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Examining attitudes toward virtual professional counseling in college students

Sylvia Lindinger-Sternart*,Sachin Jain**, Sumeedha Therthani and Kristina Faimon*******

The authors of this study aimed to explore the roles of gender, cultural backgrounds, and personality factors in influencing the preference for types of professional counseling (face-to-face, chat-based, or video based). The data from 85 college students was collected through anonymous online survey using Qualtrics. The data primarily is comprised of participants from United States, India, several African and European countries. There were 12 demographic questions and 130 survey questions. Participants included 61 males and 24 males. Their age ranged from 18 to 53 years. After summarizing data, researchers analyzed the relationship among 3 types of professional counseling scores (Chat-based, video-based, and face to face), 9 demographics categories, 9 masculine norms scores, and 6 extroversion scores. The results showed that few characteristics were significantly correlated to a positive attitude toward a particular counseling provision. However, whereas gender differences were not significant for most of the examined factors, the personality factor self-reliance was significantly correlated to male participants.

KeyWords: *Attitudes, Virtual Professional counseling.*

INTRODUCTION

According to the WHO (2014) mental health problems affect nearly half the world's population and this malady is not limited to age-groups, gender, or culture. As per WHO's prediction virtually all future population growth (97%) will be in developing countries. The most common mental health disorders are major depression and alcohol use disorder. The rates of overall diagnosed mental health disorders are almost equal for males and females. There are gender differences, however, in the kinds of mental disorders diagnosed in different populations. Females represent higher rates of lifetime prevalence of major depression, whereas males show almost double the female rates for lifetime prevalence of diagnosed alcohol dependence. In addition, the WHO (2014) reported high comorbidity rates with substance use disorder in men. Males showed significantly higher rates of anti-social personality disorder and committed suicide, whereas more females faced violence and anxiety disorders.

While research on counseling attitudes is well established, few studies have focused on attitudes toward synchronous professional counseling such as chat-based (CB) and video-based (VB) professional counseling. The National Board for Certified Counselors [NBCC] (2012) defined chat-based and video-based professional counseling as synchronous

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distance interaction in which information is provided and received through video or written messages in real time. In this study, the researcher focused on chat-based and video-based counseling where the professional distance occurs synchronously. Studying attitudes toward synchronous professional counseling is important due to an increasing popularity of services via the internet. A growing body of research shows that counseling via the Internet can have a similar effect as face-to-face counseling (Richards & Viganó, 2013). Another major reason in favor of investigating the attitude of synchronous distance professional counseling is that this method can offer a resource for underrepresented populations from various cultural backgrounds that represent high levels of stigma. Help-seeking via the Internet is more anonymous (Young, 2005), and thus, synchronous distance professional counseling may be a reasonable option for underrepresented populations to seek professional help. In particular, synchronous distance professional counseling may increase significantly in college students, as they are used to use computers and the Internet as important communication tools. Considering that attitudes toward face-to-face based (FB) professional counseling seem to be significantly correlated to help-seeking behaviors (Vogel, Wade, & Hackler, 2007), understanding college students' attitudes toward synchronous professional counseling would be informative for effectively developing and providing counseling services in universities and societies. Research has shown the impact of psychoeducational interventions on help-seeking attitudes (Gonzalez, Tinsley, & Kreuder, 2002). When seeking professional support at an early stage, the development of more serious mental health problems may be prevented through the provision of distance professional counseling.

Mental health disorders, according to the National Institute of Mental Health (NIMH, 2013), are the leading cause of disability in the United States, but many individuals stay undiagnosed or avoid seeking professional help. The WHO (2014) reports physicians identify less than 50% of those who exhibit diagnostic symptoms for mental health disorders. Most physicians do not have enough information to make proper diagnoses and they do not make appropriate references. Moreover the majority of individuals who experience onset of a mood, anxiety, or substance use disorder do not seek help within the first year with appropriate professions. Research reports that high levels of stigma toward help-seeking contribute significantly when avoiding professional counseling services (Galdas, Cheater, & Marshall, 2005; Komiya, Good, & Sherrod, 2000). The conformity to masculine norms is correlated to help-seeking attitude in male populations (Vogel et al., 2007).

The present study investigated attitudes toward synchronous professional distance counseling as compared face-to-face based counseling among college students from various backgrounds. More specifically, the

researcher examined the influence of gender, cultural backgrounds and personality factors on college students' attitudes toward synchronous distance professional counseling via the Internet versus face-to-face based counseling. Previous literature suggested investigating whether such variables are associated to attitudes toward counseling via the Internet (Rochlen, Zack, & Speyer, 2004).

The primary objectives of this study were to investigate whether these attitudes differ according to cultural backgrounds, gender, majors of study, estimated mental health problems, and personality factors. In addition, the factor conformity to masculine norms that influences help-seeking attitudes in males was included. Ruzek et al. (2011) found that 35% of Asian American males who attempted suicide have never sought any professional counseling. The results showed that these individuals contacted nonprofessional online self-help groups. Help-seeking can cause feelings of weakness in men and may not suit with their conformity of masculinity (Vogel & Heimerdinger, 2011). Males' attitude toward seeking professional counseling is associated with their self-stigma and conformity to masculine norms (Vogel et al., 2007; WHO, 2014). Since help-seeking via the internet may be more anonymous, the provision of adequate chat-based and video-based professional counseling may offer a valuable option.

Counseling via the Internet versus Face-to-face:

Professional counseling via the Internet has received more attention and recognition as a valuable counseling provision during the last years. Health care providers use the Internet to connect and communicate with their clients and more often provide mental health services through the online method. Recently, more clinicians operate their entire practice via the Internet. The provision of professional counseling via the Internet includes benefits such as greater accessibility for under-served populations that would not seek face-to-face counseling and feelings of less vulnerability due to perceived anonymity (Leibert, Archer, Munson, & York, 2004; Young, 2006), convenience, and counselor credentials such as academic background (Young, 2006). A study by Luxton et al. (2016) investigated in a randomized controlled trial the effectiveness, safety, and feasibility of eight sessions of behavioral activation treatment for depression (BATD) via videoconferencing (VC) at the clients' homes and in a traditional face-to-face setting. The researchers assessed veterans' baseline, mid of the treatment (4 weeks), post treatment (8 weeks), and post treatment after 3 months. The findings showed similar reductions in depressive symptoms and hopelessness in both groups but there was a slight benefit of face-to-face counseling compared to telehealth. The researchers did not find differences related to treatment satisfaction between the two groups. A study by Rochlen, Land, and Wong (2004) investigated in one hundred ninety-one male participants perceptions of online versus face-to-face counseling. The researchers

provided cognition- or emotion-based counseling approaches via online counseling and face-to-face counseling. They found significant improvements in attitudes toward online counseling across the entire sample but in particular in male participants reviewing online counseling essays.

However, there were also some concerns related to reduced visual cues, the inability to intervene in a crisis, and lack of therapeutic control (Leibert et al., 2006). Researcher of a study with randomly paired students and two groups investigated the difference between a conversation either face-to-face or an Internet chat program. The researchers measured the following four concepts: emotional understanding, self-disclosure, closeness, and depth of processing. The results showed that the face-to-face group reported higher levels of satisfaction with the experience, higher degree of closeness and self-disclosure with their conversation partner. The face-to-face group participants also reported higher levels of positive and negative affect but there were no significant differences between the two groups in regard to the level of emotional understanding of their partner. Also, there was no significant difference found between face-to-face group and Internet chat group in levels of depth processing. In addition, The face-to-face groups also showed lower levels of conflict. The authors concluded that professional counselors should be aware that it may take more time to build a positive working alliance when using chat communication via the Internet instead of meeting in person (Mallen, Day, & Green, 2003). In addition, professionals expressed caution regarding ethical issues of online counseling, including informed consent, confidentiality, and security (Maheu & Gordon, 2000; Lindinger-Sternart & Piazza, 2015).

A major key element of successful professional counseling is the working alliance between the clinical mental health counselor and the client. Previous research showed the provision of professional counseling via the Internet offers an equal opportunity to build a strong therapeutic relationship with the client compared to face-to-face counseling (Murphy, Parnass, Mitchell, Hallett, Caylet, & Seagram, 2009). A study with inmates' perceptions of the working alliance, post-session mood, and satisfaction with mental health services through tele mental health and face-to-face delivery. The results did not find any significant differences in overall satisfaction, perceptions of the work alliance, and post-session moods (Morgan, Patrick, & Magaletta, 2008). A study by Hanley (2009) found strong therapeutic relationships in young persons who were using online counseling. Some studies have found that counseling via the Internet helps clients to admit and disclose their problems and depth of working alliances were perceived more positive with online counseling compared to face-to-face counseling (Kiropoulos et al., 2008; Leibert et al., 2006).

There is some research about the effectiveness of counseling via the Internet related to mental health issues. A study by Gainsbury and Blaszezynski (2011) concluded that online counseling is an effective way for clients who struggle with addiction as it increases the treatment acceptance and maintenance in clients characterized with reduced help-seeking behavior (Cunningham, 2007). Skov-Ettrup, Dalum, Bech, & Tolstrup (2016) designed a randomized controlled trial with participants to compare the effectiveness of various counseling services. They four conditions were (1) proactive telephone counseling, (2) reactive telephone counseling and (3) an internet- and text-message-based intervention, and (4) a self-help booklet that was the control group for smoking cessation. The results showed at a 12-months follow-up a higher prolonged abstinence of smoking in the proactive telephone counseling group compared with the booklet group. There was no clear evidence of differences in prolonged abstinence between the reactive telephone counseling group and the internet- and text-message-based intervention with the control group who received only the self-help booklet. A meta-analysis about psychotherapeutic interventions via the Internet showed an average effect size of 0.53 and revealed that synchronously and asynchronously delivered online counseling did not differ significantly. However, chat-based counseling was statistically superior to video-conferencing (Barak, Hen, Boniel-Nissim, & Shapiro, 2008).

