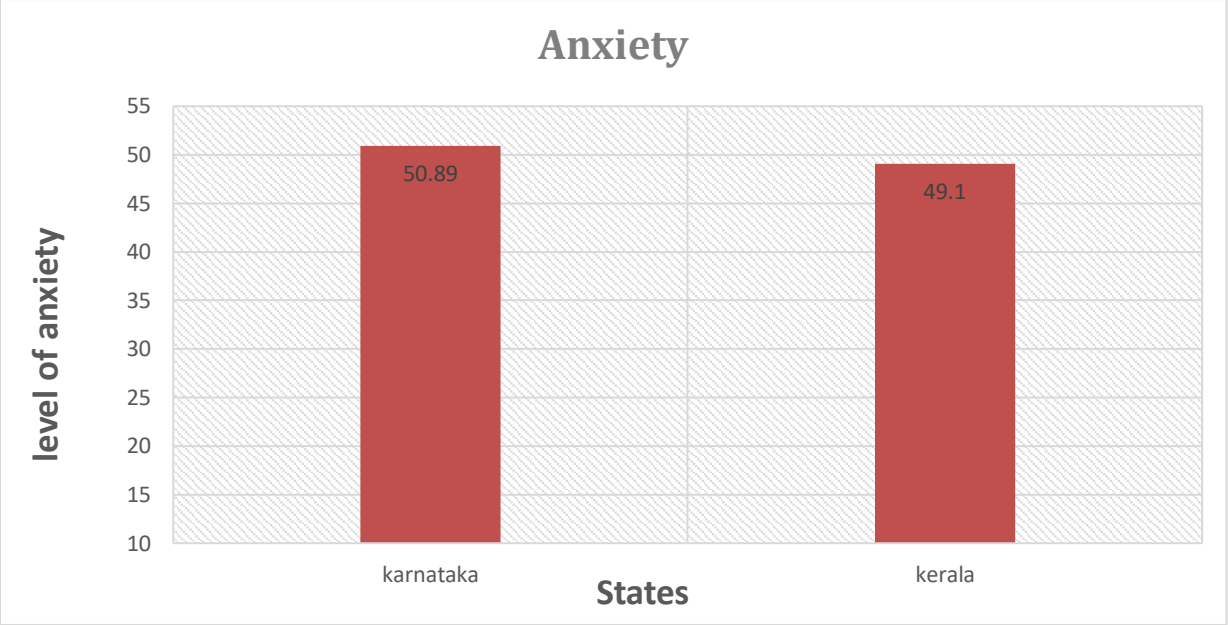

Figure 1

Table no 1 shows that the result of anxiety between Kerala and Karnataka students. The results shows, Karnataka students exhibited slightly higher level of anxiety compared to Kerala students. However, there is no significant difference between Kerala and Karnataka students with respect to anxiety. The first hypothesis states that there is no significant difference in anxiety between Kerala and Karnataka students has been accepted.

Table 2

Shows mean, SD and t-value of anxiety between Karnataka and Kerala students.

	Group	N	Mean	Std. Deviation	t-Value
Depression	**Karnataka**	60	50.17	9.15	.190 NS
	Kerala	60	49.82	10.85	

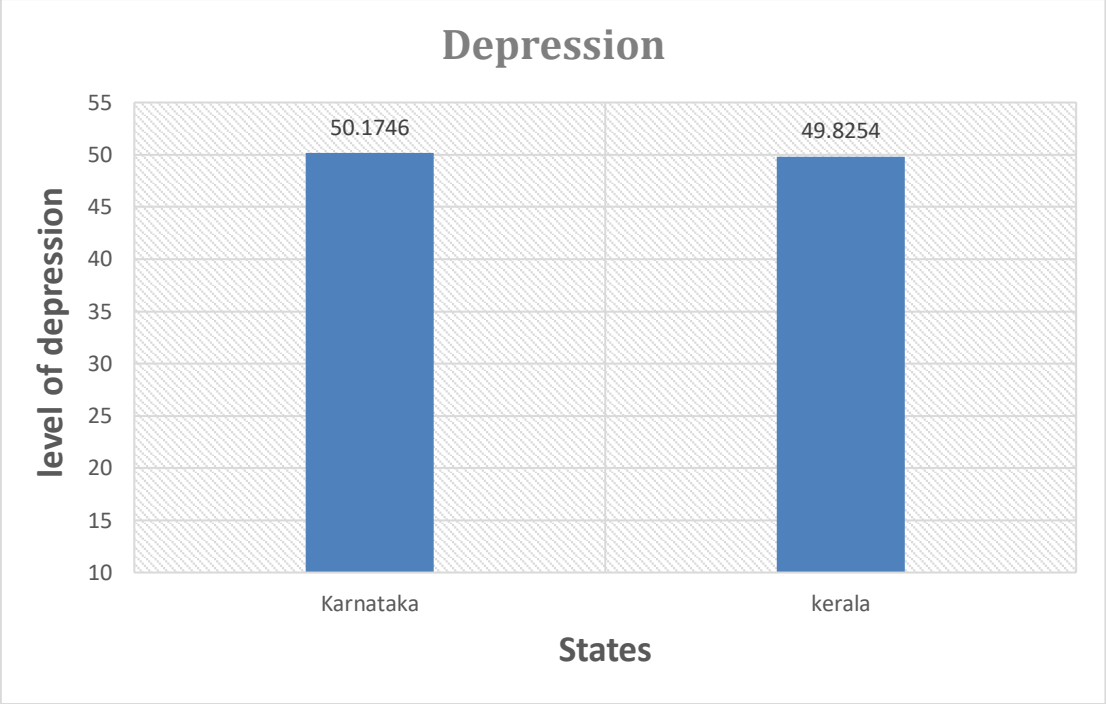

Figure 2

Table no 2 shows that the result of depression between Kerala and Karnataka students. The results shows, Karnataka students exhibited slightly higher level of depression compared to Kerala students. However, there is no significant difference between Kerala and Karnataka students with respect to depression. The first hypothesis states that there is no significant difference in depression between Kerala and Karnataka students has been accepted.

SUMMARY AND CONCLUSION

Anxiety and Depression disorders are the most common mental disturbances in adolescence. During this life, the incidence of these clinical disorders rises dramatically, and even more adolescents suffer from the symptoms of depression or anxiety that are just below the clinical threshold. Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth,

disturbed sleep or appetite, and poor concentration. Moreover, depression often comes with symptoms of anxiety.

Conclusion

- There is no significant difference in the level of anxiety therefore the null hypothesis is accepted
- There is no significant difference in the level of depression therefore the null hypothesis is accepted

Recommendations for Future Research

- Larger number of samples can be included for the future study.
- The influence of other demographic variables like age, Socio-Economic Status(SES), birth order, caste or religion can be included for the future research.
- The same study can be conducted for the students of other age groups and belonging to other geographical areas.

Limitations of the Study

- The sample size was too small hence the result cannot be generalized.
- The sample was selected from the limited areas
- Many other demographic variable and psychological variables are not included in the study

REFERENCES

Anxiety in the Classroom- Rachel Ehmke- https://childmind.org/article/classroom-anxiety-in-children/

Anxiety, depression, and peer relationships during adolescence: Results from the Portuguese national health behaviour in school-aged children survey- argarida Gaspar de Matos, Paula Barrett, Mark Dadds and Alison Shortt- European Journal of Psychology of Education- Vol. 18, No. 1 (March 2003), pp. 3-14

Classroom Accommodations to Help the Anxious Child at School-Katie Hurley, LCSW-https://www.psycom.net/classroom-help-anxious-child-at-school.

DSM-TR 4th Edition- Anxiety and depression-Published by the American Psychiatric Association Washington, DC

ICD 10th Classification- Diagnostic Criteria for research-World Health Organization Geneva, 1993

MPQ manual- by Anisha Shah, Deepa Sarugunraj and V.G kaliyaperumal dept of clinical psychology and biostatistics NIMHANS Bangalore India and dept of psychiatry and behavioral sciences Anxiety prevention and treatment research center Medical University of south Carolina Charleston, South Carolina,U.S.A.

Physical Activity, Depression and Anxiety Among the Elderly- Carla M. Teixeira, José Vasconcelos-Raposo, Helder M. Fernandes and Robert J. Brustad- *Social Indicators Research*- Vol. 113, No. 1 (August 2013), pp. 307-318- Published by: Springer-https://www.jstor.org/stable/24719415

Students with Anxiety: Implications for Professional School Counselors- E. Heather Thompson, Phyllis Robertson, Russ Curtis and Melodie H. Frick- Professional School

Counseling-Vol. 16, No. 4, Special Issue on School Counselors and Student Mental Health, Part I (January 2013), pp. 222-234

A Study of achievement motivation among 12th standard college going students

Ramesh D. Waghmare*

ABSTRACT

Achievement motivation is a concept that can be used for the explanation of individual differences in achievement and success in various contexts as well as an explanation of motivated behaviour. To study by research seared variables in Gender and Area of Living and achievement motivation. Total sample of present study 100, in which 50 were male (Urban 25and Rural 25 Students) and 50 females (Urban 25and Rural 25 Students).The scale was used for data collection Achievement Motivation Test (ACMT) by Dr. V. P .Bhargava.2x2 factorial designs was used and data were analysis by Mean, SD and 'F' values. Results show that 1) Male Students high Achievement Motivation than Female Students. 2) Rural Students high Achievement Motivation than Urban Students. 3) There is interaction significant different between Gender and Area of Living on Achievement Motivation.

Keywords: *Gender, Area of Living, Achievement motivation*

* Assistant Professor, Godawari College Ambad, Dist. Jalna (M.S.)
E-mail: rdjalna@rediffmail.com, Mob: +91 9765606178

INTRODUCTION

Achievement motivation is a concept that can be used for the explanation of individual differences in achievement and success in various contexts as well as an explanation of motivated behaviour. Despite the fact that a generally accepted definition of achievement motivation is still lacking because of disagreement over the traits it encompasses, numerous studies have been conducted on this subject. Researchers agree that achievement motivation is an important factor in professional life, particularly in achieving high professional success when external demands for focusing activity on achieving goals are minimal. It is of particular importance for those activities that have low structure levels and high autonomy.

Achievement motivation is a miniature system applied to a specific context, the domain of achievement-oriented activities, which is characterized by the fact that the individual is responsible for the outcome anticipates unambiguous knowledge of results, and there is some degree of uncertainty or risk yet it is our belief that the type of theory that views the strength of an individual's goal –directed tendency as jointly determined by his expectations about the consequences of his actions, and by incentive values of expected consequences will have wider utility when these concepts these concepts are applied toward other goals.

REVIEW OF LITERATURE

In a study, Tamilselvi and Devi (2017) this study found that there is no significant difference in achievement motivation between Male and Female students and there is no

significant difference in achievement motivation between Rural and Urban school students. Nagarathanamma & Rao (2007) found no significant difference between boys and girls with regard to achievement motivation level. Adsul et al. (2008) this study indicated that male students were found to be having a high achievement motivation female students having a below average level of achievement motivation. Shekhar and Devi (2012) studied achievement motivation in college students and found that boys and girl are significantly different on levels of achievement motivation. Girls are more motivated than boys. Liu & Zhu (2009) found significant differences in achievement motivations of male and female senior high school students, male students have higher achievement motivations than female students. Ahluwalia (1985), Singh (1986) and Sodhi (1989) revealed that rural and urban school students do not differ significantly in relation to their achievement motivation. Chetri, (2014) in her study revealed non- significant difference in achievement motivation of adolescent students with regard to gender and locale variation. Mishra, H.P. (June 2017) this study indicate that there is no significant difference in the achievement motivation of secondary school boys and girls. And the students of urban area have better achievement motivation than the students of rural area. Neelima Mandav, (2017) this study found that there is significant difference between high school boys and girls in their achievement motivation and there is significant difference among rural, sub-urban and urban adolescent students in their achievement motivation.

Statement of the problem

A Study of achievement motivation among 12th standard college going students

Objectives

- To Study of achievement motivation of Male and Female 12th standard college going students
- To Study of achievement motivation of Urban and Rural 12th standard college going students
- To Study the significance of interaction of Gender and Area of Living on achievement motivation.

Hypotheses

- There is no significance difference between achievement motivation than male and female 12th standard college students.
- There is no significance difference between achievement motivation than male and female 12th standard college students.
- There is no interaction between Gender and Area of living in terms of achievement motivation of 12th standard college going students.

METHOD

Participants

The present study sample go was selected from Art's college students of Ambad city from Jalna district in Maharashtra. To select the sample in which students study of Art's 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 100, in which 50 were male (Urban 25and Rural 25 Students) and 50 females (Urban 25and Rural 25 Students). The subject selected in this sample will be used in the age group of

18 years to 19 years (Mean - 18.16, SD - 1.51.) and Ratio 1:1. Thus total sample includes as shown in the following table.

Gender and Area of Living

	Male	**Female**	**Total**
Urban	25	25	50
Rural	25	25	50
Total	50	50	100

Research Design

2x2 factorial designs use for the present study.

		A	
		A1	A2
B	B1	A1,B1	A2,B1
	B2	A1,B2	A2,B2

A- Gender A1- Male A2- Female

B- Living of Area B1- Urban B2- Rural

Variables of the Study

Variable	**Type of variable**	**Sub. Variable**	**Name of variable**
Gender	IndependentVariables	02	1) Male 2) Female
Living of Area	IndependentVariables	02	1) Urban 2) Rural
Achievement motivation	DependentVariables	01	Achievement motivation

Age **Faculty** **Class**	Control variable	1) 18-19 Years 2) Only Arts Faculty Students 3) 12^{th} students

Research Tools

Achievement Motivation Test (ACMT)

Present test was designed by Dr. V. P. Bhargava. The test consists of '50' items of incomplete sentences. Which are to be completed by these by putting a check. Mark on any one of five alternatives responses given against each item. Item by choosing one of the alternative responses which indicates is true filling. With respect to the point asked through a particular item. Test-retest reliability after an interval of one month of 67 comparing the similar item. 79 for English version of the test and that the value of reliability were 91 and 78 validity was found that the test value of reliability were 91 and 78 validity was found that the test scores on this test and that with the test-scores on this test and that with the test- scores for SCT of Dr. Mukherji had an agreement of 80 with educational and achievement test (general) it had an agreement of 75.

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.

Data analysis

The Mean and SD with graphical representation for Gender (Male and Female College Students) and Area of Living (Urban and Rural Students) on Achievement Motivation was analysed. 2x2 factorial designs was selected to adequate of statistical analysis of ANOVA in order to examine the roll of main as well as subsequently on Achievement Motivation.

RESULTS AND DISCUSSION

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

Table No. 01

Mean SD and F Value of Achievement Motivation on Gender

Gender	Mean	SD	N	DF	F Value	Sign.
Male Students	113.86	10.10	50	98	42.64	0.01
Female Students	103.64	8.20	50			

(Critical value of "f" with df 99 at 0.01 = 3.86 and at 0.05 = 6.70)

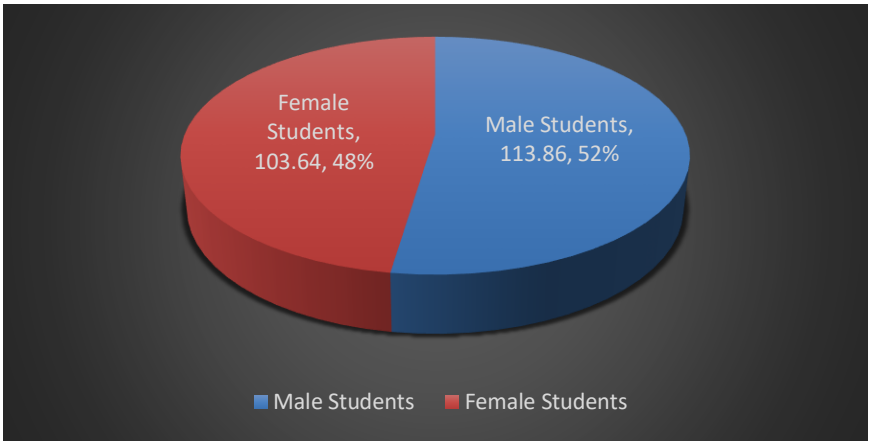

Figure 1: Shows Male and Female Students

Observation of the table No. 01 and Figure No. 01 indicated that the mean value of two classified group seems to differ from each other on Achievement Motivation. The mean and SD value obtained by the male Students113.86, SD 10.10 and Female Students was 103.64, SD 8.20, but on the basis of mean observation it would that mean difference 10.22. Both group 'F' ratio was 42.64 at a glance those Male Students shows high score than Female Students.