Some studies found evidence of the effectiveness of online counseling for specific mental health issues such as depression (Barth et al., 2013; Cowpertwait & Clarke, 2013), social anxiety (Boettcher, Berger, & Renneberg, 2012), and eating disorders (Mitchell et al., 2008). Mitchell et al. (2008) employed video-conference counseling to provide 20 sessions of cognitive-behavioral therapy (CBT) over a 16-week period to treat bulimia nervosa in a sample of 128 diagnosed clients. Participants were randomly assigned to face-to-face or online counseling. The results showed similar retention scores in both group but abstinence rates were higher for clients who received online counseling. The authors concluded that counseling via the Internet was acceptable to the majority of clients and generally equivalent in outcome compared to face-to-face treatment (Mitchell et al., 2008). A meta-analytic review by Spek et al. (2007) concluded that the effectiveness of counseling via the Internet showed a moderate effect size for depression and a large effect size for the treatment of anxiety.

The increased convenience of accessing professional counseling via the Internet provides for clients the opportunity to explore counseling options with reduced feelings of shame or weakness. In addition, the delivery of clinical mental health counseling via the Internet is cost-effective and does not require mobility or build a barrier because of geographical distance. The past studies have shown that both face-to-face

and online counseling do not differ significantly in their effectiveness to develop a strong and positive working alliance between the professional counselor and the client. It can be concluded that counseling services via the Internet are as effective and successful as face-to-face counseling (Barak et al., 2008).

The research questions explored in the study were:

Do individuals differ in their attitudes toward types of provided professional counseling according to cultural backgrounds?

Do individuals differ in their attitudes toward types of provided professional counseling according to their gender?

Do individuals differ in their attitude toward the provision of professional counseling according to their conformity to masculine/feminine norms?

Do individuals differ in their attitudes toward types of provided professional counseling according to their major of study?

Do individuals differ in their attitudes toward types of provided professional counseling according to their estimated problems?

Do individuals differ in their attitude toward the provision of professional counseling according to their personality characteristics extroversion versus introversion?

METHOD

Participants and Data Collection:

The data is collected through an anonymous online survey using Qualtrics. The data primarily is comprised of participants from United States, India, several African and European countries. There were 12 demographic questions without identifier and 130 survey questions. Participants had to be 18 years to be included in the study. The survey questions are in four levels (Strongly Disagree (0) - Disagree (1) - Agree (2) - Strongly Agree (3)). From 150 participants, only 121 (81%) responded to the survey, but 36 people could not complete the survey. The final size of participants (57%) included 61 males and 24 males. Their age ranged from 18 to 53 years. After summarizing data, this project mainly analyzes the relationship among 3 types of professional counseling scores (Chat-based, video-based, and face-to-face), and three explanatory variables of interest (1) demographics with nine areas, (2) conformity to masculine norms with nine areas using the CMNI-46, and (3) extroversion with six scales, with each having ten subscales utilizing friendliness, gregariousness, assertiveness, activity level, excitement-seeking, and cheerfulness that had only eight subscales.

Variables of the Present Study:

Response Variables:

The authors used three response variables (CBFF, VBFF, and CBVB). The difference between the scores for the chat-based counseling preference (CB) and for the face-to-face counseling preference (FF) was described as CBFF. VBFF described the difference between the scores

for the video-based counseling preference (VB) and for the face-to-face counseling preference. The third response variable CBVB defined the difference between the scores for the chat-based counseling preference and for the video-based counseling preference.

Explanatory Variables:

The author used three categories (demographic data, masculine norms, and extraversion) of explanatory variables for this study. First, the demographic data consisted of nine nominal scales. These scales were age, gender, country of birth, country of residence, ethnicity, race, education level, professional status, and major of study. Second, the explanatory variable of conformity to masculine norms consisted of the following nine scales: Winning, emotional control, risk-taking, violence, power over women, playboy, self-reliance, primacy of work, and heterosexual self-presentation. The explanatory variable of extraversion included six scales. The following five scales had ten subscales: Friendliness, gregariousness, assertiveness, activity level, excitement-seeking, and cheerfulness had eight subscales.

Measurements:

Demographic Data: The demographic data assessed the following nine nominal scales: (1) age, (2) gender, (3) country of birth, (4) country of residence, (5) ethnicity, (6) race, (7) educational level, (8) professional status, (9) major of study.

Conformity to Masculine Norms: The researchers used the Conformity to Masculine Norms Inventory-46 (CMNI-46) (Parent & Moradi, 2009), which is a brief form of the Conformity to Masculine Norms Inventory (CMNI; Mahalik, Locke, Diemer, Ludlow, Scott, Gottfried, & Freitas, 2003). The utilized CMNI-46 measures conformity to masculine norms and questions are answered on a 4-point Likert-type scale. The order of the 46 questions is coherent with the item order of the CMNI and the items reflect Winning, Emotional Control, Risk-Taking, Violence, Power over Women, Playboy, Self-Reliance, Primacy of Work, and Heterosexual Self-Presentation.

Personality Factors Extraversion/Introversion. The researchers used questions to assess participants' Personality Factors – Extroversion/Introversion from the International Personality Item Pool (IPIP). The full IPIP is in the public domain and contains of more than 3,320 items assembled by Dr. Goldberg (the URL for accessing it is http://ipip.ori.org/). The items of IPIP could be freely downloaded and the researchers used questions of the IPIP-NEO Representation of the NEO PI-R®. The IPIP-NEO is not equivalent to the commercial inventory for measuring traits within the Five Factor Model of personality on which it is based, the NEO PI-R®, developed by Paul T. Costa, Jr. and Robert McCrae. The scoring and narrative report routines for the items of the IPIP-NEO were developed by Dr. John A. Johnson, Professor of Psychology, Penn State University. The original IPIP-NEO

inventory consists of 300 items and takes usually 40 minutes to complete. The authors of this study used six scales to assess the Personality Factors of extraversion/introversion (58 items). The scales friendliness, gregariousness, assertiveness, activity level, and excitement-seeking have ten subscales, whereas cheerfulness has eight subscales. The instruction about measuring the used domains was provided by the website (Srivastava, S. ([2020]).

The website http://ipip.ori.org/newBigFive5broadKey.htm provided a comparison between the five broad domains in Costa and McCrae's Neo Personality Inventory (NEO-PI-R) and the corresponding Preliminary IPIP-NEO Scales measuring similar constructs.

The Cronbach's alpha (or coefficient alpha) measures of internal consistency related to a set of items as a group were good for the IPIP-NEO scales as they showed higher scores than the NEO-PI-R. The coefficient alpha of the IPIP-NEO scale Friendliness showed internal consistency (α = .71 similar to NEO-PI-R Warmth (α = .72). The IPIP-NEO scale Gregariousness had a higher coefficient alpha (α = .78) compared to NEO-PI-R (α =.64). The coefficient alpha of the IPIP-NEO scale Assertiveness showed high internal consistency (α = .83) similar to NEO-PI-R Warmth (α = .82). The IPIP-NEO scale Activity level showed the same high coefficient alpha (α = .78) as the NEO-PI-R (α =.84). The IPIP-NEO scale Excitement-seeking showed a higher coefficient alpha (α = .81) compared to NEO-PI-R (α =.75). The IPIP-NEO scale Cheerfulness showed also a higher coefficient alpha (α = .86) compared to NEO-PI-R Positive Emotions (α =.78).

The convergent validity of the IPIP-NEO using Spearman rank correlation co-efficient (rho) showed also strengths but were for most scales lower compared to the NEO-PI-R. The correlation co-efficient of the IPIP-NEO scale Friendliness was good (rho =.76) but lower compared to NEO-PI-R Warmth (rho =.91). The correlation co-efficient of the IPIP-NEO scale Gregariousness showed good scores (rho =.78) but was lower compared to NEO-PI-R (rho =.98). The correlation co-efficient of the IPIP-NEO scale Assertiveness showed moderate scores (rho =.70) compared to NEO-PI-R (rho =.98). The correlation co-efficient of the IPIP-NEO scale Activity level showed also moderate scores (rho =.67) compared to NEO-PI-R (rho =.95). The correlation co-efficient of the IPIP-NEO scale Excitement-seeking reflected good scores (rho =.77) compared to NEO-PI-R (rho =.95). The correlation co-efficient of the IPIP-NEO scale Cheerfulness reflected good scores (rho =.74) but were also lower than the scale NEO-PI-R Positive Emotions (rho =.90).

Data Analysis:

The aim of this project is to study whether people prefer specific type of professional counseling, especially for males. Thus, the sum of the scores of the 8 questions for each type of professional counseling is taken to

represent the preference of such type of counseling. It is certainly plausible to use the total score as a measure for the preference of a certain type of counseling, but by taking paired difference between two types of counseling, it is possible to reduce the variation from one participant to another participant. CBFF, VBFF, and CBVB denote the difference between CB and FF, VB and FF, and CB and VB, respectively. These values mean how much they prefer one type of counseling over another type of counseling.

To check the statistical significance of demographic factors, conformity to masculine norm, and extroverted personality in the preference of the types of professional counseling, the general linear model is chosen. Each factor is taken as the sole explanatory variable to see its isolated effect, and the paired difference variables of CBFF, VBFF, and CBVB are taken as the response variables. Thus, for each factor, three models are developed. If the p-value of the model is less than alpha level of 0.05, it can be concluded that the factor is statistically significant in preference of one counseling type to another counseling type.

The analysis is done on the whole data and two subsets of data: on males only and for females only. To check the statistical significance of a factor for each response variable, the p-value of the model in ANOVA is checked. If the p-value is less than 0.05, then it can be concluded that statistical significance is found. If the explanatory variable is nominal, then the mean of each explanatory group is reported, and the interpretation will be that the mean of each group is significantly different from the mean of another group. If the explanatory variable is scale, then the intercept and the slope are reported, and the interpretation would depend on the sign of the intercept and the slope.

The authors used three categories (demographic data, masculine norms, and extraversion) of explanatory variables for this study. First, the demographic data consisted of nine nominal scales. These scales were age, gender, country of birth, country of residence, ethnicity, race, education level, professional status, and major. Second, the explanatory variable of conformity to masculine norms consisted of the following nine scales: Winning, emotional control, risk-taking, violence, power over women, playboy, self-reliance, primacy of work, and heterosexual self-presentation. The explanatory variable of extraversion included six scales: Friendliness, gregariousness, assertiveness, activity level, excitement-seeking, and cheerfulness.

•Demographic data (9 areas) Gender, Country of Birth, Major, etc.

•Masculine norms (9 areas) Emotional Control, Risk-Taking, Violence, etc.

•Extraversion (6 areas) Excitement-Seeking, Cheerfulness, etc.

For overall data, all explanatory variables are checked for each response variable. There are in total 24 explanatory variables, and 3 response variables, and therefore 24×3 = 72 models are checked. Among 72

models, 5 models are found to be significant: CBFF vs ethnicity, CBVB vs ethnicity, CBVB vs Self-Reliance, CBVB vs Primacy of Work, and CBFF vs Assertiveness.

Table 1:*P-value of the model and the coefficient of the explanatory variable for overall data*

Model	CBFF vs Ethnicity	CBVB vs Ethnicity	CBVB vs Self-Reliance	CBVB vs Primacy of Work	CBFF vs Assertiveness
P-value	0.001	0.034	0.000	0.017	0.016
Mean or Coefficient	1 = -6.667 2 = -1.769	1 = -3.333 2 = 0.756	int = -2.511 slope = 2.257	int = 2.688 slope = -1.606	int = 4.661 slope = -0.351

For chat-based counseling Ethnicity, was a significant predictor. It can be concluded that the average of the preference of chat-based counseling over face-to-face counseling of Hispanic or Latinos is different from that of non-Hispanic/Latinos. On average, Hispanic or Latinos prefer face-to-face counseling over chat-based counseling more than non-Hispanic/Latinos.

For video-based counseling similar conclusion can be drawn. The average preference of chat-based counseling over video-based counseling of Hispanic or Latinos is different from that of non Hispanic/Latinos, and on average, Hispanic or Latinos prefer video-based counseling over chat based counseling while non-Hispanic/Latinos prefer chat-based over video-based.

For Self-Reliance, since the intercept is -2.511 and the slope is 2.257, it can be concluded that when a person scores 0 in self-reliance, then the person would prefer video-based more than chat-based counseling, but as a person is more self-reliant, then he/she more prefers chat-based counseling over video-based counseling.

For Primacy of Work, since the intercept is 2.688 and the slope is -1.606, it can be said that if a person scores 0 in primacy of work, then he/she prefers chat-based to video-based counseling, but as the person prioritizes work, then he/she would become preferring video-based to chat-based counseling.

For Assertiveness, as the intercept is 4.661 and the slope is -0.351, it seems that people generally prefer chat-based to face-to-face counseling, but as a person is more assertive, his/her preference becomes less strong.

Since the focus of the study is more on the males, the analysis on the male subset is also done. Excluding sex from the explanatory variable, 23 explanatory variables are left. Among 23×3 = 69 models checked, only four models are found to be significant as shown in Table 2.

Table 2: *P-value of the model and the coefficient of the explanatory variable for males only*

Model	CBVB vs Ethnicity	VBFF vs Violence	CBVB vs Self-Reliance	CBFF vs Assertiveness
P-value	.079	0.049	0.009	0.023
Coefficient	1 = -3.5 2 = 0.632	int = -7.038 slope = 2.203	int = -2.403 slope = 2.076	int = 5.277 slope = -0.373

For CBVB vs Ethnicity, the average for group 1 is -3.5 and the average for group 2 is 0.632, and this difference between two group means shows significance. Thus it can be concluded that Hispanic or Latinos seem to prefer video-based counseling to chat-based counseling while non-Hispanic or non-Latinos prefer chat-based counseling to video-based counseling. The strength of preference is higher with Hispanic/Latino group since the absolute value of the mean is much bigger for group 1.

For VBFF vs Violence, as the intercept is -7.038 and the slope is 2.203, it can be said that when a man scores 0 for violence, then he will prefer face-to-face counseling over video-based counseling, but if a man scores more than 3.20 (=7.038/2.203) on average for the questions about violence, then he will prefer video-based counseling to face-to-face counseling.

For CBVB vs Self-Reliance, the result is very similar to the one for overall data. Since the intercept is -2.403 and the slope is 2.076, it can be said that when a man scores 0 in self-reliance, then he would prefer video-based more than chat-based counseling, but as a person is more self-reliant, then he more prefers chat-based counseling over video-based counseling.

For CBFF vs Assertiveness too, the conclusion is similar to the one on the overall data. As the intercept is 5.277 and slope is -0.373, it can be concluded that in general men prefer chat-based counseling to face-to-face counseling, but as a man is more assertive, the preference becomes less strong.

Although the focus is on the males, the models for females are also checked to see if there is any difference between the results for males and the results for females. Since there are only 24 females, and since there is not much of diversity, meaning that most of them are in one group (for example, 23 of them live in United States, and just one of them lives in 'other' country), the results of the tests may not be valid. Therefore, it would be best to consider this section as just getting a general idea about the significance for females. Again, 25×3 = 75 models are checked, and as shown in Table 3, 6 of them are found to be significant. Overall, the model CBVB vs Self-Reliance looks similar to the model for the males,

Table 3: *P-value of the model and the coefficient of the explanatory variable for females only*

Model	CBFF vs Ethnicity	VBFF vs Ethnicity	VBFF vs Major	CBVB vs Winning	CBVB vs Self-Reliance	CBVB vs Primacy of Work
P-value	.011	.002	.002	0.010	0.006	0.040
Coefficient	1 = -12.5 2 = -1.524	1 = -9.5 2 = -2.619	1 = -4.0 4 = -2.875 5 = -2.07 = -16.0 8 = -2.5	int = -2.970 slope = 2.690	int = -2.782 slope = 2.719	int = 3.887 slope = -2.334

and the CBFF vs Ethnicity model and the CBVB vs Primacy of Work model are similar to the ones in overall data. However, three models (VBFF vs Ethnicity, VBFF vs Major, and CBVB vs. Winning) are new.

DISCUSSION

One of the strongest arguments in favor of introducing video-conferencing counseling is that many clients have a stigma to seek help for mental health problems. Research shows that there are increasing numbers of individuals who are interested in receiving distance professional services such as video-conferencing counseling and that there is a link between the increased anonymity and less fear of stigma when seeking mental health service through the internet (Young, 2005). If individuals are worried about stigma and particularly men who follow their masculine norms, the provision of more anonymous video-conferencing counseling would be a beneficial way to serve this population. Research also shows that men from various backgrounds prefer help-seeking from Internet platforms (Chang, Chang, & Zhang, 2004) to face-to-face counseling service. For example, in the Latino culture, the concept of machismo is linked with negative attitudes towards seeking out help, especially surrounding mental health issues (Ballesteros, J.L. & Hilliard, R.C.2016), so they may be more likely to utilize the online environment to receive counseling. When examining how to address the ever-increasing mental health needs of students, it is important to provide opportunities for students to learn about what online counseling is and that is an available service. With knowledge about students' attitudes surrounding stigma, particularly self-stigma, it is necessary to promote and educate about online counseling, as a viable option.

The authors of this study used three response variables that described the differences between the scores for the preferences of counseling formats

(CBFF, VBFF, and CBVB). In addition, the researchers used three categories (demographic data, masculine norms, and extraversion) of explanatory variables for this study. All explanatory variables were checked for each response variable that summed up to total 24 explanatory variables, and 3 response variables, and therefore, 24x3 = 72 models were examined. The researchers analyzed data among 72 models and 5 models were found to be significant: CBFF vs ethnicity, CBVB vs ethnicity, CBVB vs Self-Reliance, CBVB vs Primacy of Work, and CBFF vs Assertiveness.

The first research question "Do individuals differ in their attitudes toward types of provided professional counseling according to cultural backgrounds?" was supported as for chat-based counseling Ethnicity was a significant predictor. The results showed that the average of the preference of chat-based counseling over face-to-face counseling of Hispanic or Latinos is different from that of non-Hispanic/Latinos. On average, Hispanic or Latinos preference of face-to-face counseling over chat-based counseling was higher than in non-Hispanic/Latinos. This finding is consistent with the results of previous studies involving college students (Chang et al., 2011; Rochlen, 2004a) and a study by Ballesteros and Hilliard (2016) supports this result in Latino college students. There is lack of research about attitudes toward counseling formats, including chat-based and video-based counseling related to ethnicity. A qualitative study by Chavira et al. (2017) aimed to understand attitudes toward Cognitive Behavioral Therapy (CBT) and modes of service delivery to Latino youth with anxiety. They found that parents of Latino youth with anxiety expressed positive attitudes toward mental health counseling and preferred telephone-based approach over therapist supported bibliotherapy as the phone-based approach offered the opportunity to address their perceived barriers. This may indicate that clients prefer to interact with a professional counselor compared to designed online programs that a client could work through by him- or herself. Thus, both video-based and chat-based counseling can be valuable approaches to clients who are geographically distant or have limited mobility.

In the current study, the cultural background played also a role when comparing the preference of video-based to chat-based counseling. The findings in this study showed that Hispanic or Latinos preferred video-based counseling over chat-based counseling whereas non-Hispanic/Latinos preferred chat-based over video-based counseling. Ballesteros and Hilliard (2016) investigated the general attitude toward online counseling in 231Latino college students and found a significant preference of face-to-face counseling over online counseling and a significant but weak relationship with self-stigma. A study by Bathje et al. (2014) investigated the attitudes and barriers to seek professional counseling in Korean students and found that self-stigma has a negative

impact toward seeking face-to-face counseling services but not seeking online counseling services.