In the present study was hypothesis related Achievement Motivation and Gender. It was "There is no significance difference between achievement motivation than male and female 12th standard college students''. Gender effect represent the Achievement Motivation was significant (F- 42.64, 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 Students differ from Achievement Motivation. The findings of the not supported the hypothesis, they are this hypothesis rejected the present study. Its means that Male Students high Achievement Motivation than Female Students. A similar finding was found that Adsul et al. (2008) this study indicated that male students were found to be having a high achievement motivation female students having a below average level of achievement motivation. Liu & Zhu (2009) found that male students have higher achievement motivations than female students. An Opposite finding was found that Nagarathanamma & Rao (2007) found no significant difference between boys and girls with regard to achievement motivation level.

Table 2

Mean SD and F Value of Achievement Motivation on Area of Living

Area of Living	Mean	SD	N	DF	F Value	Sign.
Urban Students	106.34	10.10	50	98	9.48	0.01
Rural Students	111.16	11.98	50			

(Critical value of "f" with df99 at 0.01 = 3.86 and at 0.05 = 6.70)

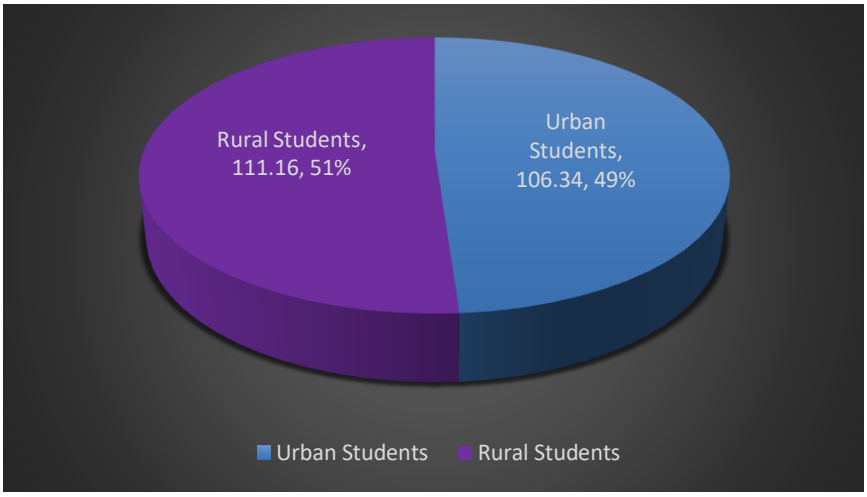

Figure 2: Shows Rural and Urban Students

Observation of the table No.02 and Figure No.02 indicated that the mean value of two classified group seems to differ from each other on Achievement Motivation. The mean and SD value obtained by the UrbanStudents106.34, SD 10.10 and Rural Students were 111.16, SD 11.98, but on the basis of mean observation it would that mean difference 4.82. Both group 'F' ratio was 9.48 at a glance those Rural Students shows high score than Urban Students.

In the present study was hypothesis related Achievement Motivation and Area of Living. It was "There is no significance difference between achievement motivation than Urban and Rural 12th standard college students''. Area of Living effect represent the Achievement Motivation was significant (F- 9.48, 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 Urban and Rural Students differ from

Achievement Motivation. The findings of the not supported the hypothesis, they are this hypothesis rejected the present study. Its means that Rural Students high Achievement Motivation than Urban Students. An Opposite finding was found that Ahluwalia (1985), Singh (1986) and Sodhi (1989) revealed that rural and urban school students do not differ significantly in relation to their achievement motivation. Mishra, H.P. (June 2017) this study indicate that the students of urban area have better achievement motivation than the students of rural area.

Table 3

Mean SD and F Value of Achievement MotivationonGender X Area of Living

Gender X Area of Living	Mean	SD	N	DF	F Value	Sign.
Urban Male Students	107.16	8.06	25			
Rural Male Students	120.56	7.05	25	96	30.05	0.01
Urban Female Students	105.52	8.40	25			
Rural Female Students	101.76	7.70	25			

(Critical value of "f" with df99 at 0.01 = 3.86 and at 0.05 = 6.70)

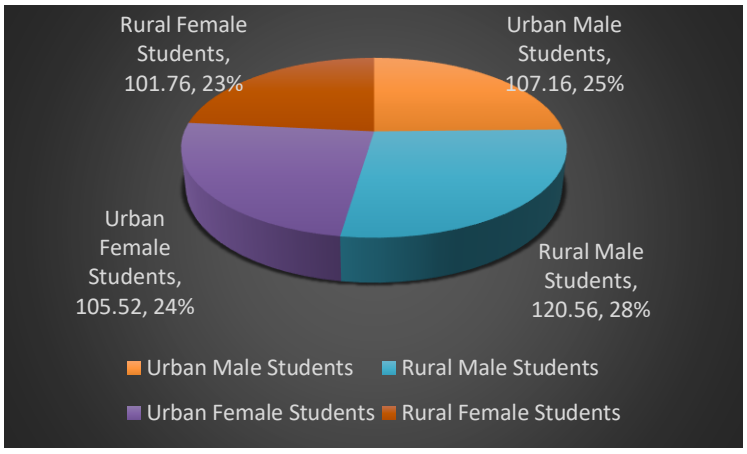

Figure 3: Shows Rural Male & Female Students and Urban Male & Female Students

Means and SD obtained by the four classified groups on the measure of Achievement Motivation were given in the table 03 and Figure No.03. The four classified groups were the

sum, which were classified on the basis of two independent variables namely Gender and Area of Living.

Examination and it shows of the means and SD of the four classified groups scores obtained on Achievement Motivation is more or less normally distributed. On this measure, high score indicates high Achievement Motivation, so if the mean scores were examined then all groups had shown high Achievement Motivation. For example Rural Male Students mean score was 120.56 & SD was 7.06, it was concluded this score was high then the other groups (Urban Male Students = Mean 107.16 & SD 8.06, Urban Female Students= Mean 105.52& SD 8.40, Rural Female Students= Mean 101.76& SD 7.70).

Interaction between Gender X Area of Living is significant F (1, 99) = 30.05, P =0.01 and 0.05 levels. It means that There is interaction significant different between Gender and Area of Living on Achievement Motivation.

Delimitations of the study

1) The finding of the study is based on very sample.
2) The sample was restricted to Ambad city from Jalna Dist. in Maharashtra.
3) The study was restricted to only arts college students only.
4) The study was restricted students are only 18-21 years only.

Conclusions

1) Male Students high Achievement Motivation than Female Students.
2) Rural Students high Achievement Motivation than Urban Students.
3) There is interaction significant different between Gender and Area of Living on Achievement Motivation.

REFERENCES

Adsul, R., K., Kamble, V., & Sangli, K., W. (2008). Achievement Motivation as a function of Gender, Economic Background and Caste Differences in College Students. Journal of the Indian Academy of Applied Psychology, 34, 323-327.

Ahluwalia, I. (1985). "A Study of factors affecting achievement motivation". Ph.DPsy. Agra U. In fourth survey of research in education (1983-1988) ED; M.B; Buch (1991). New Delh: National Council for Educational Research and Training, Sri Aurobindo Marg, 1: 333.

Ambedkar, V. (2012). Achievement motivation and achievement in E of Mathematics ofadolescent students. Source: Golden Research Thoughts [2231-5063] vol:2 iss:6

Atkinson, John, W., & Feather, N., T. (1966) A Theory of Achievement Motivation New York Wiley.

Bhargava, V., P. (1994). Manual for Achievement Motive Test, Agra: National Psychological Corporation.

Chetri, S. (2014). "Achievement Motivation of Adolescents and Its Relationship with Academic Achievement". International Journal of Humanities and Social Science Invention, 3(6): 08-15.

Kumar, A., & Yadav, D. (2015). "A comparative study of academic achievement motivation of senior secondary students", A quarterly peer reviewed International Journal of Research & Education, 4(3).

Mishra, H., P. (2017) Achievement Motivation of Secondary School Students in Murshidabad District of West Bengal. International Journal of Peace, Education and Development, 5(1): 15-23.

Nagarathnamma, B., & V. Thirumal, Rao, (2007). Achievement motivation and Academic Achievement of adolescent Boys and Girls. Indian Psychological Review, 68, 131 – 136.

Neelima Mandav, (2017). Self-concept and achievement motivation of adolescent students. International Journal of Academic Research, Vol.4, Issue-8(1), 45-50.

P., Chandra, Kala, & P., Shirlin, (2017). "A study on achievement motivation and socio economic status of college students in tirunelveli district." International Journal of Research - Granthaalayah, 5(3)SE, 57-64.

Salili, F. (1996). Achievement Motivation a cross cultural comparison of British and Chinese students. International journal of experimental educational psychology 16(3), 271-277.

Shekhar, C., & Devi, R. (2012). Achievement motivation across gender and different academic majors. Journal of educational and developmental psychology; vol2, No; 2.

Shekhar, Chandra, & Kumar, Rajinder, (2016). Gender differences in achievement motivation, self-efficacy academic stress and academic achievement of secondary school students. Internat. J. Appl. Soc. Sci., 3 (5&6): 117-124.

Tamilselvi, B. & Devi, S., T. (2017) A study on achievement motivation of higher secondary students in Coimbatore district. International Journal of Advanced Education and Research, 2 (3), 81-84.

Achievement Motivation and Stress Tolerance among Police Officers

Shameema Abdul Azeez* and Reeba Susan Abraham**

ABSTRACT

Achievement motivation is one of the most relevant and influential type of motivation in the present world. In our current society, we face a lot of stressful situations. One reason for this is the need for achievement. One group of people who are facing stress due to the need for achievement is police officers, who serve the country and its laws. Police officers often face many needs to achieve as a part of their profession, like maintaining laws, helping people for their problems, providing service for the people of their particular region, lawfully punishing the culprits, etc. These needs that help in the development of their career creates stress in them. The achievement motivation of the police officers, thus, in fact influences their stress tolerance level.

The present study aims to explore the existence of a relationship between the achievement motivation and stress tolerance among police officers. The present study follows a descriptive design. Random sampling technique was used to draw the sample from the population. A sample of 60 police officers, including males and females were selected as sample for this study. The tools used to collect the data for the present study were Achievement Motivation Scale (n-Ach), developed by Prof. Pratiba Deo and Dr. Asha Mohan and Stress Tolerance Scale, developed by Reshmi, et al (1999). Parametric statistical techniques such as Karl Pearson's correlation and independent *t*-test were used for the analysis of the data.

Keywords: *Achievement motivation, Stress tolerance*

* Student, M.Sc. Psychology, Sree Sankaracharya University of Sanskrit, Kalady, Kerala
E-mail ID: shameemaazeez786@gmail.com, Mob: +91 7025323361
** Assistant Professor, H.M.College of Science and Technology, Manjeri

INTRODUCTION

How the need for achievement does influences the stress tolerance level? How is this significant among police officers? The field of Psychology plays a major role in studying this topic. Achievement motivation involves moving in the direction towards either success or avoidance of failure. The need to Achievement motivation achieve is a need for the sake of clarity in which every human being has a strong desire to achieve some or other things like money, fame, reputation, degree, merit position, medals, good life partner, spiritual attainment, etc., not only for raising his status in the eyes of others but also for the satisfaction he gets out of his own accomplishment. As a result of need for achievement, stress tolerance level increases. Stress is defined as an experience that occurs when an individual's demands outweigh their resources to meet these demands which results in the increase of mental and emotional strain. Thus, achievement motivation is highly linked with stress tolerance level, and it becomes common among police officers.

ACHIEVEMENT MOTIVATION

Motivation is an internal process that makes a person move toward a goal. The type of motivation produced by motive for achievement has been named as achievement motivation. Irving Sarnoff (1983) defined achievement motive in terms of the way an individual orients himself towards objects or conditions that he does not possess. If he values those objects and conditions, and he feels that he ought to possess them he may be regarded as having an

achievement motive. Achievement motive may be considered as a disposition to approach success or a capacity for taking pride in accomplishment when success is achieved in one or other activity. As far as the origin and development of the achievement motive is concerned, it can safely be said that it results from one's early training as well as experiences and subsequent learning. Achievement motivation is a type of motivation – a function of different beliefs including goals, norms, oneself and reality that are relevant to an individual's growth. It includes combination of high performance and the desirability of the outcome, in addition to the motivational forces that influence behavior. Emotions play a major role in motivation, if there is no emotion involved, no action occurs.

THEORIES OF ACHIEVEMENT MOTIVATION

ACHIEVEMENT GOAL THEORY

Achievement motivation theory was developed by Nicholls in 1984. According to the achievement goal theory, in order for students to accomplish a task, they must have already obtained the necessary skills and knowledge, but they must also have the desire and determination to invest their energy and resources in order to complete the task.

EXPECTANCY-VALUE THEORY

This theory was developed by John William Atkinson in 1950's to 1960's. The expectancy-value theory of motivation believes that expectancy-related beliefs result due to individuals' choices, persistence and their achievement behaviors. This theory also involves the integration of personal motives with their personality in order to demonstrate how identity shapes an individual's values, goals and behaviors.

SELF-WORTH THEORY

This theory was developed by Covington in 1992. The self-worth theory assumes that the highest human priority is the search for self-acceptance. It is thought that this need for self-acceptance causes a development of a fear of failure to approach success.

STRESS TOLERANCE

Stress tolerance is the ability to be relaxed and composed when faced with difficulties. Having positive stress tolerance is being able to stay calm without getting carried away by strong emotions of helplessness and hopelessness. Stress can be defined as an experience that occurs when an individual's demands outweigh their resources to meet these demands which results in the increase of mental and emotional strain. Stressors are the occurrence of conditions or events that evoke emotional or mental strain. Stressors can be broken down into two sub-categories, life changes and micro stressors.

THEORIES OF STRESS

GENERAL ADAPTATION SYDROME MODEL OF STRESS

This model was developed by Hans Selye. According to General Adaptation Syndrome Model of Stress, demands placed on an individual result in an increase in performance. There is a point however where optimal performance is reached, and further demands will act to decrease an individual's performance. This relationship is sometimes illustrated by the human performance curve.

THE FIGHT OR FLIGHT RESPONSE THEORY

Walter Cannon coined the term the "Fight or Flight" responses that is commonly used to describe the way in which our body reacts to stress. Cannon originally found this response in animals, but it was later found to also present in humans. The fight or flight response describes the way mammals respond to a threat.

ACHIEVEMENT MOTIVATION AND STRESS TOLERANCE

Although stress can create many negative impacts upon one's achievement motivation, achievement motivation itself can also cause stress levels to rise. The creation of unrealistically high expectations for oneself can cause an increase in stress level due to the realization of not being able to reach these expectations. Although there are many negative aspects in relation to stress and the effect it is has on achievement motivation, stress can positively impact motivation. As stress is caused due to lack resources to meet certain demands, the motivation to change the effects of stress on the body is helpful in changing the situation an individual may be in.