The second research question "Do individuals differ in their attitudes toward types of provided professional counseling according to their gender?" could not be confirmed. This finding is similar to a study by Ballesteros and Hilliard (2016) who found a preference toward face-to-face counseling in Latino college students but no significant difference of attitudes related to gender.

The research question "Do individuals differ in their attitude toward the provision of professional counseling according to their conformity to masculine/feminine norms?" was partially supported. The results showed that when the person would score 0 in Self-Reliance, then the person would prefer video-based counseling over chat-counseling, while if the person had higher scores of Self-Reliance, then s/he prefers chat-based counseling over video-based counseling. In contrast, when a participant scored 0 in Primacy of Work, the s/he preferred chat-based counseling over video-based counseling, while a person who prioritizes work showed preference to video-based counseling over chat-based counseling. There is lack of research about the attitudes among various online counseling deliveries. A study by Rochlen and Wong (2004) found a preference toward face-to-face counseling over online counseling in men with low levels of restrictive emotionality compared to high levels of emotionality.

There were no significant results to the research questions "Do individuals differ in their attitudes toward types of provided professional counseling according to their major of study?" and "Do individuals differ in their attitudes toward types of provided professional counseling according to their estimated problems?".

The research question "Do individuals differ in their attitude toward the provision of professional counseling according to their personality characteristics extroversion versus introversion?" was slightly confirmed with the construct of assertiveness that showed a significance in general preference of chat-based counseling over face-to-face counseling, however, as the person is more assertive, the preference is lower.

Online counseling offers higher education a different strategy to reach students especially those who need, but who do have not access, mental health services because of the stigma associated with it (Kitzrow, 2003). The service of online counseling can be adapted to meet the needs of students in higher education, this may involve creating a hybrid type of program, meeting first online and then offering the option of in person. Sampson, Kolodinsky, and Greeno (1997) have proposed that some people may feel more at ease seeking in person counseling after the opening online connection. This helps to make the first contact and they get more of a sense of what professional counseling is. The online environment may be more favorable to college students because of the

disinhibition effect, allowing them the space to reveal intimate details to a therapist without feeling ashamed (Cook & Doyle, 2002). Men are less likely than women to appreciate face-to-face counseling and may be more open to seek services where there is an extra layer of identity protection, having been socialized in a different way than women surrounding the social norms about discussing feelings.

This is important to help college counseling services engage their students using technology and giving access to students who will not seek out traditional counseling. It would be advantageous for colleges to address the mental health of their students so that they can be more fully engaged in the learning process.

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Vedic view of personality

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Indian psychology is an approach to psychology based on the Indian ethos. In the Ayurvedic System of Medicine, the type of personality has been determined from two angles- Physiological and Psychological, as body and mind are very close to each other. To understand personality, they focus on Gunas and Doshas.

Key words: *Vedic view, personality*

INTRODUCTION

The concept of Guna dates back to Atharva Veda, it was discussed in Bhagawat Gita and later included in Sankhya Darsana. Sankhya is a dualistic philosophy, which postulates two interdependent, simultaneously existing realities purusha (consciousness) and prakriti (nature or matter). Apart from the purusha, which forms the inner core of the personality, everything in the universe, physical and psychological, including the mind, are regarded as originated from prakriti, which is constituted of three gunas /Triguna viz. sattva, rajas and tamas. Based on the above gunas personalities are categorized into three viz. sattvic, rajasic and tamasic types. In Ayurvedic text personality is described as 16 types, 7 sattva, 6 rajas and 3 tamas, which are majorly trait characteristics.

According to Ayurveda Prakriti (personality) expresses itself as an individual manifestation of the three Doshas/ Tridosha (Bio-energies or life forces)- Vata, Pitta and Kapha. the particular ratio of vata, pitta, and kapha within each of us provides us with a blueprint for optimal health, and garners a significant influence on our individual physical, mental, and emotional character traits—as well as our unique strengths and vulnerabilities. So while we are all made up of the same five elements: earth, fire, air, water, and space, we are each entirely unique, due to the concentration of the energies (doshas) we are made up of. Doshas are the energies that construct our physical body and determine the conditions of growth, aging, health and disease. The combination of these three doshas can create seven kinds of personality types.

The ancient Indian model of 'Personality', given in the Tattiriya Upanishads, consists of the 'five' sheaths/ layers around the human soul. These 5 layers are also considered the five sheaths of human's personality. They are 'Annamaya' (food sheath), 'Pranamaya' (vital air sheath), 'Manomaya' (mental sheath), 'Vijnanamaya' (intellectual sheath), and 'Anandamaya' (bliss sheath). This Pancha Koshas theory is the Vedantic psycho- philosophical view of human personality and similar to the trait perspective of personality where each Kosha exhibits certain characteristics. These five koshas are located one inside the other with the sheath of the physical body being the outermost and the sheath

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of bliss being the innermost. Further, these five layers lie down in three bodies (sharira trya) viz Gross, Subtle and Causal body. The Pancha Kosha can be thought of as hiding one's true nature. Once they are removed, they leave a void, which also needs to be removed to reveal Atman and connect with divine.

The study of the psyche has long been a major aspect of Western Psychology, and individual differences in thinking, feeling and behaving have fascinated psychologists, who have come up with various personality types. However, these personality types don't seem to be so universally applicable. So we need to look to a more ancient Indian system to explain personality.

Indian psychology is an approach to psychology based on the Indian ethos, the characteristic spirit of the Indian civilization. One could also say that it is a psychology rooted in Indian philosophy, yoga and their life-affirming spirituality. It is about 5000 years old discipline and is developing day by day.

In the Ayurvedic System of Medicine, the type of personality has been determined from two angles- Physiological and Psychological, as body and mind are very close to each other. Brain, nervous system and hormonal secretion from different glands influence person's mental makeup. The ancient Indian medical men observed person's temperament, personality traits and personality construct on both physiological and psychological bases.

The sages of India, many centuries ago (more than five thousand years), taught the practice of Ayurveda, a health and healing system that treats the mind, body, senses and spirit. Ayurveda is about finding balance; it is a practice that allows us to recognize subtle energies, or doshas, that make each one of us unique. In Ayurvedic wisdom, personality types are also discussed, but unlike Psychology – which is largely based on behavior – their understanding comes from two important aspects, Guna and Doshas.

Triguna and Personality Psychology:

The concept of Guna dates back to Atharva Veda, it was discussed in Bhagawat Gita and later included in Sankhya Darsana. Sankhya is a dualistic philosophy, which postulates two interdependent, simultaneously existing realities purusha (consciousness) and prakriti (nature or matter). Apart from the purusha, which forms the inner core of the personality, everything in the universe, physical and psychological, including the mind, are regarded as originated from prakriti, which is constituted of three gunas viz. sattva, rajas and tamas.

According to Ayurveda, nature (prakriti) consists of three primal qualities, which are the main powers of cosmic intelligence that determine our spiritual growth. These are called gunas in Sanskrit.

The theoretical expositions on triguna and their manifestations in human nature have attracted the attention of Indian psychologists. The concept

has been examined theoretically (Misra et al.,2000; Pannaga and Kumar,2008; Rao.1971; Singh and Sirswal, 2008; Srivastava,2012) and empirically (Das,1987,1991; Kapur et al., 1997 ; Sebastian & Mathew,2002 ; Wolf, 1998 etc.).

The concept of Triguna has been utilized to explain the concept of personality in modern era as well. Indian researchers have also deliberated on this concept of Triguna in their writings (Das, 1991; Sebastian & Mathew,2001; Kapur et a,l 1997; Paranjpe, 2004; Srivastava, 2012). The development of consciousness is apparently rooted in this concept of Triguna. These are known as Sattva, called as stability; Rajas, called as activation and Tamas, called as inertia. Manas has been ascribed as the mental functions and mental processes (Mnaovritti, manopravritti). They are considered to be manifestations of Triguna .

Bhagawad Gita, at different places gives the models of highly developed human potential in its totality. It also describes three gunas and says that we all are combinations of these gunas (characteristics) which are Sattva, Rajas, and Tamas. Following are explanations given about the three attributes of human personality. These three gunas lead to different kinds of temperament and are primarily influenced by both physiological and psychological parameters.

The Sattvic Guna:

Sattva guna is the 'spiritual quality'. It is the element of prakriti which is of the nature of pleasure, and is buoyant of light (laghu), and bright or illuminating (prakasha). The basic attributes of Sattva are purity, compassion, love, clarity, harmony, understanding and essential goodness. Pleasure in its various forms, such as satisfaction, joy, happiness, bliss, contentment, etc. is produced by things in our minds through the operation of the power of sattva inhering in them both. When Sattva guna is dominant, a person has inherent desire to be good and caring. There is a resolute constancy of mind and senses. When sattva is prevalent, the light of wisdom shines through the individual. Sattvic intellect clearly understands the difference between desirable and undesirable, undutiful and dutiful action. When sattva is dominant a person does his work as a duty. An action is done with calm understanding and the person is free from doubts. Sattva dominant person pays homage to divine and spiritual values.

Strength, respect for Gurus, nonviolence, meditation, kindliness, silence, self-control, and purity of character are the motive force of sattvic action. One of the limitations of sattvic guna is that it binds a person through attachment to happiness and knowledge. The sattva guna also brings with it the problem of goodness.

The Rajsic Guna:

Rajas guna is the 'active quality'. Rajas is characterized by passion, action, confusion, extraversion, aggression, and sensuality. Rajas guna is

considered to give rise to passion and desire, it causes greed, activity, undertaking of works, restlessness, and desire. Rajas dominant person is full of attachment, full of longings for fruits of action. Due to dominance of self-interest, the intellect gives distorted picture of right and wrong. Renunciation and detachment are not fostered by Rajas dominant person. Enthusiasm, interest, and activity are some of the major attributes of this guna.