In a study, DivyaSree and Dilshad Bin Ashraf (2010) conducted a study on Achievement Motivation and Stress Tolerance among Kerala Police. The results indicate that there were significant difference in achievement motivation and stress tolerance between drinkers and non-drinkers and between vegetarians and non-vegetarians. No significant difference was found between married and unmarried personals in either two of the variables.

In a study, Kissari Ali (2015) conducted a study on psychological stress and its relationship with competitive sport anxiety and its rapport with the achievement motivation among hand ball male players. The results showed that there is negative correlation – and inverse relationship between burden training and success achievement motivation, the results resulted in a completely positive correlation between the family pressures and success

achievement motivation, the results show all the relationship of a positive correlation between the self-blame and failure avoidance, and there is a correlation between relationship success achievement motivation and physical anxiety.

In a study, Lakshmi Chand (2015) conducted a study on frustration tolerance in relation to achievement motivation and sports achievement. Results designate considerable key as well as interface effect of achievement motivation and sports achievement on frustration tolerance capacity of male sportspersons.

In a study, Rucker (2012) conducted a study on the relationship between motivation, perceived stress and academic achievement in students. It was found that both grade and native language affected the level of perceived stress. In addition to that, the feeling of stress was significant correlated within the failing rate of courses. Not being motivated was found to be associated with higher levels of stress and a lower Grade Point Average.

In a study, Hsu, Chen, Yu, Lou (2010) conducted a study on job stress, achievement motivation and occupational burnout among male nurses. Results show that, the contribution of job stress to occupational burnout of male nurses was confirmed.

In a study, Zulfiqar-Ullah Siddiqui, Mahvish Fatima and Hafiz Mohammed Ilyas Khan (2013) conducted a study on the impact of social and family role stress on the achievement motivation of Indian teachers. Statistical analyses of questionnaire returns of 200 teachers reveal that the impact of social and family role stress was not significant on the achievement motivation of the subjects.

In a study, Boggitti Rajesh Jayaratnam and Dileep (2013) conducted a study on field hockey better psychological effect through achievement motivation and stress. It was

concluded that twelve weeks yogic exercises significantly altered motivation and stress of the inter university hockey players. It was concluded that six weeks autogenic exercises significantly altered motivation and stress of the inter university hockey players.

METHOD

Description of method or procedure of the study describes the basic research plan. Method of research is a total of procedure followed by the investigator to make it scientific and valid to the extent possible (Pearson, 2003). It is the core of every research work. The success of all research studies depends on the method adopted and the tools and techniques employed.

This chapter describes the objectives, hypotheses and description of sample, tools, method of data collection and statistical analysis.

OBJECTIVES

- To study whether achievement motivation has an effect on stress tolerance of police officers.
- To study whether there is any difference in achievement motivation between males and females.

HYPOTHESES

H1. There will be a significant relationship existing between achievement motivation and stress tolerance.

H2. There will be a significant difference in achievement motivation between males and females.

H3. There will be a significant difference in stress tolerance between males and females.

POPULATION AND SAMPLE

The sample was drawn by descriptive sampling method to understand the Achievement Motivation and Stress Tolerance among police officers. Total sample size is 60 which include 30 males and 30 females respectively.

TOOLS

In the present study, two tools were used:

1. Achievement Motivation Scale (Prof. Pratibha Deo and Dr. Asha Mohan, 2002)
2. Stress Tolerance Scale (Reshmi et al, 1999)

Achievement motivation scale (Prof. Pratibha Deo and Dr. Asha Mohan, 2002)

Achievement motivation scale (n-Ach) was developed by Pratibha Deo and Asha Mohan consisting of 50 questions. Two stencil keys are to be used for scoring, one for positive items and other for negative items. The positive items the weight of 4, 3, 2, 1 and 0 for the categories always, frequently, sometimes, rarely and never respectively. The negative item is to be scored 0, 1, 2, 3 and 4 respectively for the same categories that are given above. Separate key for positive and negative items are provided. The reliability of achievement motivation scale for mixed group was found to be 0.69 and for male it was found to be 0.67 and 0.78 for females respectively.

Stress tolerance scale (Reshmi et al, 1999)

Stress tolerance scale was developed by Reshmi, et al (1999). Stress tolerance scale consists of 30 items. There were both positive and negative statements. For collecting responses from the sample, a 5 point scale was adopted. The respondents were expected to select one of these for each item. The 5 alternative responses provided included the following categories – Strongly agree, Agree, Undecided, Disagree and Strongly Disagree. The

reliability coefficient of stress tolerance scale is 0.82 and the validity coefficient was estimated as 0.72.

PROCEDURE USED FOR DATA COLLECTION

The samples were the police officers of different police stations in Malappuram district in Kerala. Request letter was given to the main police officers of these police stations for the purpose of approaching other police officers. The researcher approached the police officers, established a rapport, explained the purpose of this study and after that the instructions were given. Confidentiality was also maintained.

ADMINISTRATION OF THE TOOL

The tools used for present study, namely Achievement Motivation Scale and Stress Tolerance Scale were administrated in a uniform manner. The tools were distributed to the subjects individually, with an oral instruction of how to respond to each scale. Instructions for responding to the statements were printed in the tool itself very clearly.

STATISTICAL ANALYSIS

Karl Pearson's correlation was used to find the relationship between achievement motivation and stress tolerance and Independent sample *t*-test was used to find the gender differences.

RESULTS AND DISCUSSION

This chapter deals with the analysis of the data. The Karl Pearson's correlation and Independent sample *t*-test were used to find the result.

First the correlation between the study variables was inspected.

Hypothesis 1: There will be a significant relationship between Achievement Motivation and Stress Tolerance.

Table 1

Shows the Karl Pearson's correlation coefficient between Achievement Motivation and Stress Tolerance

		Stress tolerance
Achievement Motivation		
	Pearson Correlation	0.320
	Significance	0.013
	N	60

From table 1, it is understood that correlation coefficient between Achievement Motivation and Stress Tolerance among police officers was found to be 0.320 (r=0.320) and the level of significance was 0.013 which shows there is a correlation between the two variables studied.

Hence, the hypothesis "there will be a significant relationship between Achievement Motivation and Stress Tolerance" is accepted.

Hypothesis 2: There will be significant difference in Achievement Motivation between males and females.

Table 2

Shows Mean, SD and t value of achievement motivation and stress tolerance in police officers

Variables	Gender	N	Mean	SD	*t* value
Achievement Motivation	Males	30	121.00	4.060	0.896
	Females	30	121.97	4.295	

P>0.05

From table 2, the mean and standard deviation of the male and female are 121, 121.97 and 4.060, 4.295 respectively, and the *t*-value of the test is 0.896, which shows that there is no significant difference between males and females with respect to Achievement Motivation.

Hence, the hypothesis "there will be a significant difference in Achievement Motivation between males and females" is rejected.

Hypothesis 3: There will be a significant difference in Stress Tolerance among males and females.

Table 3

Shows the mean and standard deviation in stress tolerance between males and females

Variables	Gender	N	Mean	SD	*t* value
Stress Tolerance	Males	30	91.90	5.074	1.338
	Females	30	89.83	6.773	

P>0.05

From table 3, the mean and standard deviation of males and females is 91.90, 89.83 and 5.074, 6.773 respectively, and the *t*-value of the test is 1.338, which shows that there is no significant difference between males and females with respect to stress tolerance.

Hence, the hypothesis "there will be significant difference in Stress Tolerance between males and females" is rejected.

CONCLUSION

From the study we can conclude that there is a significant relationship existing between achievement motivation and stress tolerance among police officers, thus the hypothesis is accepted. There is no significant difference in achievement motivation between males and females, thus the hypothesis is rejected. There is no significant relationship in stress tolerance between males and females students, thus the hypothesis is rejected.

LIMITATIONS

The present study was conducted in a very limited geographical area and the sample size is relatively less. Descriptive sampling method was used in this study, which limit the generalizibility.

IMPLICATIONS

Findings of the study necessitate a more inclusive exploration of Achievement Motivation and Stress Tolerance among police officers with increased sample size and in different geographical areas.

REFERENCES

Agarwal, Y. (2015). A study of frustration tolerance in relation to achievement motivation and sports achievement, *International Journal of Applied Research*, Volume 2(6), PP-01-05.

Ali, K. (2015). Psychological stress and its relationship with competitive sport anxiety and its rapport with the achievement motivation among hand ball players. *The Swedish Journal of Scientific Research*, Volume 2(2), PP-9-21.

Artino, A., R., Holmboe, E. & Durning, S., J. (2012).Can achievement emotions be used to better understand motivation, learning and performance in medical education*?.Med Tech.*

Cannon, W. (2008).Retrieved from http://en.wikipedia.org/wiki/Walter_Bradford_Cannon on 21 July, 2008.

Chand, L. (2015). A study of frustration tolerance in relation to achievement motivation and sports achievements, *International Journal of Applied Research*, Volume 1(6), PP-92-94.

Cox, T., & Mackey, C. (1976). A psychological model of occupational stress. A paper presented to the Medical Research Council. *Mental Health in industry, London*: November.

Eccles, J., S., & Harold, R., D. (1991).Gender difference in sport involvement: Applying the Eccles'expectancy-value model. *Journal of Applied Sport Psychology*, Volume 3, PP-7-35.

Eccles, J., S,., & Wigfield, A. (1995). In the mind of the Achiever: The structure of adolescents' academic achievement related-beliefs and self-perceptions. *Personality and Social Psychology Bulletin*, Volume 21,PP-215-225.

Goodman, N. (2013). *How to raise your stress tolerance.* Entrepreneur India.

Heth, J., T., & Somer, E. (2002*).*Characterizing stress tolerance: Controllability awareness and its relationship to perceived stress and reported health. *Personality and Individual Differences*, Volume 33(6), pp 883-895.

Jayaratnam, B., R., & Dileep, N., S. (2013). Field hockey better psychological effect through the motivation and stress. *International Journal of Scientific and Research Publications*, Volume 3(1), pp 1-4.

Locke, E., A., & Latham, G., P. (2002). Building a practically useful theory of goal setting and task motivation: a 35-year odyssey. *Am Psychol.*

Neill,J.(2015).Retrieved from http://en.m.wikiversity.org/wiki/Motivation_and_emotion/Book/2015/Stress_and_achievement_motivation.

Payne, R. (2005). Relaxation Techniques-A Practical Handbook for the Health Care Professionals.(3rd edition). New York: *Churchill Livingstone.*

Reddy, A., K., & Reddy, S., V. (2016). Impact of gender, intelligence and stress on academic achievement of primary school students. *International Journal of Humanities and Social Science Research*, Volume 2(7), pp 01-04.

Roberts, K., E., & Abrahamson, F., E. (2005). Achievement involvement and stress coping in elite wrestling. *Scandinavian Journal of Medicine and Science in Sport*, Volume 12, pp 1-27.

Selye, H. (1974). Stress with distress. Philadelphia: *Job Lippincott Co.*

Selye, H. (2008). Retrieved from http://en.wikipedia.org/wiki/Hans-Selye on 21 July,2008.

Siddiqui, Z., U., Fatima, M., & Khan, H., M. (2013). The impact of social and family role stress on the achievement motivation of Indian teachers. *Geografia Online Malaysia Journal of Society and Space*, Volume 9(2), pp 1-8.

Comparative Study of Socio-Economic Status on Well-Being and Quality of Life among Old Aged Men

Shalu Mishra* and Dr. Seema Rani Sarraf**

ABSTRACT

This study was carried out with the objective of comparing the well-being and quality of life among old aged men regarding high and low socio-economic status. The sample consists of a total number of 30 old aged men of age group 50-70 years from Lucknow, India. The sample was divided into two groups according to their socio-economic status i.e. high and low after the administration of appropriate tool. The tools that were administered are Socio-Economic Status Sale developed by Ashok K. Kalia and Sudhir Sahu, Well-Being Scale developed by Ryff and Quality of Life Scale by B. L. Dubey, Padma Diwedi and S.K. Verma. The results were analyzed using the Student's t-test. It was found that there was a high level of significant difference in well-being and quality of life of low and high socio-economic status.

Keyword: *Socio-Economic Status, Wellbeing, Quality of Life*

Student, National P.G. College, Lucknow, U.P. India, E-mail ID: shalumishra107@gmail.com,
Mob: +91 9454363936
** Assistant Professor, National P.G. College, Lucknow, U.P. India

INTRODUCTION

SOCIOECONOMIC STATUS

Socioeconomic status (SES) is an economic and sociological combined total measure of a person's work experience and of an individual's or family's economic and social position in relation to others, based on income, education, and occupation. When analyzing a family's SES, the household income, earners' education and occupation are examined, as well as combined income, whereas for an individual's SES only their own attributes are assessed. However, SES is more commonly used to depict an economic difference in society as a whole. Socioeconomic status is typically broken into three levels -: high, middle, low. Low income and education have been shown to be strong predictors of a range of physical and mental health problems. There are some factors which used to affect the socio- economic status of an individual:

Income: Income refers to wages, salaries, profits, rent and any flow of earnings received. Income can also come in the form of unemployment or worker's compensation, social security, pensions, interests or dividends, royalties, trusts, alimony, or other governmental, public, or family financial assistance.

Education: Education also plays a role in income. Median earnings increase with each level of education. As conveyed in the chart, the highest degrees, professional and doctoral degrees, make the highest weekly earnings while those without a high school diploma earn less. Higher levels of education are associated with better economic and psychological outcomes

Occupation: Occupational prestige, as one component of SES, encompasses both income and educational attainment. Occupational status reflects the educational attainment required to obtain the job and income levels that vary with different jobs and within ranks of occupations.

Wealth: Wealth, a set of economic reserves or assets, presents a source of security providing a measure of a household's ability to meet emergencies, absorb economic shocks, or provide the means to live comfortably. Wealth reflects intergenerational transitions as well as accumulation of income and savings. Income, age, marital status, family size, religion, occupation, and education are all predictors for wealth attainment.

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. QOL has a wide range of contexts, including the fields of international development, healthcare, politics and employment. It is important not to mix up the concept of QOL with a more recent growing area of health related QOL (HRQOL). An assessment of HRQOL is effectively an evaluation of QOL and its relationship with health. Standard indicators of the quality of life include not only wealth and employment but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging.

According to the World Health Organization (WHO), quality of life is defined as “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.

WELLBEING

Well-being, wellbeing, or wellness is a general term for the condition of an individual or group. A high level of well-being means in some sense the individual or group's condition is positive According to Naci and Ioannidis, Wellness refers to diverse and interconnected dimensions of physical, mental, and social well-being that extend beyond the traditional definition of health. It includes choices and activities aimed at achieving physical vitality, mental alacrity, social satisfaction, a sense of accomplishment, and personal fulfillment.

Carol Ryff: Six-factor Model of Psychological Well-being

Carol Ryff multidimensional model of psychological well-being postulated six factors which are key for well-being: self-acceptance, personal growth, purpose in life, environmental mastery, autonomy and positive relations with others.

METHOD

PURPOSE

The purpose of the present study is to see the effect of socio - economic status on well being and quality of life among old age.

OBJECTIVES

- To compare the well being among old aged people regarding low and high socio-economic status
- To compare the quality of life among old aged people regarding in low and high socio-economic status.

HYPOTHESES

- There will be a significant difference in well being of old aged people regarding low and high socio- economic status
- The quality of life of old aged people regarding in low and high socio-economic status will differ significantly.