Rajas is the principle of activity in things. It always moves and makes other things move. It is of the nature of pain, and is mobile and stimulating. It helps the elements of sattva and tamas which are inactive and motionless in themselves, to perform their functions

The Tamsic Guna:

Tamas guna is the 'material quality'. Tamas is described as inertia, laziness, ignorance, heaviness and dullness. It arises from hopes and illusions. Tamas produces ambiguity, idleness, fantasy, and persistence. Tamas guna dominant people are cautious, apprehensive, and revengeful. Tamasic guna also suggests disillusionment and cynicism. When Tamasic guna is dominant, a person derives happiness which originates and ends in self-delusion and miscomprehension. The positive manifestation of Tamas guna is willingness to work very hard. One of the limitations of these attributes are attachment to possessions and self-centered tendencies.

Tamas is the principle of passivity and negativity in things. It is opposed to sattva in being heavy (guru) and in obstructing the manifestation of objects. By obstructing the principle of activity in us it induces sleep, drowsiness, and laziness. It also produces the state of apathy or indifference (visada).

All three gunas are always present in all beings, and objects surrounding us, but vary in their relative amounts. The gunas show our mental and spiritual state through which we can measure our propensity for psychological problems.

We each have these three qualities of the mind in varying degrees and will have a predominant guna, which informs the way in which we see the world and also determines the type of person we will become. The psychological qualities of our mind are unstable, so this means we will switch between the different gunas with every different situation we find ourselves in .These gunas act together and never exist in isolation. They interact and compete with each other resulting in the preponderance of one over the others. The degree of predominance of one guna determines the individual's personality type. Based on the above understanding, personalities are categorized into three viz. sattvic, rajasic and tamasic types (Rao,2003).

Sattva, rajas and tamas have been compared respectively to whiteness, redness, and darkness. In our Indian mythology the energy of Sarasvati is

Sattva (whiteness), Lakshmi is Rajas (redness), and Kali is Tamas (darkness).

These gunas describe our personality and body types. Each guna has a different quality, with an associated element, and each person has all three gunas, but in varying proportions

Elements	Gunas
Space	Sattva
Air	Rajas
Fire	Sattva & Rajas
Water	Sattva & Tamas
Earth	Tamas

Sattva and Rajas Interaction and Its Impact on Attributes:

This combination is considered to be the 'spiritually active quality'. When rajas is restrained and guided by sattva, people become ethical and noble in thought and action. Due to the influence of spiritually active quality, a person becomes self-assured and spiritual.

Rajas and Tamas Interaction and Its Impact on Attributes:

This combination is indicative of 'materially active quality'. When the active quality of rajas combines with material quality of tamas, it determines the ability to deal with people and events. It helps in building relationships and achieving objectives. This can also be called 'human relation' ability.

Triguna and its Dimensions:

Sattva-- Priti (Pleasure), Prakasha (Illumination)

Rajas—Apriti (Disagreement), Pravritti (Pleasure)

Tamas—Visada (Despair), Niyama (Restraint).

Personality Types Based On Triguna:

In Ayurvedic text personality is described as 16 types, 7 sattva, 6 rajas and 3 tamas, which are majorly trait characteristics.

Conclusion:

The findings of the study revealed that there is a positive relation between personality dimensions and psychological well-being of adolescents followed by a negative relationship between neuroticism and psychological well being, and a positive relationship between extraversion, agreeableness, and overall personalityon psychological well being of the research participants.

Implications:

Types of Sattvika personality are:

1.Brahma

Brahma Type are pure individuals and have freedom from passion and envy, they are loving to all creatures. They are highly learned people who honour knowledge, are respectful and loving, observe fasts and rituals. The individual with these characteristics are noted to be emotionally stable.

2. Arsa (Sharing the traits of Rishis)

The predominant characteristics are engaged in sacrifices, study, vow, and celibacy. The intelligence and imagination are defining characteristics of these people.

3. Aindra (Traits of Indra)

Happy go lucky individuals, brave, and outgoing are grouped under these categories. Incidentally this is an exception to the mention of company of women for the sake of pleasure especially in sattwik type of category.

They get respect as leaders and are loved by their followers.

4. Yamya (Sharing the traits of Yama)

The traits are characterized as readiness for action, freedom from attachment and similar to God of death. They follow their goals single mindly with courage, determination and fortitude. They are highly intelligent people who do not get swayed by others.

5. Varuna

Persons with these trait clusters are sober and conservative. They are clean and brave. They are gifted speakers who are deeply spiritual and maintain their composure at all times.

6. Kuvera

The Kuvera is a God of wealth, hence the persons with these traits possess luxuries and have liking for pleasure and recreation.

7. Gandharva

Fondness for dancing singing and music are the predominant traits of people. These people are practiced in arts of seduction, are of great beauty, dress sharply and enjoy sensual pleasure.

Types of Rajasik personality are:

1. Asura

Such persons are deceitful, violent, shrewd, assertive and tough minded. They come across as cruel taskmasters and are courageous in the pursuit of their goals.

2. Raksasa

Intolerance, overeating, and indulging in sleep are defining characteristics. they are obsessed with sex.

3. Paisacha

The characteristic traits of these types are fondness for women, gluttonous habits, and cowardice disposition. They do not maintain personal hygiene and are emboldened when no one is around them to check them.

4. Sarpa

Sharp reaction and bravery in wrath terrorizing are some of the defining traits. This type of personality alternates between timidity and violence.

5. Praita

They have excessive desire for food and have greediness. The undisciplined traits are also present. They are gluttous, and hate working with others. They gossip to harm and to take attention away from their faults.

6. Sakuni

Group dependent, tense, and attachment with passion are noted in these types of individuals. Persons of this personality are clever opportunist, enjoy food, make fun when attached to family or group but are coward when alone.

Types of Tamasik personality are :

1.Pasava

They share the traits of animal; they are less intelligent, may not follow human rules of propriety, may have deviant qualities, They sleep more and indulge in sex excessively.

2.Matsya

The instability is the hallmark of this trait cluster. They are passionate and have wrathful disposition. They like continuous change, are prone to eat and sleep a lot. They can not be depended on.

3. Vanaspatya

This type of personality is a harmless fool, who enjoys simple pleasures and stays with a group.

The gunas are in the state of both conflict and co-operation with one another. They always go together and can never be separated from one another. Nor can any one of them produce anything without the help of other two. The nature of things is determined by the predominant guna, while the others are there in a subordinate position. The classification of objects/persons into good, bad and indifferent, or into pure, impure and neutral, or into intelligent, active and indolent, has reference to the preponderance of sattva, rajas and tamas respectively. In the words of Aurobindo (1980), "All men have in them in whatever degree the rajasic impulse of desire and activity and the sattvic boon of light and happiness, some balance, some adjustment of mind to itself and its surroundings and objects, and all have their share of tamasic incapacity and ignorance".

Evolution and transformation of gunas take the person from darkness to awareness (of objects, others, and self) which is the crux of the efforts to bring positive changes in one's behavior (Rastogi, 2004).

Trigunas (the three qualities) have profound role in the determining the behavioural characteristics of a person and thus they are most effective in framing of personality and in making of variant personality pattern. When three gunas are balanced the personality is balanced but if there is disturbance in any of the three gunas, the personality gets disturbed. . "It is the Sattva Guna that is responsible for

preparing mind to produce positive thought waves. Sattva guna tries to bring a balance between the rajasic and tamasic gunas (Rao, 2003).

Tri Doshas and Personality Psychology

Ayurveda, the ancient Indian medical wisdom, describes personality as 'prakriti' a sanskrit word that means nature or natural form of constitution of an individual. According to ayurveda the entire cosmos is an inter play of five great elements- earth, water, fire, space (ether), and air. Prakriti (personality) expresses itself as an individual manifestation of the three Doshas (Bio-energies or life forces)- Vata, Pitta and Kapha. These principal energies referred to as doshas govern the entire cosmos. Doshas along with five great elements are present in every single living and non-living being, but in different proportions. They create different climate, foods, races, and even different individuals in a race. In fact, the particular ratio of vata, pitta, and kapha within each of us provides us with a blueprint for optimal health, and garners a significant influence on our individual physical, mental, and emotional character traits—as well as our unique strengths and vulnerabilities. So while we are all made up of the same five elements: earth, fire, air, water, and space, we are each entirely unique, due to the concentration of the energies (doshas) we are made up of. Doshas are the energies that construct our physical body and determine the conditions of growth, aging, health and disease.

Vata, pitta, and kapha are each essential to our physiology in some way, so no one dosha is better than, or superior to, any other. Each of them has a very specific set of functional roles to play in the body. These doshas describe our personality and body types. Each dosha has a different quality, with an associated element, and each person has all three doshas, but in varying proportions.

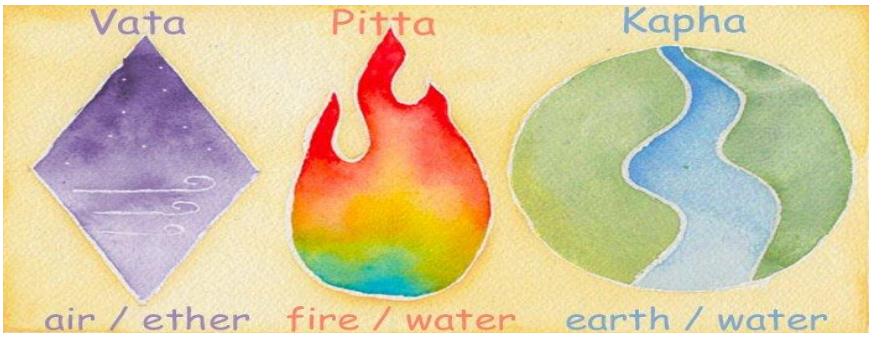
The Vata Dosha is made up of space and air, the elements that are associated with motion. Vata is the energy of movement. Vata governs blood circulation, breathing, our heartbeat, the movement of our thoughts from one direction to another; along with the movement of fluids in the body. Because pitta and kapha can not move without vata, it is considered leader of these doshas.