SAMPLE

Total number of 30 respondents, only male of age group 50 –70 years was taken from Lucknow city. These respondents were divided into two groups according to their socio-economic status e.g. high and low after the administration of the appropriate tool.

TOOLS

SOCIOECONOMIC STATUS (SES)

The SES scale is developed by Ashok K. Kalia and Sudhir Sahu. Scoring process of the SES is easy, and objective. To get the total SES scores, the researcher is required to count the SES scores of the answer/options mentioned in the square box, which has been ticked by the respondent.

WELL BEING SCALE

This scale is developed by Ryff. This scale is of 42 items version. Scoring ranges from 1to 6 i.e.(strongly disagree or strongly agree) .In this, negative items are (3,5,10,13,14,15.16.17,18,19,23,26,27,30,31,32,34,39,41).If the individual scored 6 in one of these items, the adjusted score is 1,if 5 the adjusted score is 2 and so on. Scoring is done in 6 DIMENSIONS: Autonomy, Environmental Mastery, Personal Growth, Positive Relations, Purpose in Life, Self-Acceptance.

QUALITY OF LIFE SCALE (QLS-R)

QLS-R is developed by B.L. Dubey, Padma Diwedi, S.K. Verma. This scale consists of likert type scoring system containing of five categories of agreement-disagreement. The scoring weights for each items range from one to five (strongly agree to strongly disagree). The total scores ranges from 24 to 120. Items two and five are scored in reverse direction.

ADMINISTRATION

After deciding the tool to be used for the data collection, the next step that followed was the distribution of the questionnaires to the members of the sample with an aim to have as many completed questionnaires as returned as possible. The method of data collection chosen for the present study was to distribute the questionnaires personally to the members of the sample

RESULTS

Table 1

Showing the raw score and significant difference of Well-being among High and Low Socioeconomic Status (SES) using t-test

SAMPLE	RAW SCORE	MEAN	OBTAINED t SCORE	df	TABLE VALUE	
HIGH SES	2763	184.2			0.01	0.05
LOW SES	1776	118.4	7.46	28	2.76	2.05

Inference- The table shows 7.46 obtained value of t and the table value of t is 2.05 at 0.05 level and 2.76 at 0.01 levels. Hence significant difference is found.

Table 2

Showing the raw score and significant difference in Quality of life among High and Low Socioeconomic Status (SES) using t-test

SAMPLE	RAW SCORE	MEAN	OBTAINED t SCORE	df	TABLE VALUE	
HIGH SES	1222	81.46			0.01	O.O5
LOW SES	952	63.4	4.56	28	2.76	2.05

Inference- The table shows 4.56 obtained value of t and the table value of t is 2.05 at 0.05 level and 2.76 at 0.01 levels. Hence significant difference is found.

INTERPRETATION AND DISCUSSION

The purpose of the study was to see the effect of socioeconomic status (SES) on well-being and quality of life. The sample selected for this study was 30 old aged men, out of which 15 old aged men were from low socioeconomic status and rest 15 were from high socioeconomic status. The research question of this study was to find if there is any significant difference in well-being and quality of life among high and low socioeconomic status old aged people. t- Test was administered among two groups of old aged men. In well-being obtained value of t was 7.46 whereas the table value of t at 0.01 levels and 0.05 levels of significance was 2.76 and 2.05 respectively. So the obtained value was more then the table value. Hence the hypotheses that "There will be a significant difference in well being of old

aged people regarding low and high socio- economic status" were accepted. So the study showed that there is significance among the low and high socioeconomic status in well-being. The second objective of this study was "to compare the quality of life among old aged people regarding in low and high socio-economic status". t -Test was administered among the two groups of old aged men. In quality of life they obtained value of t was 4.56 whereas the table value of t at 0.01 levels and 0.05 levels of significance was 2.76 and 2.05 respectively. So the obtained value was more than the table value. Hence the hypotheses that "the quality of life of old aged people regarding in low and high socio-economic status will differ significantly" was accepted. So this study shows quality of life differ among low and high socioeconomic status old aged men. The result shows well-being and quality of life differs among low and high socioeconomic status (SES).

MAJOR FINDINGS

- There is significance difference in well-being and quality of life among low and high socioeconomic (SES) status old aged men.
- The mean score in well-being among low and high socioeconomic status was (184.2 and 118.4).This shows well-being is more in high socioeconomic status(SES) as compared to low socioeconomic status(SES). This is because of socioeconomic status (SES) effect.
- The mean score in quality of life among low and high socioeconomic status is (81.46 and 63.4). This shows quality is life is adequate in high socioeconomic status (SES) as compared to low socioeconomic status (SES).

CONCLUSIONS

- The result of the study shows there is a significant difference in the well-being and quality of life among low and high socioeconomic status (SES) old aged men. In the well-being and quality of life the mean of high socioeconomic status people is more than the low socioeconomic status people. So, it can be concluded that well-being and quality of is adequate in high socioeconomic status (SES) old aged people.
- The result of the study shows socioeconomic status has an impact on well-being and quality of life.

REFRENCES

Barcaccia, Barbara, (2013). Quality of Life: Everyone Wants it. But what is it?

Gustav, Cassel, (1931 / 1932). The Theory of Social Economy.

Kahneman, D., & Deaton, A. (2010). "High income improves evaluation of life but not emotional well-being"

Max Weber, (1922).Economy and Society.

Ryff, C., D., & Keyes, C., M. (1995). The structure of psychological well-being revisited. Journal of Personality and Social Psychology, 69(4), 719-727

Ryff & Keyes (1995). The Ryff scales of Psychological well-being

Dissociative Fugue - The changing definition

Vartika Varyani* and Dr. Arunima Upadhyay**

ABSTRACT

Dissociative fugue is one of the most dramatic disorders in clinical psychology; here the individual runs away from home and lives a totally new life with new identity without any recollection of his previous life. Among all the subtypes of dissociation disorders, dissociative fugue is one which is often under diagnosed which might be because of its close relation of symptom-logy to dissociative amnesia. We only have handful of case studies to bank upon as its prevalence rate according to DSM IV TR is 0.2%, therefore people have less knowledge about this disorder. The aim of this paper is to focus on explore dissociative fugue disorder and understands it with reference to its aetiology. Researcher has been very intrigued by Dissociative fugue disorder. The rationale of formulating this paper is to explore the knowledge available for dissociative disorders and provide a deep understanding about the same. This paper is an attempt to discuss previous researches and combine all the relevant information regarding dissociative fugue.

Keywords: *Dissociative disorders, Dissociative fugue*

* Student of M.Sc Psychological Counselling, Indian Institute of Psychology and Research, IIPR, Bangalore, E-mail ID: vartikavaryani@gmail.com, Mob: +91 8968469488
**Assistant Professor & Coordinator Examinations, Indian Institute of Psychology & Research, IIPR, Bangalore

INTRODUCTION

Dissociation is defined as an unconscious defence mechanism involving segregation of any group of mental or behavioural processes from the rest of the person's psychic entity. Dissociative disorder has a long history; it dates back to Palaeolithic cave paintings in the images of shamans. Earlier it was expressed as possession of demons. Around 1800 it was considered the case of multiplicity.

As the shift of interest in this area changed from religious to more scientific medical realm in 18th century; researchers started focusing more on this area of "dissociation. In the 19th century, the diagnosis was primarily dual, double or duplex consciousness. Benjamin Rush (1811) defined it as "Disconnect between two hemispheres of the brain". Rush, considered as the father of American psychiatry, gave the cerebral hemisphere disconnections as the functional reflection of dual personality.

The term dissociation was first coined by the French Psychiatrist Pierre Janet; who was influenced by the earlier conceptualization of hysterical seizures by Moreau de Tours (North, 2015; Bowman, 2006). Janet used his work with patients of hysteria to formulate and develop his own theory. (North, 2015; Bowman, 2006). Janet (regarded as the founder of modern approaches to dissociative disorders) considered dissociation to represent abnormal splitting of mental processes resulting in compartmentalization of the personality into segments inaccessible to one another (North, 2015; Paris, 2012; Decker, 1986; North, Ryall & Wetzel, 1993; Janet, 1907). Janet proposed a model called "stress-diathesis-model" which focused on environmental and biological factors of an individual that influence the onset of the disorder. (North, 2015; North, Ryall & Wetzel, 1993).

The work of Charcot greatly influenced Sigmund Freud; he worked under Charcot and was fascinated by the hysterical phenomenon which was majorly observed when the patient is under hypnosis. The classic case of Anna O., who was treated for a hysterical condition by Freud's Austrian colleague Josef Breuer (Breuer, 1891) exhibited dual personalities and episodes of amnesia, paralysis, aphonia, deafness, diplopia, visual hallucinations of snakes, memory disturbances, and loss of ability to speak her native language.

Freud also came up with the concept of unconscious and believed that unconscious is the reservoir of all the sexual conflicts of the individual. Freud (1900, 1905) developed a topographical model of the mind, whereby he described the features of the mind's structure and function. Freud used the analogy of an iceberg to describe the three levels of the mind. the unconscious mind comprises mental processes that are inaccessible to consciousness but that influence judgements, feelings, or behaviour (Wilson, 2002). According to Freud (1915), the unconscious mind is the primary source of human behaviour. Like an iceberg, the most important part of the mind is the part you cannot see. Our feelings, motives and decisions are actually powerfully influenced by our past experiences, and stored in the unconscious.

He then divided personality into id, ego and superego where id works on pleasure principle, ego is in relation to reality and superego dominates other through the morals and values of an individual. Any conflict among these three lead to what Freud termed as intra-psychic conflict which is source of all anxiety faced by the individual. Freud then assumed that people uses certain defence mechanisms to overcome such anxieties. These defence

mechanisms majorly work on the principle of shifting the anxiety-provoking material into unconscious mind. Excess usage of such defence mechanisms lead to mental health problems.

Historical perspective

Dissociative phenomena have been a recognized part of human history for a very long time. Written records from ancient Egypt described cases of spirit possession, which in retrospect have been interpreted as dissociative phenomena (North, 2015; Coons, 1984). Evidence of dissociation was also recorded in Christian scripture. Biblical passages in Mark 5:1–20 describe a man possessed with unclean spirits who lived in a cemetery, injured himself with stones, and broke all chains used to restrain him. When Jesus asked his name, the man said, "My name is Legion, for we are many." Jesus transferred the unclean spirits into a herd of swine that ran off a cliff and drowned in the sea. This story has been interpreted as representing a case of dissociative identity disorder, successfully cured with exorcism (North, 2015; Miller, 1989).

Through the end of the eighteenth century, spirit possession remained a dominant explanation for experiences of altered states of identity, and cases emerged in which the person's self had been taken over or "possessed" by demons or evil spirits. Accounts of spirit possession in this period included descriptions of dramatic hysterical and hypochondriacal presentations and convulsive fits (North, 2015; Abse, 1987). The practice of exorcism of demons and evil spirits came to dominate as the preferred treatment for such problems around this time. Consistent with these trends, occult fads such as table-tipping, spirit-rapping, divining, spirit séances, and use of Ouiji boards to communicate with the dead began in the United States in the nineteenth century and increased in popularity that spread to other parts of the world.

Approaches to treatment of altered states of experience of self began to evolve as physicians came to consider these cases to be medically rather than spiritually based (Ellenberge, 1970) Paracelsus advanced an elaborate theory of magnetism in the human body and its role in medical illness (Binet, 1891). About a century after Paracelsus, Franz Anton Mesmer incorporated this theory into a new approach to treat medical disease, based on the notion that tidal influences of the planets exert a universal magnetic force on humans, which he called "animal magnetism." His patients were predominantly women, many of whom presented with prominent hysterical features. Mesmer's magnetism treatment was applied with a magnet (which he realized was not the therapeutic element) in conjunction with other therapeutic techniques including mental imaging, hand gesturing, and touch methods. His methods induced states of anaesthesia, paralysis, and hysterical convulsions in his patients. Mesmer was apparently quite a showman in demonstrations of these dramatic states and their cures in his patients. His critics were convinced that influences of suggestion and social contagion played a central role in the emergence of the hysterical presentations that emerged, and many considered him a charlatan (Binet, 1891).

Mesmer's practice of magnetism, later termed mesmerism, eventually evolved into the modern practice of hypnosis (Veith, 1965). Hypnotism, like magnetism and mesmerism, was also extensively applied in treating hysterical syndromes. The use of these methods was sometimes observed to result in the emergence of separate personalities within individuals (Abse, 1982). Fascination with magnetism is thought to have further contributed to the growing popularity of occult practices and charlatanism in the nineteenth century.

Clinicians treating battlefield casualties in World Wars I and 11 readily noted dissociative symptoms, such as amnesia, fugue, automatisms, and somatoform symptoms, in

traumatized soldiers as part of traumatic war neurosis, as it came to be known in World War 11. The extent of amnesia described in psychiatric battlefield casualties in World War 11 ranged from relatively brief periods of time to complete amnesia for life history (generalized amnesia), as well as fugue episodes. (Leowenstein, June 2013)

Treatment of these World War I1 amnesia cases included hypnosis, narcosynthesis with sodium amobarbital (Amytal), or individual and group psychotherapy, or a combination of these. Attempts were made to treat these soldiers on the front lines and to return them rapidly to combat. Detailed case descriptions of dissociative amnesia and fugue can be found in clinical studies from that time. Soldiers from the Korean conflict also were noted to have amnesia as part of the posttraumatic syndromes related to combat experiences and were treated with similar modalities. (Leowenstein, June 2013)

The observations of these military psychiatrists were mostly lost until the resurgence of interest in trauma and dissociation in the 1970s and 1980s. Authorities cite several social and cultural factors leading to this revival. These include the return of the Vietnam veterans and the systematic academic study of their psychiatric problems; the recognition of the prevalence of childhood physical and sexual abuse with its associated mandated reporting; development of clinical attention to, mandated reporting of, and research on child abuse and family violence; the rise of feminism with its critique of psychological theories that ascribed sexual abuse reports to fantasy; increased academic rigor in theories about hypnosis, such as Earnest Hilgard's neodissociafion theory, and greater acceptance of academic hypnosis research; popular interest in multiple personality owing to works, such as Sybil; and the DSM-111, with its promulgation of diagnostic criteria for the dissociative disorders and PTSD. (Leowenstein, June 2013)

Development of Diagnostic Manual

The first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) of the American Psychiatric Association (American Psychiatric Association, 1952) listed "dissociative reaction" together with "conversion reaction" in a section for "psychoneurotic disorders" that also included anxiety (e.g., "anxiety hysteria") and depressive "reactions." The text noted that dissociative reaction was formerly classified as a type of conversion hysteria. The second edition of the manual (*DSM-II*) (American Psychiatric Association, 1968) listed dissociation and conversion as two different types of "hysterical neurosis" within a section entitled "Neuroses" that also included a separate diagnosis of "depersonalization neurosis (depersonalization syndrome)" as well as a diagnosis of "hypochondriacal neurosis" (American Psychiatric Association, 1968). The manual endorsed a position that the "distinction between conversion and dissociative reactions should be preserved".

DSM-III separated dissociative from somatoform disorders and grouped conversion with the somatoform disorders. The dissociative disorders section was placed immediately after the somatoform disorders section to reflect the recognition of a conceptual proximity of these two groups of syndromes. The opening statement of the *DSM-III* dissociative disorders section stated that the essential feature of dissociative disorders involved "alteration in the normally integrative functions of consciousness, identity, or motor behaviour" (North, 2015; American Psychiatric Association, 1980). The *DSM-III* dissociative disorders included psychogenic amnesia, psychogenic fugue, multiple personality, depersonalization disorder, and atypical dissociative disorder. The text explained that placement of depersonalization disorder in this section was controversial because depersonalization disorder, unlike all the other disorders in this section, did not involve memory disturbance.

Model of dissociative disorders

Freud believed that many basic human wishes were in direct conflict with either reality or the superego and that the result of this conflict was painful anxiety. To protect the mind against anxiety, the go repressed the wish and mounted defences against it. The dissociative disorders according to this perspective are nothing but simple extreme and maladaptive defences. In fugue, person acts out the repressed wishes directly or symbolically-goes off and have adventures and create another self for protecting the mind against the anxieties of earlier self.

Psychodynamic therapy is most common treatment for the dissociative disorder. When trauma is involved, or thought to be involved, the treatment generally proceeds in three stages. Stage 1 involves setting the patient down, establishing an atmosphere of trust and helping the patient to gain some mastery over the symptoms. Then, in Stage 2, the traumatic memory is recovered and grieved over. Stage 3 is devoted to the reintegration of the traumatic memory so that the patient no longer has to use dissociation to wall it off. (Alloy, Riskind, & Manos, 2006)

Developmental model of dissociation is based on clinical observations and research findings concerning the role of childhood emotional neglect in the development and maintenance of dissociative symptoms. Studies have supported the view that childhood experiences of emotional neglect may foster difficulties mentalizing as well as problems with affect regulation, with these two factors interacting to generate excessively activated dissociative processes. This may suggest that individuals who were exposed to emotional neglect during their childhood and who currently suffer from dissociative symptoms may

greatly benefit from clinical interventions aimed to foster mentalized affectivity. (Schimmenti, 2017)

Medical model suggests that areas of brain associated with memory and perception gets affected in an individual suffering from dissociative disorders. Several neuro-imaging studies have related their findings to higher scores on psychometric scales like the dissociative experiences scale (DES), measuring trait dissociation with the subscales depersonalization/de-realization, amnesia, and absorption, or the dissociation stress scale (DSS), a measure of state dissociation, including items on psychological and somatic dissociation and one item on aversive inner tension. (Krause-Utz, Frost, Winter, & Elzinga, 2017)

Memory and intellectual deficits

It is reported that in patients of dissociative fugue, semantic knowledge of the individual is intact. The primary deficit that these individual exhibit is their compromised episodic or autobiographical memory. However, several cases have suggested that implicit memory is generally intact. Some of the memory deficits in the case of dissociative amnesia and fugue have been compared to related deficits in explicit perceptions that occur in conversion disorders. (Butcher, Mineka, & Hooley, 2014)

This theory has on its side the observation that the dissociative disorders do appear to operate in such a way as to grant wishes that the person could not otherwise satisfy. (Alloy, Riskind, & Manos, 2006)

According to The American Psychiatric Publishing Textbook of Psychiatry , Sixth Edition:“The dissociative disorders involve a disturbance in the integrated organization of

consciousness, memory, identity, emotion, perception, body representation, motor control, and behaviour. “

Nosology

There are different types of dissociative disorders: dissociative identity disorder, dissociative amnesia and dissociative fugue. Dissociative fugue is a psychiatric disorder characterized by amnesia coupled with sudden unexpected travel away from the individual’s usual surroundings and denial of all memory of his or her whereabouts during the period of wandering. Dissociative fugue is a rare disorder that is infrequently reported. (Igwe, 2013).

Dissociative fugue (Fugue- means flight) is also seen as a defence by actual flight (running away from his home surrounding). This is often accompanied by confusion about personal identity or even assumption of a new identity. During the fugue, such individuals are unaware of memory loss for prior stages of life, but their memory for what happens during the fugue state itself is intact. (Khilstorm, 2005; Khilston &Schacter, 2000). The behaviour during the fugue state often reflects a rather different lifestyle from the previous one. Days, weeks, or sometimes even years later, such people may suddenly emerge from the fugue state and find themselves living a new life, with no idea how they got here. (Carson, Butcher, & Hooley, 2007).

Dissociative fugue is further classified as: (1) localized amnesia; where the person can’t remember specific event, or time or period and the forgotten period is usually associated with a traumatic episode; (2) selective amnesia; where the person only forget some or part of the event and; (3) generalized amnesia; where person forgets who they are and where they have come from, here the memory is fully dysfunctional.

Dissociation and trauma

The long-term deleterious impact of natural and human made disasters on the psychological and physical well-being of persons has long been recognized. In a comprehensive review of the literature, McCann, Sakheim, and Abrahamson (1988) found that the following short- or long-term psychological squeal to victimization had been supported by the extant literature: (a) emotional reactions (fear, anxiety and intrusive phenomena, depression, self-esteem disturbances, anger, guilt, and shame); (b) cognitive disturbances, including dissociative processes; (c) biological reactions including hyper-arousal and somatic disturbances; (d) behavioural changes (aggressive or suicidal behaviour, substance abuse, impaired social functioning, and related personality disorders); (e) interpersonal problems in the areas of sexuality, relationships, and re-victimization, including the victim becoming a victimizer.

It is noteworthy that in this review less information about cognitive and dissociative reactions than about any of the other areas was available, despite the central role of such reactions in response to, for instance, incest (e.g., Gelinas, 1983) and other forms of trauma. Although retrospective in nature and relying mostly oneself reports, the literature on early sexual or physical abuse suggests a reliable connection between abuse and dissociative phenomenology. Such a relation has been proposed for multiple personality disorder but is also supported by other evidence. Herman, Perry, and van der Kolk's (1989) study of the history of traumatic events among borderline patients found a high prevalence of reported trauma and, of particular importance to this article, that dissociative symptoms were more strongly predicted by early trauma than by the borderline diagnosis per se.

In a related study by Ogata et al. (1990) with adults diagnosed as having borderline personality disorder, derealisation was the best statistical predictor of a history of sexual abuse and, in addition to promiscuity, unstable one-to-one relationships, chronic dysphoria, and depersonalization, was found to significantly differentiate those patients who had reported childhood sexual abuse from those who had not. Lastly, Chu and Dill (1990) in their study with 98 female psychiatric patients found that scores on the Dissociative Experiences Scale were significantly higher among patients that reported early physical or sexual abuse by family members.

In a study by Coons, Bowman, and Fellow (1989) on the prevalence of adult and childhood trauma in various clinical populations, 100% of patients with atypical dissociative disorder and 82% of those diagnosed with psychogenic amnesia reported sexual, physical, or verbal abuse or neglect during childhood, and about half of them had also experienced adult trauma. With regard to the association between psychogenic amnesia and early abuse, Briere and Conte (1989) reported that 59.6% of their sample of 468 patients with a reported history of childhood sexual abuse had not been able to remember the abuse at some point in their lives. Hence, although reports of childhood sexual or physical abuse are important factors in a number of adult psychiatric disorders (Bryer, Nelson, Miller, & Krol, 1987), there is growing evidence that dissociative symptomatology is a distinctive and frequent outcome of reported early abuse, especially chronic abuse (cf. Terr, 1991).

Epidemiology

A prevalence rate of 0.2% for dissociative fugue has been reported in the general population. The prevalence may increase during times of extremely stressful events such as

wartime or natural disaster. (Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition Text Revision, 2000)-

The disorder is thought to be more common during natural disasters, wartime or times of major social dislocation and violence, although no systematic data exist on this point. No adequate data exist to demonstrate a gender bias to this disorder; however most cases describe men, primarily in the military. Dissociative fugue is usually described in adults. (Sadock, Ruiz, & Sadock, 2014)

Diagnosis

According to *DSM IV TR*, dissociative fugue is:

- a sudden, unexpected travel away from home or one's customary place of daily activities, with inability to recall some or all of one's past (CRITERION A).
- This is accompanied by confusion about personal identity or even the assumption of new identity (CRITERION B).
- The disturbance does not occur exclusively during the course of Dissociative identity disorder and is not due to direct physiological effects of a substance or a general medical condition (CRITERION C).
- The symptoms must cause clinically significant distress or impairment in social, occupational or other important areas of functioning (CRITERION D) (Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition Text Revision, 2000)
- In *DSM V*, the criteria for dissociative fugue disorder have been emerged with criteria of dissociative amnesia. Code (F44.1) Dissociative amnesia with dissociative fugue: Apparently purposeful travel or bewildered wandering that is associated with amnesia for identity or for other important autobiographical information.

According to *ICD 10:*

Code F44.1

- Dissociative fugue has all the features of dissociative amnesia, plus purposeful travel beyond the usual everyday range. Although there is amnesia for the period of the fugue, the patient's behaviour during this time may appear completely normal to independent observers.

Excludes postictal fugue in epilepsy

A differential diagnosis is made for Malingered Fugue States- it may occur in individuals who are attempting to flee a situation involving legal, financial or personal difficulties, as well as soldiers who are attempting to avoid combat or unpleasant military duties. Malingering of dissociative symptoms can be maintained even during hypnotic or barbiturate-facilitated interviews. In the forensic context, the examiner should always give careful consideration to the diagnosis of malingering when fugue is claimed. (Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition Text Revision, 2000)

REVIEW OF LITERATURE

In a study, Allen, Console, & Lewis (1999) propose that clinicians endeavour to differentiate between reversible and irreversible memory failures in patients with dissociative symptoms who report "memory gaps" and "lost time," The classic dissociative disorders, such as dissociative amnesia and dissociative identity disorder, entail reversible memory failures associated with encoding experience in altered states. The authors propose another realm of memory failures associated with severe dissociative detachment that may preclude

the level of encoding of ongoing experience needed to support durable autobiographical memories. They describe how dissociative detachment may be intertwined with neurobiological factors that impair memory, and they spell out the significance of distinguishing reversible and irreversible memory impairment for diagnosis, patient education, psychotherapy, and research.

In a study, Coons (1999) reviewed pertinent literature, and discussed five cases of dissociative fugue. These cases were systematically studied with a comprehensive history, mental status examination, physical and neurological evaluation, review of previous medical and psychiatric records, and psychological testing including MMPI, WAIS–R, electroencephalogram, and Dissociative Experiences Scale. An unexpected finding was that, in some cases, associated criminal activity may allow the person with dissociative fugue to continue to function in spite of their loss of memory and original identity.

Futuristic approach-

In a study, Holmesa, et al., 2005 aimed to clarify the use of the term dissociation in theory, research and clinical practice. Psychiatric definitions of dissociation were contrasted with recent conceptualizations that converged on a dichotomy between two qualitatively different phenomena: detachment and compartmentalization. They reviewed some evidence for this distinction within the domains of phenomenology, factor analysis of self-report scales and experimental research. They concluded with recommendations for future research and clinical practice, proposing that using this dichotomy can lead to clearer case formulation and an improved choice of treatment strategy.

In a study, Hennig-Fast, et al. (2008) reported a study based upon the case of the patient NN who suffered from a complete loss of autobiographical memory and awareness of

identity subsequent to a dissociative fugue. Neuropsychological, behavioural, and functional neuron-imaging tests converged on the conclusion that NN suffered from a selective retrograde amnesia following an episode of dissociative fugue, during which he had lost explicit knowledge and vivid memory of his personal past. NN's loss of self-related memories was mirrored in neurobiological changes after the fugue whereas his semantic memory remained intact. Although NN still claimed to suffer from a stable loss of autobiographical, self-relevant memories 1 year after the fugue state, a proportionate improvement in underlying fronto-temporal neuronal networks was evident at this point in time. In spite of this improvement in neuronal activation, his anterograde visual memory had been decreased. It is posited that our data provide evidence for the important role of visual processing in autobiographical memory as well as for the efficiency of protective control mechanisms that constitute functional retrograde amnesia.

In a study, Chaturvedi, Desai, & Shaligram (2009) examined patterns of dissociative disorders among subjects attending psychiatric services over a period of 10 years. A total of 893 patients had been diagnosed with dissociative disorder over the past decade: 591 (66%) were outpatients and 302 (34%) were inpatients. The proportion of patients diagnosed with dissociative disorders ranged between 1.5 and 15.0 per 1,000 for outpatients and between 1.5 and 11.6 per 1,000 for inpatients. The majority of patients were diagnosed with dissociative motor disorder (43.3% outpatients, 37.7% inpatients), followed by dissociative convulsions (23% outpatients, 27.8% inpatients). Female preponderance was seen across all sub-types of dissociative disorder except dissociative fugue. They concluded that dissociative disorders are still commonly diagnosed in both inpatient and outpatient settings. Dissociative motor disorders and dissociative convulsions are the most common disorders. Unlike in the West,

dissociative identity disorders were rarely diagnosed; instead, possession states were commonly seen in the Indian population, indicating cross-cultural disparity.

In a study, Lynn, Lilienfeld, Merckelbach, Giesbrecht, & Kloet (2012) draw on the research from multiple laboratories; and challenged the prevailing posttraumatic model of dissociation and dissociative disorders. Proponents of the old model hold that dissociation and dissociative disorders are associated with (a) intense objective stressors (e.g., childhood trauma), (b) serious cognitive deficits that impede processing of emotionally laden information, and (c) an avoidant information-processing style characterized by a tendency to forget painful memories. They reviewed the findings that contradict these widely accepted assumptions and argue that a sociocognitive model better accounts for the extant data. They further proposed a perspective on dissociation based on a recently established link between a labile sleep–wake cycle and memory errors, cognitive failures, problems in attention control, and difficulties in distinguishing fantasy from reality. They concluded that this perspective may help to reconcile the posttraumatic and socio-cognitive models of dissociation and dissociative disorders.

In a study, Mueller-Pfeiffer, et al. (2012)assessed Outpatients and day care patients (N=160) of several psychiatric units in Switzerland were with the Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV Axis I Disorders, Structured Clinical Interview for DSM-IV Dissociative Disorders, Global Assessment of Functioning Scale, and World Health Organization Disability Assessment Schedule-II. The association between subjects with a dissociative disorder (N=30) and functional impairment after accounting for non-dissociative axis I disorders was evaluated by linear regression models. They found a proportion of 18.8% dissociative disorders

(dissociative amnesia=0%, dissociative fugue=0.6%, depersonalization disorder=4.4%, dissociative identity disorder=7.5%, dissociative disorder-not-otherwise specified=6.3%) across treatment settings. Adjusted for other axis I disorders, subjects with a co morbid dissociative identity disorder or dissociative disorder-not-otherwise-specified had a median global assessment of functioning score that was 0.86 and 0.88 times, respectively, the score of subjects without a co morbid dissociative disorder. These findings support the hypothesis that complex dissociative disorders, i.e., dissociative identity disorder and dissociative disorder-not-otherwise-specified, contribute to functional impairment above and beyond the impact of co-existing non-dissociative axis I disorders, and that they qualify as"serious mental illness".

Individuals who experience dissociative fugue state usually get better on their own and remember what they have forgotten. The episodes are so clearly related to current life stress that prevention of future episodes usually involves therapeutic resolution of the distressing situations and increasing the strength of personal coping mechanisms. When necessary, therapy focuses on recalling what happened during fugue state, often with the help of family or friends who know what happened, so patients can confront the information and integrate it into their conscious experience. For more difficult cases, hypnosis or the use of benzodiazepines (mild tranquilizers) have been used with suggestion from the therapist that it is OK to recall the events (Maldonado et al, 1998) (Burlow & Durand, 2007)

DISCUSSION

Dissociative fugue has always been the rare disorder, but the rarity of this disorder doesn't lower the importance of it. It is one of the most dramatic disorder ever seen- a

personal suddenly leaving his own area and moving to a different area with a new identity and new personality.

The description in one or more cognitive processes such as memory, identity, perception, consciousness or motor behaviours can be sudden or gradual. The trauma associated with it could be transient or chronic. The plethora of symptoms increases the complexities in terms of stipulated diagnosis. The overlapping of recurrent blackouts, fugues, fluctuations in habit, skills and possessions makes the clinical judgement towards the unwarranted diagnosis.