The Pitta Dosha is composed mainly of fire, with some water, and is transformative. It is neither kinetic nor static, but spreads. As fire makes its surrounding hot, and water on any surface spreads, so the pitta does. It makes up the digestive fire in our bodies, transforming food into nutrients. It is related with intelligence, understanding, thoughts and emotions.

Kapha is the combination of earth and water elements. It is binding energy. It is sticky, oily and heavy and keeps things together. Kapha keeps our cells together and our body in a shape. Kapha is responsible for solidity and all structures as well as for the right amount of body fluids. It is the energy of love and affection. It moisturizes each cell,

system and skin, keeps fluidity in joints, increases immunity and protects tissues.

Doshas	Elements
Vata	Space/Ether + Air
Pitta	Fire + Water
Kapha	Earth + Water



Types of Vata Dosha:

Five types of vata dosha are:

1.Prana Vata - Governs inhalation, perception through the senses and governs the mind. Located in the brain, head, throat, heart and respiratory organs.

2.Udana Vata - Governs speech, self-expression, effort, enthusiasm, strength and vitality. Located in the navel, lungs and throat.

3.Samana Vata - Governs peristaltic movement of the digestive system. Located in the stomach and small intestines.

4.Apana Vata - Governs all downward impulses (urination, elimination, menstruation, sexual discharges etc.). Located between the navel and the anus.

5.Vyana Vata - Governs circulation, heart rhythm, locomotion. Centered in the heart and permeates through the whole body.

Types of Pitta Dosha:

There are five types of pitta dosh as described below:

1.Pachaka Pitta - Governs digestion of food which is broken down into nutrients and waste. Located in the lower stomach and small intestine.

2.Ranjaka Pitta - Governs formation of red blood cells. Gives colour to blood and stools. Located in the liver, gallbladder and spleen.

3.Alochaka Pitta - Governs visual perception. Located in the eyes.

4.Sadhaka Pitta - Governs emotions such as contentment, memory,

intelligence and digestion of thoughts. Located in the heart.

5.Bharajaka Pitta - Governs lustre and complexion, temperature and pigmentation of the skin. Located in the skin.

Types of Kapha Dosha:

Five types of kapha dosha are:

1.Kledaka Kapha - Governs moistening and liquefying of the food in the initial stages of digestion. Located in the upper part of the stomach.

2. Avalambhaka Kapha - Governs lubrication of the heart and lungs. Provides strength to the back, chest and heart. Located in the chest, heart and lungs.

3.Tarpaka Kapha - Governs calmness, happiness and stability. Nourishment of sense and motor organs. Located in the head, sinuses and cerebra-spinal fluid.

4.Bodhaka Kapha - Governs perception of taste, lubricating and moistening of food. Located in the tongue, mouth and throat

5.Shleshaka Kapha - Governs lubrication of all joints. Located in the joints.

At the roots of vata, pitta and kapha are its subtle counterparts called prana, tejas and ojas. Unlike the doshas, which in excess create diseases, these promote health, creativity and well-being.

• Prana is our life force and is the healing energy of vata (air)

• Tejas is our inner radiance and is the healing energy of pitta (fire)

• Ojas is the ultimate energy reserve of the body derived from kapha (water)

The specific proportion of these three doshas represents a blueprint of an individual's constitution and optimal health, and has significant impact on physical, mental, emotional traits and our specific strengths and weaknesses. Prakriti, the basic construct of a person is determined at the time of conception by the dominance of tridoshas. These tridoshas govern all the functions of body at physiological, mental and behavioural level. Thus prakriti consists of a person's physiological, psychological and behavioural traits.

All three doshas remain present in every person, and express unique blends of physical, emotional, and mental characteristics. Which one of them is dominant determines the type of personality. Generally people have two doshas dominant and the third subordinate, they are called Dwidoshic personality. When all three doshas remain in equal proportion, the personality is Tridoshic. The combination of these three doshas can create seven kinds of personality types.

1.Vata Prakriti:

Individuals with vata prakriti represent the characteristics of air and space. They are quick, vibrant, dynamic, creative and airy. They are energetic, vivacious, joyful, friendly, open minded, free in spirit, embrace change and learn easily, are clear and alert, sleep long but light, have balanced digestion and an even body temperature. Sometimes they have problems with their digestion. They are dry, light, cold, rough and subtle. Their teeth are generally irregular, have dry thin hair with less shine, rough skin, small eyes, and sound making joints. They have a taste for adventure, enthusiasm, and show physical and mental hyperactivity. On the negative, all this movement could make a vata person indecisive, stressed and ungrounded. Imbalance in vata produces insecurity, and fear from loneliness, darkness, height and closed places.

2. Pitta Prakriti:

Pitta prakriti people have the combined properties of fire and water. They have moderate athletic physique, gain weight evenly or on the bottom half. Pitta people are fiery, focused, determined, confident and aggressive. They are joyful, stylish, courageous, competetive, and generally have challenge from themselves. They have hot and oily skin. Their nature is sharp, light, liquid and spreading. They are short tempered. They have strong metabolism and good appetite and digestion. and when out of balance can be dictatorial, and easily angered.

3. Kapha Prakriti :

Kapha personalities represent the characteristics of earth and water. They are languid, calm, kind, heavy, slow, cool, oily, smooth, dense, soft, stable, gross, and cloudy (sticky). They have strong stamina and good strength. They are motivated by security, stability and cohesion in life, but on the negative side, could be prone to lethargy, heaviness, and dullness.

4. Vata-Pitta Prakriti:

Vata-pitta prakriti people represent the characteristics of both vata prakriti and pitta prakriti. They generally reflect more intelligence and less labour.

5.Vata-Kapha Prakriti:

Vata- kapha prakriti people represent the characteristics of vata prakriti and kapha prakriti. They adjust with nature and environment. They like relaxness, avoid heavy mental and physical labour

6.Kapha-Pitta Prakriti:

Pitta- kapha prakriti people have pitta and kapha both doshas prominent, and they represent the qualities of the above two prakrities. They are artistic and courageous.

7.Sam Prakriti:

Tridosic or samdoshic people are rare in this universe. This prakriti is ideal type of personality. They have quality to perform excellently even in adverse conditions.

The three mental attributes, Sattva, Rajas, and Tamas correspond to the three 'doshas', Vata, Pitta, and Kapha, that make up the physical constitution. Along with the gunas the three elements of doshas with their corresponding elemental constituencies, make up the personality.

According to the Ayurvedic system of medicine, the three gunas provide the basis for distinctions in temperament and psychological make-up, as well as moral disposition.

By adjusting lifestyle, exercise, and diet – as based on analysis of the gunas and the particular doshas present – Ayurvedic wisdom can assist in modifying behavior and personality.

Because Ayurveda has constructs that are elemental and based in physiology as well as psychology, it provides a far more globally valid system of determining personality. This ancient Indian system is not only used for maintaining good health, it can also help us balance our personality 'flaws' and enhance our positive traits.

Pancha Kosha and Personality Psychology

The ancient Indian model of 'Personality', given in the Tattiriya Upanishads, consists of the 'five' sheaths/ layers around the human soul. These 5 layers are also considered the five sheaths of human's personality. They are 'Annamaya' (food sheath), 'Pranamaya' (vital air sheath), 'Manomaya' (mental sheath), 'Vijnanamaya' (intellectual sheath), and 'Anandamaya' (bliss sheath). 'Annamaya'; a segment of human system is nourished by 'anna', that is, food. 'Pranamaya' is that segment which is nourished by 'prana', that is, 'bioenergy'. 'Manomaya' is the segment nourished by 'education'. 'Vijnanamaya' is nourished by 'ego' and 'Anandamaya' is the segment nourished by bliss. This Pancha Koshas theory is the Vedantic psycho- philosophical view of human personality and similar to the trait perspective of personality where each Kosha exhibits certain characteristics.

. Much like the chakras system in the human body, five koshas are located one inside the other with the sheath of the physical body being the outermost and the sheath of bliss being the innermost. Further, these five layers are lie in three bodies (sharira trya) viz Gross, Subtle and Causal body.

1. Annamaya Kosha:

'Annamaya' (Anna means food and Maya means 'made of') is a segment of the human system which is nourished by food (anna). Here food represents the 'Physical matter' from which the body formation took place (five great elements- earth, water, fire, space and air) and ultimately dissolves into the same (after death). Because of this, the first layer of the body is linked with the Root chakra (Mooladhar chakra) and earth element present in our body.

This sheath contains the great five elements that constitute the physical body with a dominance of 'Tamo guna (Tamas)'. It's perishable in nature and hence, has a beginning and an end (birth and death).

In yoga, various asanas are helpful to nurture the body and hence the annamaya kosha.

This sheath is the result of the combination of shukla (male seed) and Sonita (female seed) and depends on food because semen is the byproduct of food synthesis only.

Personality or constitution of the individual comprising of physical, mental, social and emotional traits all depend on the condition of annamaya kosha, the formation of which continues in each birth or life one has.

Annamaya kosha relies on shat-bhava-vikara (6 changes) concept viz .Birth, Existence Growth ,Change, Decay, Death

Following methods can be adapted to purify and develop the annamaya kosha:- Upavas (fasting), Asanas (Yogic postures), Tatvashudhi (Inner Purification), Tapashcharya (Practice of austerity), Letting our soul free from worldly attachments from the physical body are the first objective of spirituality.