Prognosis of dissociative fugue is considerably better as it is relatively brief. An eclectic approach of psychodynamic and pharmacological helps the patient to recover yet refractory dissociative symptoms can persists in some rare cases. The modern understanding provides no significant data to differentiate dissociative fugue from identity disorder.

Expertise on behalf of clinician is required to formulate a treatment procedure initiating clinical stabilization, safety and a therapeutic alliance using supportive and educative interventions. The extremities and bizarre symptoms expressed by clients in the disorder requires a very clear cut therapeutic goal, neither suppression of a new identity nor fascinated explanation of all its attributes should be given undue diligence. A balanced and therapeutic outcome to attain fusion of identities and integration of memories of the experiences should precipitate.

A clinician's role goes beyond the realm of clinics. It becomes sagacious for the clinician to try to balance patients'/ clients' real responsibility and condescending psychopathology issue. A balance of real responsibility for misconduct should also be accepted by all. Since the impact touches all domains of client's life an interdisciplinary

support is required with psychosocial stressors, combat financial and; marital and legal issues.

CONCLUSION

The disorder thus becomes not only just sudden travel from one's hometown but also the uncontrollable and unexplained anxiety that the individual face in that period. Dissociative fugue, in this term means that though individual is somewhere aware that he/she isn't in the right place; and also feels incomplete in that new environment; they are unable to do anything about it which therefore in the end leads to anxiety.

The research on Dissociative fugue disorder is still at its conception and would require more researchers to take up this topic to build a vast resource of knowledge. The future of clinical Psychology and mental disorders rely on generating knowledge resources of lesser known disorders. Dissociative fugue being a rare mental disorder in which an individual loses his/her episodic memory is often in a confused state for the individual and its family. Therefore, it becomes further important to handle this disorder more consciously. The future researches can focus more on the different aspects of the disorder and causes/ triggers of the fugue state.

REFERENCES

Alloy, L. B., Riskind, J. H., & Manos, J. M. (2006). Abnormal Psychology. Tata McGraw Hill.

Allen, J. G., Console, D. A., & Lewis, L. (1999). Dissociative Detachment and Memory Impairment:Reversible Amnesia or Encoding Failure? . *Comprehensive Psychiatry*

Abse, D., W. (1987). Hysteria and Related Mental Disorders: An Approach to Psychological Medicine. 2nd ed. *Wright; Bristol, England,* UK.

Abse, D., W. (1982). *Multiple personality*. In: Roy A., editor. *Hysteria. Wiley*; New York, NY, USA: pp. 165–184.

American Psychiatric Association (1980). Diagnostic and Statistical Manual of Mental Disorders. 3rd ed. *American Psychiatric Association*; Washington, DC, USA.

American Psychiatric Association (1968). Diagnostic and Statistical Manual of Mental Disorders. 2nd ed. *American Psychiatric Association*; Washington, D.C., USA.

American Psychiatric Association (1952). Diagnostic and Statistical Manual: Mental Disorders. 1st ed. *American Psychiatric Association; Washington,* DC, USA.

Butcher, Mineka, & Hooley. (2014). *Abnormal Psychology*. Fifteen edition. United states: Pearson eductaion.

Bhadu, A., Mehta, P., Patel, K., Shah, C., & Amin, N. (2013). Dissociative fugue - a rare case. surendranagr: *Indian Journal of Basic and Applied Medical Research.*

Burlow, D. H., & Durand, V. M. (2007). *Abnormal Psychology*: An Integrated Approach. Thomsan Learning.

Bowman E.S. (2006). *Why conversion seizures should be classified as a dissociative disorder*, Psychiatr. Clin. North Am. 2006;29:185–211. doi: 10.1016/j.psc.2005.10.003.

Bernstein, E., M, & Putnam, F., W. (1986). *Development, reliability, and validity of a dissociation scale. J Nerv Ment Dis*. 174(12):727–35. doi: 10.1097/00005053-198612000-00004.

Binet A., & Fere C. (1981). *Animal Magnetism*. Kegan Paul, Trench, Trübner & Company; London, UK.

Breuer, J., Fraulein, Anna, O. (1891). In: Breuer J., Freud S., editors. *Studies on Hysteria. Basic Books*; New York, NY, USA,pp. 21–47.

Chaturvedi, S. K., Desai, G., & Shaligram, D. (2009). Dissociative Disorders in a Psychiatric Institute in India - A Selected Review and Patterns Over a Decade,*International journal of social psychiatry*.

Carson, R., C., Butcher, J., N., & Hooley, S., M. (2007). *Abnormal Psychology*, Thirteenth edition. South Asia: Pearson Education, Inc.

Coons, P., M. (1984). The differential diagnosis of multiple personality: A comprehensive review. Psychiat. Clin. N. Am, 7:51–67.

Chodoff, P. (1974). The diagnosis of hysteria: An overview. Am. J. Psychiatry, 131:1073-1078.

Decker, H., S., The lure of nonmaterialism in materialist Europe: Investigations of dissociative phenomena, 1880–1915. In: Quen J.M., editor. Split Minds/Split Brains: *Historical and Current Perspectives*. New York University Press; New York, NY, USA: 1986. pp. 31–62.

Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition Text Revision. (2000). washington: *American Psychiatrc Association*.

Ellenberger, H., F. (1970). *The Discovery of the Unconscious.* Basic Books; New York, NY, USA: 1970.

Ford, C., V. (1985). Folks D.G. Conversion disorders: An overview, *Psychosomatics,* 26:371–373. doi: 10.1016/S0033-3182(85)72845-9

Freud, S. (1915). *The unconscious*. SE, 14: 159-204

Gordon, E., Kraiuhin, C., Kelly, P., & Meares, R. (1984). The development of hysteria as a psychiatric concept, Compr. Psychiatry, 25:532–537. doi: 10.1016/0010-440X(84)90053-1.

Hales, R. E., Yudofsky, S. C., & Roberts., L. W. (n.d.). psychiatric online. Retrieved nov 9, 2017, from psychiatric online: http://psychiatryonline.org/doi/10.1176/appi.books.9781585625031.rh15

Holmesa, E., A., Brown, R., J., Mansell, W., Fearon, R. P., Hunter, E. C., Frasquilho, F., et al. (2005). Are there two qualitatively distinct forms of dissociation? *A review and some clinical implications*. Clinical Psychology Review, 1-23.

Igwe, M., N. (2013, may 31). jmedical casereports biomedcentral. Retrieved november 9, 2017, from jmedical casereports biomedcentral: https://jmedicalcasereports.biomedcentral.com/articles/10.1186/1752-1947-7-143/

Janet, P. (1907). The Major Symptoms of Hysteria: 15 Lectures Given in the Medical School of Harvard University. Macmillan; New York, NY, USA.

K.Michelson, L., & J.Ray, W. (1996). Handbook of Dissociation. Springer.

King, James, & Bible, Mark, (2015). The Official King James Bible online, authorized version, 15. Available online: http://www.kingjamesbibleonline.org/Mark-5-1_5-20/

Lynn, S. J., Lilienfeld, S. O., Merckelbach, H., Giesbrecht, T., & Kloet, D. v. (2012). Dissociation and Dissociative Disorders : Challenging Conventional Wisdom. *Current Directions in Psychological Science.*

Mueller-Pfeiffer, C., Rufibach, K., Perron, N., Wyss, D., Kuenzler, C., Prezewowsky, C., et al. (2012). Global functioning and disability in dissociative disorders. Psychiatry Research.

Miller, S., D. (1989). Optical differences in cases of multiple personality disorder. J. Nerv. Ment. Dis. 1989;177:480–486. doi: 10.1097/00005053-198908000-00005.

North, C., S., Ryall, J., M., Ricci, D., A., & Wetzel, R., D. (1993). Multiple Personalities, Multiple Disorders: Psychiatric Classification and Media Influence. Oxford; New York, NY, USA.

Paris J. (2012). The rise and fall of dissociative identity disorder. J. Nerv. Ment. Dis, 200:1076–1079. doi: 10.1097/NMD.0b013e318275d285.

Schimmenti, A. (2017). The developmental roots of dissociation: A multiple mediation analysis. Psychoanalytic Psychology, 96-105.

Stiglmayr C, Schimke P, Wagner T, Braakmann D, Schweiger U, Sipos V, et al. (2010). Development and psychometric characteristics of the dissociation tension scale. J Pers Assess, 92(3):269–77. doi: 10.1080/00223891003670232.

Stiglmayr, C., Schmahl, C., Bremner, J., D., Bohus, M., & Ebner-Priemer, U. (2009) Development and psychometric characteristics of the DSS-4 as a short instrument to assess dissociative experience during neuropsychological experiments. Psychopathology, 42(6):370-4.

Veith, I. (1965). Hysteria: The History of a Disease. University of Chicago Press; Chicago, IL, USA: 1965.

Wilson, T., D. (2004). *Strangers to ourselves*, Harvard University Press.

Mindfulness among Non-Ashtang Yoga Practitioners and Non-Yoga Practitioners

Varsha A. Malagi*

ABSTRACT

In Current scenario, everyone is very well aware of the practice of Yoga. It is spreading drastically worldwide. It has become a part of life style of many individual. Yoga basically is derived from the word yuj means 'joining together' of both mind and body. Mindfulness means completely being present in a given situation. No matter what work/action people are engaged in, complete involvement in that task without any distraction means that he/she is mindful. Many researchers have focused on the effect of Yoga, but very few have taken into consideration complete Ashtang yoga (eight limbed yoga) Practice. The current study was undertaken to assess the level of Mindfulness among Non-Ashtang Yoga practitioners who practice basic Yoga Asanas and Pranayama's and Non-Yoga practitioners who doesn't Practice yoga at all. The sample comprised of 100 participants (50 Non-Ashtang yoga practitioners and non-practitioners of yoga each) belonging to the age range of 19-25 years. Research is Exploratory in nature and the Sample Survey Research Design is adopted. Purposive sampling was adopted. The Mindfulness awareness scale of Brown and Ryan (2003) was used for the purpose of assessing Mindfulness. The obtained results were analysed using SPSS 16.0, which included analysis of Descriptive statistics and Independent samples t-test. The findings indicated that there is no significant difference in the level of Mindfulness among Non-Ashtang Yoga Practitioners and Non-Yoga Practitioners.

Keywords: *Mindfulness, Yoga, Ashtang-Yoga, Eight-limbed yoga*

* Assistant Professor, Department of Post Graduate Studies and Research in Psychology, SDM College, Ujire, Karnataka, India, E-mail ID: varshamalagi2@gmail.com, Mob: +91 7795991661

INTRODUCTION

Yoga is a means by which one establishes connect with one's own Divine Self. Physical health and mental tranquillity are two milestones one crosses in this journey, or akin to two by-products of this profound pursuit (Sathya Sai Baba, 2015).

Derived from the Sanskrit word 'yuj', Yoga means union of the individual consciousness or soul with the Universal Consciousness or Spirit. Yoga is a 5000-year-old Indian body of knowledge. Though many think of yoga only as a physical exercise where people twist, turn, stretch, and breathe in the most complex ways, these are actually only the most superficial aspect of this profound science of unfolding the infinite potentials of the human mind and soul. The science of Yoga imbibes the complete essence of the Way of Life (Sri Sri Ravi Shankar, 2018).

Yoga is a system of personal inquiry and experience which began with human beings awareness of self. The Knowledge of the body and its functions was the beginning of understanding self, knowledge of the mind and its processes was the beginning of self-awareness and experience of the transcendental force was the beginning of self-realization. The yogic postures, cleansing practices, and breathing practices help an individual to possess a healthy and vital body. The clarity of mind was obtained through systems of concentration that is through meditational practices. Yoga is crucially concerned with how an individual lives the life with respect to own personal health, hygiene and well-being; personal environment; interaction with the others; behaviour and interaction in general; life as a

learning process and relationship with the ultimate consciousness (Ananda, 2003; Chopra and Simon, 2006; Vivekananda, 2005).

Various Systems of Yoga

By and large, there are four types of persons in the world: the intellectual, active, emotional and contemplative. Those who are intellectual follow the way of jnana yoga, the way of wisdom and discernment. Those who are active follow the way Karma Yoga, the way of action and service rendered without selfish motives. Those who are emotional follow the way of Bhakti Yoga, the path of devotion and love, where the personality is dissolved and the individual becomes completely unselfish.

Those who attach the greatest importance to contemplation follow the path of Raja yoga i.e., the way designed to control and master the mind by mental concentration (Ananda, 2003). Mindfulness is a versatile state of mind-openness to new things, being completely aware of the environment and the task, a method of actively drawing novel distinctions. When we are conscious, we tend to become sensitive to the perspective and more aware of the context; we tend to be located within the gift of nature as it occurs itself without judging it in any way. (Langer, 2009a, 2009b).

It is an impartial watchfulness. It doesn't get decorated up in what's perceived. It just perceives. Mindfulness does not get crazy with the great mental states. It doesn't attempt to sidestep the dangerous/unhealthy mental states. There's no need to get stick to the pleasure things/instances nor running form the things which we don't like. When talking about Mindfulness it sees everything equally. It doesn't play favourites. (Kabatzinn, 1990).

Mindfulness is an active search for novelty, whereas mindlessness involves passively zoning out to everyday life. Mindfulness Qualities are: Non-judging, Non-striving, Acceptance patience, Trust, openness, Letting go, Gentleness, empathy, gratitude, Loving and kindness (Snyder, Lopez, Pedrotti, 2011).

Successful goal pursuit requires some degree of continuous attention (mindfulness) so that goal progress is monitored, necessary adjustments made, and efforts remain focused on, rather than distracted from, goal achievement. In addition, mindfulness may contribute to more self- determined and autonomous actions (Baumgardner, Crothers, 2009).

Mindfulness coaching techniques are researched and have shown potential effectuality in the field of psychological functioning (Baer, 2003; Grossman, 2004).

Mindfulness Meditation

It is not a hectic process to meditate; it won't disturb our everyday life routine. There's no need to put so much of effort in it, it's just about being aware of our thought process, environment/surrounding. It's very usual that people are taken up by so much of work in their day to day life that, they even forget to notice what exactly is happening in their surroundings. This meditation can be done effortlessly, like any other meditation, this doesn't include sitting at a quiet place trying to concentrate at some particular thing/trying to work on thought process, it only includes just being present at the situation, it's about knowing/being aware of what exactly you are doing.

The Benefits of Mindfulness

The deliberative practice of mindfulness often takes the form of mindfulness meditation. The aim of mindfulness meditation, generally speaking, is the "development of

deep insight into the nature of mental processes, consciousness, identity, and reality, and the development of optimal states of psychological well-being and consciousness through opening up" (Walsh, 1983).

It helps an individual to reduce symptoms of depression, stress, anxiety and so on. It helps in improving one's attention to whatever is happening in the present movement. Mindfulness makes an individual to experience warmth and kindness. By doing mindful meditation, an individual becomes aware of his own body, consciousness and helps to improve in their specific job areas such as theatre play, music, dancing and so on. Mindfulness needs complete attention when one individual is performing an act on his/her specific interested areas. It makes a person be self- compassionate, calm, joyful and resilient.

METHOD

Research Question

- What is the level of Mindfulness among Non- Ashtang Yoga Practitioners and Non Yoga Practitioners?
- Do Non- Ashtang Yoga Practitioners and Non Yoga Practitioners differ in their level of Mindfulness?

Objectives

- To assess the level of Mindfulness among Non- Ashtang Yoga Practitioners and Non Yoga Practitioners.
- To find the difference in the level of Mindfulness among Non- Ashtang Yoga Practitioners and Non Yoga Practitioners.