The first objective of spirituality is freeing the soul from the attachment and identification with the food sheath, which only can be realized when one is aware of the first sheath completely.

2. Pranamaya Kosha:

'Pranamaya' (vital air sheath) segment is nourished by 'Prana'. This sheath contains the five pranas that manifest in the physical body and connect it to the next kosha i.e. Manomaya kosha.

This sheath has a dominance of Rajo guna (Rajas), hence subtle activities are normal in this layer. This sheath is also perishable and has a beginning and an end. Prana is the life force that is present in the entire cosmos. It is derived from Moola Prakriti or the Divine Mother.

3. Manomaya Kosha:

'Manomaya' (mental sheath) is the segment nourished by knowledge.

This sheath contains gyanendriyas & karmendriyas for interaction with the outer world. Gyanendriyas are sense organs through which one perceives objects of the world and karmendriyas are organs of actions through which one manipulates with the objects of the world

This kosha is made of a combination of Sattva guna and Tamo guna. It's also perishable in nature and has a beginning and an end. The Manomaya Kosh comprises mental faculty receiving all the sensory signals. Then interprets these signals as positive or negative aspects and at the end aspires the positive desire.

The primary functions of manomaya kosha are Sankalpas and Vikalpas. Sankalpas are the aspects to interpret the intention and act accordingly and Vikalpas refer to rejecting undesirable actions mostly with negative outcome.

Our mind is comprised with certain traits referred to as Vrittis, such as lust, anger, greed, etc. Thoughts in mind continually fluctuate and hence are referred to as Vikara (changing traits). Atman has no scope for any change or modification, hence is referred to as Nirvikara (changeless).

The mind along with the five senses and corresponding sensory organs - taste (tongue), smell (nose), vision (eyes), hearing (ear), and touch (skin)- is said to constitute the manomaya kosha or "mind-sheath".

4. Vijnanamaya Kosha:

'Vijnanamaya' (intellectual sheath) is nourished by 'ego'. Vijnana literally means intellect, hence Vijnanamaya kosha is the intellect/wisdom/knowledge sheath. In the chakras system, this kosha is related to the throat chakra and predominant with the air element.

Buddhi viz intellect with the five organs of knowledge constitutes the Vijnanamaya Kosha or the knowledge-sheath and is also considered to be the part of one's being that is responsible for will, discernment, and determination.

It's characterized basically with an involvement with the intelligence when in deep sleep phase, referred to as Chidabhasa 2.

Vijnanamaya kosha is characterized by being interactive and dependent upon the other sheaths for its existence

5. Anandamaya Kosha:

Ananda means blissful experience. In Advaita Vedanta, anandamaya kosha is referred to as the innermost kosha having close proximity with the soul, hence experiences the blissful experience coming out of the soul.

Anandamaya sheath marks the segment which is nourished by emotions and consciousness. This is the intuitive expansive sheath aligned with the causal body and is often thought of as the soul (atman).

The Anandamaya Kosha in its sattvic aspect is the cause of the blissful experience of Sushupti or deep sleep pattern. The ananadamaya kosha highlights the three positive blissful qualities of the Soul viz Sat, Chit and Anand.

Sat: being truthful and eternal.

Chit: it refers to the one which is alive and has the consciousness, the main bridging line separating the living and the non-living.

Anand: it refers to an ever-joyful state.

This sheath refers to the most subtle body which is perceived in bliss.

The above five koshas, which play an important role in deciding human personality, have their own characteristics. These characteristics can be seen in a person into three levels of the body (Sharira Traya) where all five koshas reside.

1. Sthula Sharira (Gross Body):

The gross body is the physical body underlined with the sheath of Prana – the vital air.

It's the product of five Gross Elements (Earth, Water, Fire, Space, and Air).

This body is subject to six changes (Existence, Birth, Growth, Change, Decay & Death).

It is the physical medium to experience pain and pleasure.

It contains the body in seed form in Waking State (Jagrata Avastha) in which mind is fully functional (purna vikasah).

2. Linga Sharira(Subtle or Astral Body):

The subtle body is the vital energy field for balancing mental and intellectual state.

It contains Pranamaya Kosha (sheath of prana), the Manomaya Kosha (sheath of mind), and the Vigyanmaya Kosha (sheath of intellect).

It is the product of five subtle elements

It has five organs of perception (gyanendreiya) andfive organs of action (karmandreiya).

It comprises five vital forces (prana)

It contains the body in seed form in Dream State (Svapna Avastha) in which mind is partially functional (ardha vikasah).

3. Karan Sharira(Casual Body):

Karana Sharira or Causal body is the map template which is the sole cause for the gross and subtle bodies.

The causal body manifests the ego.

Anandmaya Kosh (sheath of bliss) resides in the Causal body (Karana Sharira).

It defines the state of Ignorance (avidya), Indescribable, Beginingless

It contains the body in seed form in Dream-less Deep Sleep (sushupti – Nitya pralaya) in which mind remains almost non-functional (avikasah).

Karta (the doer) and bhokta (the enjoyer), designate the intellectual sheath and the causal sheath.

In the causal sheath, the properties of nature (prakriti)—sattva, rajas, and tamas remain in balance.

These sheaths are located one inside the other, with the sheath of the physical body being the outermost and the sheath of bliss being the innermost. Freeing our soul from the attachment and identification with the food sheath '(Annamaya kosha),' or physical body is the first objective of spirituality. The ultimate goal of human life is to move away from the Anna-Maya kosha and remain in the Vigyana-Maya kosha most

of the times and progressively move into the Ananda-Maya Kosha (State of Blissful being).

The Pancha Kosha can be thought of as hiding one's true nature. Once they are removed, they leave a void, which also needs to be removed to reveal Atman and connect with devine..

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Personality dimensions and psychological well-being of adolescents: A cross sectional study

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Adolescent is considered as a age where young people are neither children nor adults, that is transition from childhood to young adulthood. Personality as a terminology could be defined as a dynamic and organized set of characteristics possessed by an individual that uniquely influence his or her cognitions, emotions, interpersonal and social orientation, motivations and behaviors in various aspect of situations. The present research study was undertaken in Varanasi with an aim to investigate the relationship of Personality dimensions and psychological well-being of adolescents among 60 adolescents (30 males & 30 females) residing in Varanasi in the age group17 to 21 years by administering NEO-FFI (Paul T. Coasta and Robert R. Mc Care, 1994) and Ryff Psychological well- being scale (Carol Ryff, 1998). As a result, it was observed that personality dimensions had a significant positive effect on psychological well-being of adolescents at p< 0.05.

Keywords:*Personality dimensions, Psychological well-being, Adolescents.*

INTRODUCTION

Personality could be defined as those characteristics of the individual that accounts for consistent pattern of feeling, thinking and behaviors that makes him unique. The word personality originated from the latin word 'persona' meaning mask. The field of personality typically addresses three issues, namely, Human universal, Individual differences, and Individual uniqueness. The personality arises from within the individual that remain fairly consistent throughout the life. The research suggested that Personality as a psychological constructbeing influenced by biological processes and needs believed to have an impacton behavior and actions.

According to the hedonic approach, Subjective psychological well-being coined by Ryan & Deci (2001) consists of the perception of pleasure, displeasure, satisfaction and happiness. According to the eudemonic approach or the psychological well-being model, it takes into account the mechanism of healthy functioning and adjustment. In a study conducted by (Ni et al, 1999), it was found that success at an activity under pressure resulted in happiness (a positive affect closely linked to Well-being), while it did not result in vitality(i.e., overall feeling good). On the other hand, a similar success under the condition of autonomy resulted in both happiness and vitality. It is also being argued that psychological well-being could lead to adoptive human functioning and positive lie experiences. A recent six-factor model of psychological well-being

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proposed by Carol Ryff (Ryff & Singer, 1998) is characterized by self acceptance, personal growth, purpose in life, environmental mastery, autonomy and positive emotions.

In the present study, personality could be defined in the view of McCrae & Costa, in which they found that big five traits are remarkably universal that could be accurately used to represent broad area of personality. There are number of therories about personality and different schools of thought in psychology that has been developed to influence major perspectives of personality. The type theories are the early perspectives on personality suggesting limited number of personality type which are related to biological influences. Moreover, the trait theories viewed personality as a result of internal charateristcs that are stable over time but differ across individuals thereby influencing behavior.

Aim:

The main objectives of this study was to assess the relationship between personality dimensions (Neuroticism, Extraversion, Openness, Agreeableness, Conscientiousness, Overall personality) and psychological well-being of adolescents.

Need for the study:

According to the literature reviewed, it was indicated that many researches are focused on subjective well-being not on psychological well-being. Most of the researches that have been done on psychological well-being and personality included third factors such as gratitude, emotional intelligence and subjective well-being. A few studies were conducted on psychological well-being and personality dimensions especially with respect to adolescents. Thus, the present study is aimed to assess the relationship between personality dimensions and psychological well-being of adolescents.

METHOD

During the conduct of the proposed study Ethical Procedures were respected. The present research study was undertaken in Varanasi with an aim to investigate the relationship of Personality dimensions and psychological well being of adolescents among 60 adolescents (30 male 30 female) residing in Varanasi in the age group17 to 21 years by administering NEO-FFI consisting of 60 items with Cronbach's-alpha reliability coefficients of 0.75-0.82(Paul T.Coasta and Robert R. Mc Care, 1994) and Ryff Psychological well being scale consisting of 18 items with test-retest reliability coefficient of 0.82 (Carol Ryff, 1998). The data analysis was done by usingt-test and $p < 0.05$ as a statistical significant value.

RESULTS

The focus of the present study was to examine the relationship between personality dimensions and psychological well-being of adolescents.