Hypothesis

There is no significant difference in the level of Mindfulness among Non- Ashtang Yoga Practitioners and Non Yoga Practitioners.

Variables

Independent Variable: Presence or Absence of Yoga Practice.

Dependent Variable: Mindfulness

Sample

Purposive Sampling method was adopted for the study. The sample consisted of 100 participants of age range 19 to 25 years. The sample was drawn from Ujire region.

Table 1

Sample composition

Group	Number of Participants
Non-Ashtang Practitioners of Yoga	50
Non- Practitioners of Yoga	50
Total	100

Inclusion Criteria:

- The practitioners of Yoga group include those who have been practicing basic yoga asanas and pranayama's daily from past two years.
- The non-practitioners of yoga group include who have not learnt and practiced yoga in their life time.
- The participants in the age range of 19-25 years.

Exclusion Criteria:

- Those who have discontinued yoga or do not practice regularly.

- Those who practice meditation.
- Participants with physical and mental health problems.

Research Design:

- Research is Exploratory in nature and the Sample Survey Research Design is adopted.

Assessment tool:

Mindfulness Attention Awareness Scale

The Mindfulness attention awareness scale was developed by Brown and Ryan in the year 2003 with adequate reliability and validity. It is a 15 item questionnaire. Participants reported how often they believed they had experiences referenced by each item on a 6-point Likert scale from 1-Almost always, 2-Very frequently, 3-Somewhat Frequently, 4-Somewhat Infrequent, 5-Very infrequently, 6-Almost Never. High averaged total scores purportedly reflect higher mindfulness.

Procedure

The Purpose of the study was explained to the participants. The participants who fulfilled the criteria were met personally by the researcher. The participant's willingness to participate in the study was ascertained after the establishment of rapport. The socio-demographic details were collected. The participants were briefed about the inventory and was provided with clear instructions. The Mindfulness Attention awareness scale, was administered, the inventory was collected and was checked for any kind of omissions. After completion of all the assessments the researcher spent some time with the participants and they were thanked for their participation and cooperation. Then the scoring was done for the responses obtained and interpretations were made.

Ethical issues

- Written consent was obtained from the participants of the research.
- The participants were assured about the confidentiality of the information provided by them.
- The obtained data has been used only for the purpose of the research.
- The participants were given freedom to withdraw from the study whenever they want.

Statistical Analysis

Descriptive statistics: Mean and Standard Deviation

Inferential statistics: Independent samples t- test

RESULTS AND DISCUSSION

The results obtained were analysed using Independent samples t-test. The independent samples t-test was used to understand the significant difference in the level of Mindfulness among Non-Ashtang Yoga Practitioners and Non-practitioners of Yoga.

Demographic variables

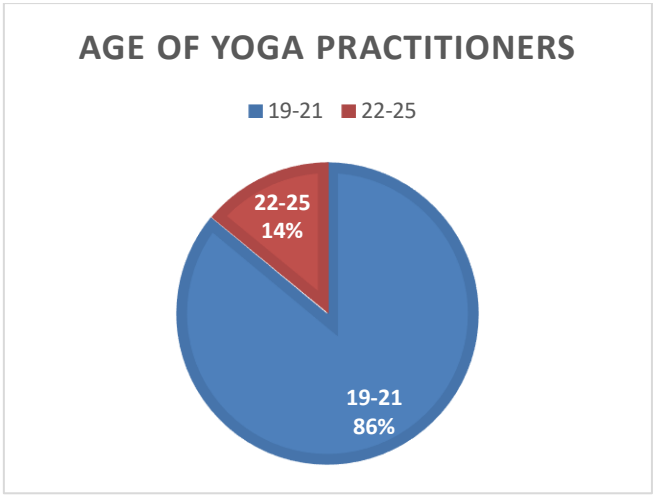

Figure 1: Age of Yoga Practitioners

The age of Yoga practitioners indicates that 86% falls under the age range of 19-21 and 14% falls under the age range of 22-25.

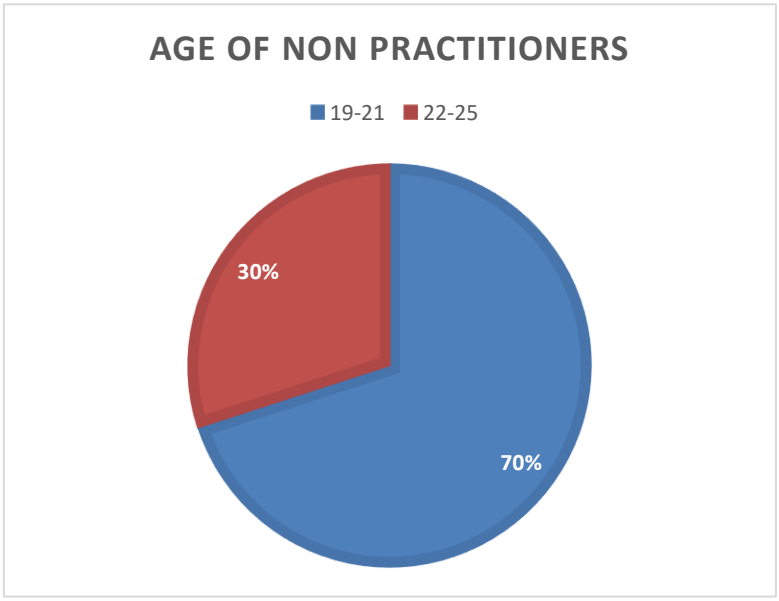

Figure 2: Age of Non Practitioners

The age of Non-practitioners indicates that 70% of the participants fall under the age range of 19-21 and 30% falls under age range of 22-25.

Religion

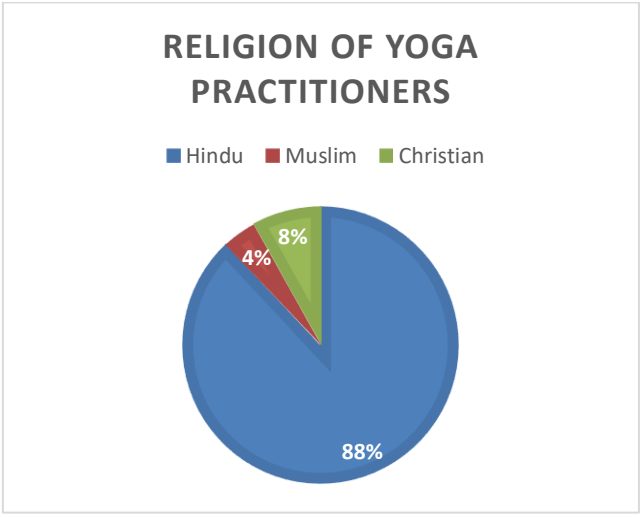

Figure 3: Religion of Yoga Practitioners

The Religion of Yoga Practitioners indicates that 88% of the participants are Hindu, 4% are Muslim and 8% are Christian.

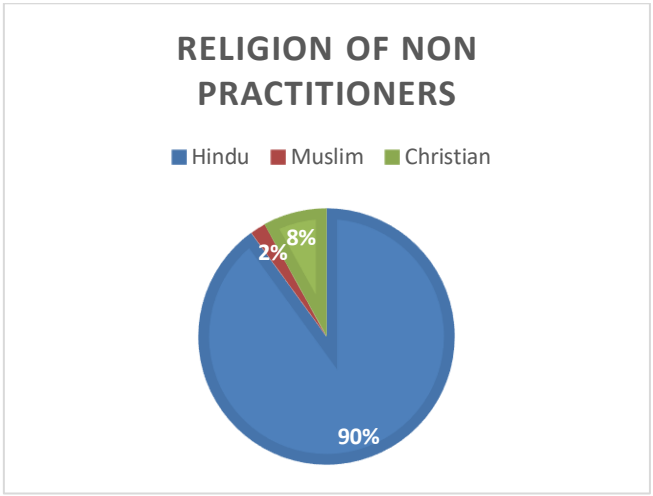

Figure 4: Religion of Non-Practitioners

The Religion of Non-Practitioners indicates that 90% of the participants are Hindu, 2% are Muslim and 8% are Christian.

Variables

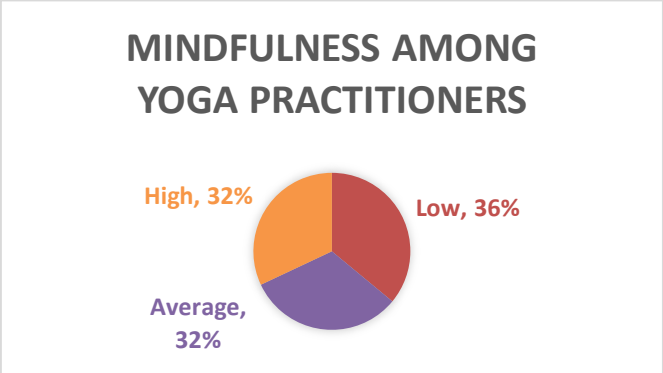

Figure 5: Level of Mindfulness attention awareness among Non-Ashtang Yoga Practitioners

The Level of Mindfulness attention awareness among Non-Ashtang Yoga practitioners indicate that 36% of participants showed low Mindfulness Awareness, while 32% of participants showed average Mindfulness Awareness and 32% showed high Mindfulness Awareness.

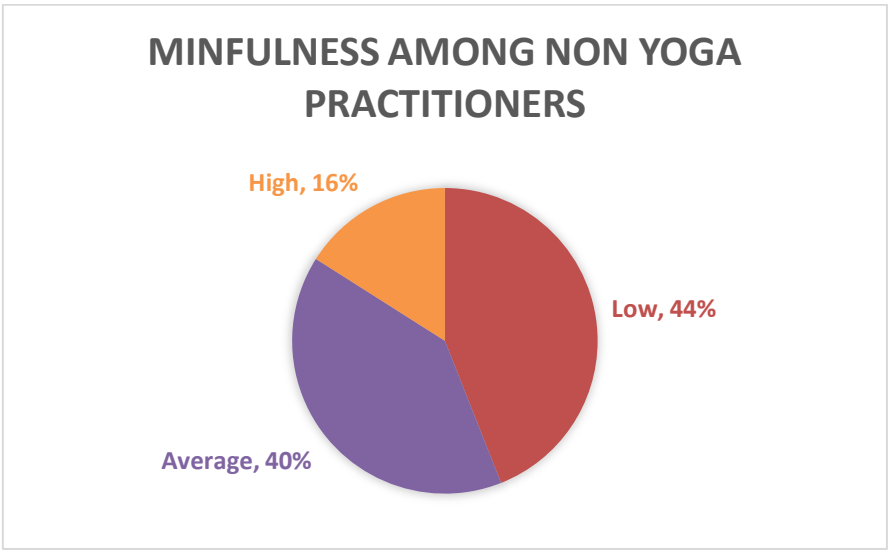

Figure 6: Level of Mindfulness attention awareness among Non-Yoga Practitioners

The Level of Mindfulness attention awareness among Yoga practitioners indicate that 44% of participants showed low Mindfulness awareness, while 40% of participants showed average Mindfulness awareness and 16% showed high Mindfulness Awareness.

Independent Samples t –test

Table 2

Mean, Standard Deviation and t value for Mindfulness among Non-Ashtang Yoga practitioners and non-practitioners of yoga.

Groups	N	Means	SD	t	df	Significance
Non-Ashtang Yoga Practitioners	50	63.36	11.515	0.739	98	0.461
Non-Yoga Practitioners	50	61.70	10.927			

The hypothesis stating that there is no significant difference in the level of Mindfulness among Non-Ashtang Yoga practitioners and Non-practitioners of Yoga was tested using independent samples t- test. The obtained t value is 1.561 which is not significant. Thus, the obtained result indicates that there is no significant difference in the level of Mindfulness attention awareness among Non-Ashtang Yoga Practitioners and Non-Practitioners of Yoga. Hence, the null hypothesis is accepted.

SUMMARY OF THE RESEARCH

The present study was undertaken to study the level of Mindfulness among Non-Ashtang Yoga practitioners and non-practitioners of Yoga. The Presence or Absence of Yoga

Practice is the independent variable; Mindfulness is the dependent variable. The sample included 100 participants, comprising of 50 practitioners and 50 non-practitioners of yoga. The Purposive Sampling Technique was used to collect the data. The Sample Survey Research Design was adopted in the study. The participants who are in the age range of 19-25 years were included in the study. The practitioners of yoga group included who have been practicing basic yoga asanas and pranayama's on the daily basis for duration of at least past two year but not practicing Ashtang Yoga. The non-practitioners of yoga group included those who never practice yoga. The participants who have discontinued practicing yoga and the ones who practice yoga alternatively were excluded from the study. The participants who practice other meditation like Cyclic, Omkar, Zen etc. were also not considered for the study. The Mindfulness awareness scale of Brown and Ryan (2003) was used to assess the mindfulness among the participants of the study. The obtained results were analysed using Independent Samples t-test.

Findings of the study

1. Mindfulness Awareness among Non-Ashtang Yoga practitioners is neither too high nor too low.
2. Majority of Non practitioners of Yoga have low level of Mindfulness Awareness.

The Independent Sample t-test was undertaken to know the difference in the level of Mindfulness among Non-Ashtang Yoga practitioners and Non-practitioners of Yoga. Non-Ashtang Yoga practitioners and Non-practitioners of yoga did not differ significantly in their level of Mindfulness.

Conclusion

The overall findings of the study indicated that, though practice of yoga has little bit influence on the participants Mindfulness, the practice of only Basic Yoga Asanas and Pranayama's has no significant influence on the level of Mindfulness of the participants, but if the practice of entire Ashtang Yoga sometimes referred to as eight-limbed Yoga which includes Yamas, Niyamas, Yoga asanas, Pranayama, Pratyahara, Dhyana, Samadhi is practiced, it may have greater influence on the level of Mindfulness.

Limitations

- Only quantitative method was used.
- The impact of other factors such as environmental influence, hobbies, interests, meditation practitioners etc, which are also the major contributing factors were not considered for the study.
- The results inferred from the study cannot be generalized as the sample collection was restricted to one geographical area.

Scope for further Research

- The study can be conducted to identify the influence of Ashtang Yoga in the level of Mindfulness among Non-yoga practitioners.
- The study can also be conducted to identify the level of Mindfulness among Ashtang Yoga practitioners.

REFERENCES

Ananda, S. (2003). The complete book of yoga: Harmony of body and mind. Delhi: *Orient Paperbacks.*

Baer, R., A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. *Clinical Psychology: Science and Practice*, 10(2), 125-143.

Baumgardner, S.R. & Crothers, M.K. (2009). *Positive Psychology*. Delhi: Pearson.

Chopra, D. & Simon, D. (2006). The seven spiritual laws of yoga. India: *Wiley India Limited.*

Grossman, P., Neimann, L., Schmidt, S., & Walach, H. (2004). Mindfulness-based stress reduction and health benefits: A meta-analysis. *Journal of Psychosomatic Research*, 57, 35-43. DOI: 10.1016/S00223999 (03)00573-7

Kabat-Zinn, J. (1990). Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness. *Dell Publishing New York*

Langer, E. (2009a). Mindfulness versus positive evaluation. In S. J. Lopez & C.R. Syner (Eds.), *Oxford handbook of positive psychology* (pp.279-294). New York: Oxford university press.

Langer, E. (2009b). *Clockwise: Mindful health and the power of possibility*. New York: Random house.

Sathya, Sai, baba, (2015). Practice Yoga for Physical, Mental and Spiritual Well-Being. 13(6). Retrieved January 2, 2018, from

http://media.radiosai.org/journals/vol_13/01JUN15/yoga-day-sathya-sai-baba-discourse.htm

Sri, R., S. (2018). Retrieved January 2, 2018, from https://www.artofliving.org/in-en/yoga

Snyder, C., R., Lopez Shane, L., J., & Pedrotti, J., T. (2014). *Positive Psychology: The Scientific and Practical Exploration of Human Strengths*. New Delhi: Sage

Murray, R., & Zetner, J., (1989). *Nursing concepts for health promotion*. New Jersey: Prentice Hall.

Vivekananda, R. (2005). Practical yoga psychology. Bihar, India: *Yoga Publications Trust*.

Walsh, R., N. (1983). Meditation practice and research. *Journal of Humanistic Psychology*, 23, 18-50

The Impact of Self-Efficacy and Assertiveness among Adolescents

Srishti Chanana*

ABSTRACT

Self-efficacy is a construct that entails an individual's beliefs that they will be able to effectuate certain task. Being assertive the capability to speak up for one self in a fashion that is respectful and honest. It is a happy medium between the two extremes of passivity and aggressiveness. The aim of the present study is to assess the relationship between self-efficacy and assertiveness among adolescents and to understand how they play a vital role and gender differences on the domain of assertiveness. A purposive sample consisting of 200 participants belonging to the 14-18 years of age, was taken. The measures used in the study were General Self-efficacy Scale and Rathus Assertiveness Schedule. This paper employs a quantitative analysis using correlation and t-test method. The result points out that the relationship between self-efficacy and assertiveness is comprehended to be positive. Also, there were no significant differences among the scores on males and females when assessed through the Rathus Assertiveness Schedule.

Keywords:*Self-efficacy, Assertiveness, Motivation, Aggressively*

* Psychologist,Panjab University, E-mail ID: srishtichanana03@gmail.com, Mob: +91 9810112453

INTRODUCTION

Adolescence is referred to as a period of crisis because of maturity problems and complexity of life, since it is the transitional stage from childhood to adulthood.

The term self-efficacy was coined by Albert Bandura (1986) as an aspect of social cognitive theory. Self-efficacy could be defined as the perceived potential of an individual in congruence with a specific aspect. Adolescence is a critical period where an individual is exposed to diverse of life experience. Hence, social self-efficacy is a protective component that enhances healthy development and social functioning during adolescence.

Assertiveness is to assert to a state an opinion, claim a right, or establish authority. It is the act of standing for your own personal rights i.e., expressing your thoughts, feelings and opinion in appropriate ways. It is the process of direct or appropriate communication of an individual's opinions, needs and wants without putting down or pushing others in any domain of life (Arrindell & van der Ende, 1985).

The relationship between assertiveness and self-efficacy tends to be positive. Self-efficacy fosters the aspect of interpersonal relationships and social interactions which are integral to people with poor beliefs in their ability fail to be assertive and to cope with conflictual social interactions in everyday lives (Gini et al, 2008). Studies on Assertiveness and Self-Efficacy have been conducted in diverse areas, on various age-groups, in various contexts. Rumrill (1999) proposed that higher self-efficacy, social competence and assertiveness were associated with more frequent requests for job-accommodations. Yamada et al (2013) showed that incorporating self-efficacy formation and cognitive development in basic life skills teaching was effective for developing assertive communication skills.

Review of Literature

Empirical evidence exists on the relationship and influence of self-efficacy. According to the researchers, self-efficacy intertwines the effects of skills, pre-acquired experience, mental ability, and other self-beliefs on subsequent achievement. Bandura (1997) provides extensive evidence to suggest that perceptions of self-efficacy are powerful determinants of achievement outcomes in varied fields. In a meta-analysis, Stajkovic and Luthans (1998) found that the average weighted correlation between self-efficacy and work-related performance was r = 0.38, which transforms to an impressive 28 percent gain in task performance. According to a research on college students who are pursuing science and engineering courses, have very high self-efficacy which influences the academic persistence which is essential to maintain high academic achievement among the students (Hackett, 1995; Lent, Brown, & Larkin, 1984; Lent & Hackett, 1987). Self-efficacy in a classroom setting causes an impact on the cognitive strategy use and self-regulation through use of meta-cognitive strategies, and it is correlated with in class seat-work and homework, and essays and reports exams and quizzes, etc. Pintrich and De Groot (1990) concluded that self-efficacy facilitates cognitive engagement in a way that increased self-efficacy is more likely to show elevated achievement by increasing use of cognitive strategies.

METHOD

Hypotheses

1. There will be a positive relationship between self efficacy and assertiveness among adolescents.

2. There will be no significant differences among males and females on assertiveness.

Design

The objective of the present study was to assess the relationship between self-efficacy and assertiveness among adolescents and to investigate the gender differences on assertiveness. For this, two measures, General Self-Efficacy Scale and Rathus Assertiveness Schedule, were chosen, and administered on a sample 200 (100 males and females) of adolescents who were in the first year of college, in a face to face interaction. The data was then compiled and scoring was done. Thereafter, the results were represented and discussed.

Sample

For the present study, a sample of 200 adolescents, 100 males and females each, were taken. The participants were students of first year of under graduate studies belonging to middle socio-economic status.

Measures

General Self-Efficacy Scale

The General Self-Efficacy Scale was constructed by Schwarzer and Jerusalem, 1992. The scale was constructed to assess a general sense of perceived self-efficacy. The scale was designed for the general adult population, including adolescents. The scale consists of 10 items. Responses are made on a 4-point scale. Cronbach's alphas ranging from .76 to .90. The 10 items are designs to assess the general self-efficacy; each item defines as successful coping.

Rathus Assertiveness Schedule

Rathus Assertiveness Schedule was developed by Spencer Rathus, 1973. One way to gain insight into how assertive you are is to take the following self-report test of assertive behavior. It is a 30 item scale trying to measure assertiveness. Test-retest reliability was established using a Pearson-product moment correlation coefficient over a two month period (r = .78), indicating moderate to high stability of test scores.

Procedure

The present study aims to assess the relationship between self-efficacy and assertiveness among adolescents. The two indices, General Self-Efficacy Scale and Rathus Assertiveness Schedule, were administered on each participant individually prior to rapport formation. The participants were informed about the confidentiality of their responses.

RESULTS

The results were computed by adding scores of the two measures as per their respective manuals. This was followed by calculation of correction using Pearson product correlation of coefficient between the scores of individuals on both General Self-efficacy Scale and Rathus Assertiveness Schedule. T-ratios were then computed between the scores of males and females on the dimensions of Rathus Assertiveness Schedule and their significance was tested. Following are the tables depicting the results.

Table 1

Showing the sum total, mean value and the correlation value between general self-efficacy scale and Rathus assertiveness scale.

Value	General self-efficacy scale	Rathus assertiveness index	Correlation
Sum	17375	4216	0.0104
Mean	86.875	21.08	
Std. Deviation	26.750	19.952	

Table 2

Showing Sum Total, Mean Value And T-Value OnRathusAssertivenes Schedule Among Males And Female

Dimentions	Rathus assertiveness schedule	
Values	**Males**	**Females**
Sum	17375	4216
Mean	20.86	21.34
St. Deviation	19.761	20.222
T-value	0.865	

DISCUSSION

The aim of the present study is to assess the relationship between self-efficacy and assertiveness among adolescents and examine the gender difference on assertiveness. In the present research, two hypotheses were formulated.

The first hypothesis is that there will be a positive relationship between self-efficacy and assertiveness among adolescents. For this, correlation was done on the scores of General Self-Efficacy Scale and Rathus Assertiveness Schedule. The correlation value was found out to be 0.10432. This indicates a positive association between the scores of both the indices that

would imply a relationship between the two variables move in a tandem. For instance, when self-esteem increases there is heightened assertiveness, since the individual becomes positive enough to assert himself. On the contrary, when there is a decline in the self-esteem, the process to assert declines. The possible reasons for a positive relationship might be, assertiveness is important for a healthy self-esteem and for your overall wellbeing.

The second hypothesis formulated was that there will be there no significant differences among males and females on the dimension of assertiveness assessed by Rathus Assertiveness Schedule. The T-scores were calculated to statistically investigate among both the genders. The degree of freedom d(f) came out to be 198. The T-ratio computed were 0.865 and the Tcrit value from the table 1.65 for 0.05 level of significance and 2.35 at 0.01 level of significance. The obtained t-value is less than Tcrit value from the table therefore the hypothesis that there will be no significant differences among males and females on the dimension of assertiveness has been accepted. The higher rate of assertiveness in boys is related to culture and social norms, but in today's world the scenario is changing. Our cognitive process changes with the culture we reside in, today females are imbibed with equal morals, values and confidence as males do. Therefore, there was no significant difference among males and females with respect to assertiveness.

Conclusion

The present study takes in two hypotheses, firstly, that there will be a positive relationship between self-efficacy and assertiveness among adolescents and secondly, that there will be there will be no significant differences among males and females on the dimension of assertiveness assessed by Rathus Assertiveness Schedule. Both the hypothesis was retained.

REFERENCES

Akbarbegloo, M., Valizadeh, L., Zamanzadeh, V., &Jabarzadeh, F. (2015). The relationship between self-efficacy and psychosocial care in adolescents with epilepsy. Epilepsy research and treatment, 2015.

Armum, P., &Chellappan, K. (2016). Social and emotional self-efficacy of adolescents: measured and analysed interdependencies within and across academic achievement level. International Journal of Adolescence and Youth, 21(3), 279-288.

Bandura, A. (2008). An agentic perspective on positive psychology. Positive psychology, 1, 167-196.

Charles, S. T., & Carstensen, L. L. (2010). Social and emotional aging. Annual review of psychology, 61, 383-409.

Eslami, A. A., Rabiei, L., Afzali, S. M., Hamidizadeh, S., &Masoudi, R. (2016). The effectiveness of assertiveness training on the levels of stress, anxiety, and depression of high school students. Iranian Red Crescent Medical Journal, 18(1).

Gustafson, R. (1992). A Swedish psychometric test of the Rathus assertiveness schedule. Psychological reports, 71(2), 479-482.

Hasanzadeh, R., &Mahdinejad, G. (2012). Investigation of the Relationship between Self-assertiveness and School's attitude. Journal of Elementary Education, 22(1), 81-88.

Kirmani, A., & Campbell, M. C. (2004). Goal seeker and persuasion sentry: How consumer targets respond to interpersonal marketing persuasion. Journal of consumer research, 31(3), 573-582.

Kirst, L. K. (2011). Investigating the relationship between assertiveness and personality characteristics.

Klassen, R. (2002). Writing in early adolescence: A review of the role of self-efficacy beliefs. Educational psychology review, 14(2), 173-203.

Masumoto, K., Taishi, N., &Shiozaki, M. (2016). Age and gender differences in relationships among emotion regulation, mood, and mental health. Gerontology and Geriatric Medicine, 2, 2333721416637022.

Nevill, D. D., &Schlecker, D. I. (1988). The relation of self efficacy and assertiveness to willingness to engage in traditional/nontraditional career activities. Psychology of Women Quarterly, 12(1), 91-98.

Nyklíček, I., Vingerhoets, A., &Zeelenberg, M. (Eds.). (2010). Emotion regulation and well-being. Springer Science & Business Media.

Ostir, G. V., Markides, K. S., Peek, M. K., & Goodwin, J. S. (2001). The association between emotional well-being and the incidence of stroke in older adults. Psychosomatic medicine, 63(2), 210-215.

Quoidbach, J., Berry, E. V., Hansenne, M., &Mikolajczak, M. (2010). Positive emotion regulation and well-being: Comparing the impact of eight savoring and dampening strategies. Personality and individual differences, 49(5), 368-373.

Rathus, S. A. (1973). A 30-item schedule for assessing assertive behavior. Behavior therapy, 4(3), 398-406.

Singh, B., &Udainiya, R. (2009). Self-efficacy and well-being of adolescents. Journal of the Indian Academy of Applied Psychology, 35(2), 227-232.

Steptoe, A., Deaton, A., & Stone, A. A. (2015). Subjective wellbeing, health, and ageing. The Lancet, 385(9968), 640-648.

Tahmassian, K., & Moghadam, N. J. (2011). Relationship between self-efficacy and symptoms of anxiety, depression, worry and social avoidance in a normal sample of students. Iranian journal of psychiatry and behavioral sciences, 5(2), 91.

Urdan, T., &Pajares, F. (Eds.). (2006). Selfefficacy beliefs of adolescents. IAP.

Urry, H. L., & Gross, J. J. (2010). Emotion regulation in older age. Current Directions in Psychological Science, 19(6), 352-357.

Zapf, D. (2002). Emotion work and psychological well-being: A review of the literature and some conceptual considerations. Human resource management review, 12(2), 237-268.

MANUSCRIPT PREPARATION

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

The manuscript must be written in English typed in MS Word with double space, 12-pt Times New Roman, on A4, sheets (**not exciding 16 pages all together**) leaving appropriate margin (left and top 3-cm, right and bottom 2-cm) and should be numbered from the Title page.

1. One hard copy of each manuscript along with a CD, and/or soft copy through e-mail (word version in attach file) should be sent to the Editor-in-Chief as mentioned below.
2. The first page should contain: Title, Name(s) and Affiliation of Author(s), Address of corresponding author including e-mail address and cell number.
3. The 2nd page includes: Title, Short-running head, Abstract within 200 words, and Key-words (maximum 5).
4. From the 3rd Page (i) Introduction, (ii) Method, (iii) Results, (iv) Discussion and Conclusion, Acknowledgements (if any), References, Appendix (if any), etc.
5. Minimum number of Tables or Figures should be cited not repeating each other.
6. Authors are requested to make necessary language correction before submitting a manuscript to PIJPS.

SAMPLE of REFERENCES

References (for Journal):

Gibbons, S., S. Machin and O. Silva (2008): "Choice, Competition and Pupil Achievement", Journal of the European Economic Association, vol. 6(4), 912-947.

For Book/Chapter:

Pueschel,S.M., Sustrova, M. (1996). Psychiatric Disorders and Behavioural Concerns in Persons with Down's syndrome. Down Syndrome Psychological and Psychobiological and Socio-Educational perspectives. Whurr Publishers Ltd, London,179-189.

Manuscript should be uploaded to:

http://phonixcentre.in/submit.php

PHONIX INTERVENTION CENTRE

Phonix Intervention Centre, a centre for counseling & special education is a multi disciplinary centre where all psychological issues are taken care like special education, counseling, cognitive behavior therapy, behavior therapy, occupational therapy, speech therapy, all works under the same roof in order to provide all required support to the client without any hassle.

Phonix name derived from the name of bird "Phoenix" who can't fly high but she never gives up and one day she succeed. So our believe is every individual can grow the highest of their potential if one could get the proper direction.

MISSION

TO HELP PEOPLE TO REACH THEIR MAXIMUM POTENTIAL.

VISION

- To promote normative holistic development in children, young and wholesome family.
- To bring awareness about common childhood problems and disabilities.
- To create our society all disability friendly.
- To make our school disability friendly.
- Not only identify the problem but also provide help and support to the children.
- Help parents to understand and accept their conditions of children.

DIFFERENT WINGS OF PIC

- Learning Ability Centre
- Psychological and Educational Assessment Centre
- Counseling and Psychotherapy Centre
- Training / Workshop
- School Mental Health
- Publication – PIJPS
- Parents Support Centre

CONTACT INFORMATION

PHONIX INTERVENTION CENTRE
C-4/123-124, Sector – 6, Rohini, Delhi – 110085 India
www.phonixcentre.in | phonixcentre@gmail.com
Cell : +91 8527085707 | +91 9560733261

Phonix Intervention Centre

a centre for counseling & special education

C – 4/123 - 124, Sector -6, Rohini, Delhi – 110085, India

8527085707 | 9560733261

www.phonixcentre.in | phonixcentre@gmail.com