Table1: *The correlations between personality dimensions and psychological well-being of adolescents.*

Personality dimentions	Psychological well-being
Neuroticism	-0.479**
Extraversion	0.267*
Openness	0.040
Agreeableness	0.294*
Conscientiousness	0.250
Overall personality	0.25*

*** Significant at 0.01 level; *Significant at 0.05 levels.*

The group correlations were carried out between the dimensions of personality and psychological well-being. It was observed that there is no gender differences (70.10 ± 8.294 males; 71.47 ± 7.343females) with respect to psychological well being among adolescents The results indicated that there is a significant negative correlation between neuroticism and psychological well-being, and significant positive correlation between Extraversion, Agreeableness, and Overall personality of the participants.

DISCUSSION

The purpose of the present study was to examine the relationship between personality dimensions and psychological well being among male and female adolescents. It could be acknowledged that the big five framework of personality traits from McCrea & Coasta, 1992 emerged as a robust model for understanding the relationship between personality and various academic behaviors. On the basis of results being generated, it could be concluded that psychological well- being is related to long standing traits of personality (Gale et al., 2011).

The study showed that neuroticism is negatively correlated with psychological well-being. Similar result was observed in a study conducted (Abbott et al., 2008) on a sample size of 1134 women in the age range of 16-26 years with an objective to assess the relationship between personality dimensions and psychological well-being by adminstering Moudsley personality inventory and Ryff's psychological well-being scale. This study clearly indicated that people with high neuroticism possess low level of psychological well-being due to

irrational ideas, inability to control their impulses and cope up appropriately with stress.

In a small cross-sectional study conducted (Schmutt & Ryff, 1997) on a sample of n=215 men & n=139 women in the age range of 44-65 years, with an objective to assess co-relation between psychological well-being and personality by administering NEO-FFI and Ryff scale, it was observed that autonomy was linked with neuroticism, and positively correlated with agreeableness & extraversion.

In a study conducted (Salami, 2011) on a sample of 400 Adolescents from secondary school in South Western Nigeria with an objective to examine the relationship between the BIG-FIVE Personality factors and psychological well-being of adolescents and the moderating role of emotional intelligence in that relationship by administering NEO-FFI, Emotional Intelligence and psychological well-bing scale (ryff & keys,1995). As a result, it was observed that significant correlation existed between psychological well-being and personality factors.

In a study conducted on a sample of 300 high school adolescents (143 males, and 157 females) of Iranian migrants in Kuala-Lumpur, Malaysia in the age range of 13 to16 years old with an objective to determine the relationship between personality traits and psychological well-being among the participants by administering Five Factor Inventory (FFI-NEO) Iranian version by Costa and McCrae, (1992) and psychological well-being Scale by Ryff, and keys (1995). As a result, it was observed that there was a negative significant relationship between neuroticism trait and adolescent's psychological well-being, while extraversion and agreeableness traits had positive correlation with psychological well-being.

Conclusion:

The findings of the study revealed that there is a positive relation between personality dimensions and psychological well-being of adolescents followed by a negative relationship between neuroticism and psychological well being, and a positive relationship between extraversion, agreeableness, and overall personalityon psychological well being of the research participants.

Implications:

The results obtained from this study would lay a foundation for future studies on the same lines and ways to solve the problems of adolescents by evaluating the effect of guidance and counseling in terms of treatment planning and career counseling.

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Overview of intellectual disability and treatment modalities

Jesse Altsuler*, Anna Altsuler**,Sachin Jain,***

Intellectual disabilities are characterized by impairments of mental abilities that limit adaptive functioning in conceptual, social, and practical domains. The conceptual domain includes language, literacy, math, reasoning, memory, and knowledge. The social domain refers to empathy, social/interpersonal communication skills, and the ability to maintain friendships. The practical domain involves managing one's own personal care, job, money, recreation, and school. Intellectual disability does not have an age requirement, but symptoms must begin in development (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 2013). This population has unique challenges to overcome. Many social and environmental factors can lead to an increase in a person's symptoms. Properly trained professionals must be able to accurately assess and develop treatment plans that incorporate holistic treatment approaches.

Keywords: Intellectual disability, treatment modalities.

INTRODUCTION

Intellectual disability, otherwise known as intellectual development disorder, is a disability that has been classified under several names. The DSM-V replaced the previously used term of "mental retardation" with intellectual disability in 2013. According to American Psychiatric Association's revision of the DSM-V, the name "intellectual development disorder" is incorporated into the manual to portray the deficits in cognitive ability that begin in development (before 22 years old). The term was revised to align with the World Health Organization and other professional disciplines (2013). Society has been harsh to those with intellectual disabilities and has viewed them as burdens on their families and those around them. Negative stereotypes about intellectual disabilities are still perpetuated today. The mentally disabled are often ridiculed by others and treated unfairly. The treatment of those who are different and vulnerable must reflect kindness and compassion.

Historically, the view on those who were mentally disabled was harsh. Philosophers like Plato and Aristotle believed that a person's value was essentially equivalent to their ability to reason. At the time of around 350 B.C.E., people believed that those who had intellectual disabilities were less human and were socially inferior. Care for the intellectually disabled has often focused on providing basic needs (food, shelter, and clothing) and has fallen on family members and churches. Over time, societies have viewed intellectual disabilities in different cruel and unfair manners. For example, in the 13th century, England declared people with intellectual disabilities to be incapable of making decisions or managing their affairs. Guardians were created to take over their financial affairs

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(Wickham, n.d.). Today, it is common for those with intellectual disability to rely on family members for guardianship and helping them make necessary life decisions.

Compared to other eras, some might argue that in the 17th century, the views on those with learning difficulties attempted to be compassionate. Instead of spreading the idea that people with intellectual disabilities were stricken with disease, it was believed that they were marked by God (Williams, 2002). Western views became heavily influenced by Judaism, Christianity, and Islam; these religions had an optimistic view that supported the idea "idiocy" was a condition of blessed simplicity and innocence. Although it appears that people made an effort to be kind, this view perpetuates the idea that those with disabilities are childish and helpless. According to Wickham, Catholics and Protestants actually banned people thought to have intellectual disability, which prevents them from achieving salvation in the church. While this view appears to be more positive than the views of Plato's era, negative stereotypes have continued to surround people with lower intelligence for centuries.

Around this same time, the work of Thomas Willis, became popularized. Willis viewed a lack of intelligence as being caused by a defect in the brain from birth or serious injury. He thought that some with low intelligence were more capable than others. He was one of the first people to define the disease, contemplate the causes, and suggest treatments. Over time, scientists focused on understanding the connection between the brain and intelligence in the context of intellectual disabilities (Williams, 2002). These ideas that stemmed from Willis continued to preserve the idea that this population had a lower worth to society. Eventually, scientists even began to think that people with lower intelligence could be sorted out of the population.

In many cases, those with intellectual disabilities had to endure horrible treatment. In the early 20th century, the eugenics movement fervently took over the world. According to Smith, some might blame Charles Darwin's ideas of genetics for the spread of this movement. Hitler was one clear example of someone who participated in the use of negative eugenics. Less than one-hundred years ago, Hitler used mass murder to eliminate a large portion of mentally challenged populations. Hitler, along with many others (even some within the United States) participated in forced sterilization of those who were considered genetically inferior (2006). In the beginning of the 20th century in the United States, various states began to pass laws allowing or requiring the involuntary sterilization of those with developmental disabilities (Diekema, D.S., 2003). These laws were justified with the argument that society would be worse off if people with disabilities reproduced. In total, more than 50,000 Americans with intellectual disability were involuntarily sterilized (Wehmeyer, M.L., 2003). This is a truly sad chapter of history; with the past in mind, it is vital for current and future

populations to remember that our ideologies can have far-reaching impacts. Those with intellectual disability are often greatly impacted by the majority's views and belief systems.

Toward the end of the twentieth century, it appears that there has been a shift in mentality in the field of intellectual disability. According to Freedman, 1975 marks shifts from institution to community, segregation to inclusion, and services to supports. Furthermore, Freedman states that the field experienced a "significant paradigm shift in how we view and approach persons with [intellectual disability]" (2004). This shift was evidenced by changing disability concepts, classification, definitions, and terminology. Toward the end of the 20th century, these times have been described as marked by self-advocacy, increased emphasis on consumer self-determination, person-centered planning, and quality of life..

Symptoms and DSM codes:

According to the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-V-TR), intellectual disability involves impairments of mental abilities in social, conceptional, and practical domains. The onset of symptoms is during the developmental period with concurrent impairments in adaptive functioning. The DSM-V-TR lists separate codes including Mild 317, Moderate 318.0, Severe 318.1, and Profound 318.2. Mild intellectual disability IQ level falls in the range of 50-55, to approximately 70. Moderate intellectual disability IQ levels are in the range of 35-40 to 50-55. Severe IQ ranges are 20-25 to 35-40. Profound IQ ranges fall in the range of below 20 or 25 (American Psychiatric Association, 2013).

Diagnostic Features:

Intellectual disability has the main characteristic of significantly sub-average general intellectual functioning that includes significant limitations in adaptive functioning in the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 2013). Intellectual disability does not have an age requirement, but symptoms typically begin in the first two decades of life. Limitations in communication may include difficulties in conversation or problems producing speech. Communication difficulties can impact one's ability to cope with life's demands. Determining communication deficits is necessary in order to properly diagnosis and to write a treatment plan that is accurate. Functional deficits in health and safety can impact a person's ability to take care of one's self. Those with an inability to take care of their own basic needs may require assistance. This can include help with bathing and assistance with brushing teeth. A person with intellectual disability

may need assistance with home living skills. These can include one's ability to take care of household responsibilities such as preparing and cooking meals or vacuuming one's home and putting dishes away. Social skills include one's interacting appropriately with those at home or in the community. A lack of social skills can also lead to difficulty in accessing available community resources. A deficit in social skills can be especially troublesome with a person who has an inability to work without assistance. They may often need the assistance of the person in which they are having social difficulties, which can lead to a deficit in needs being met. This can lead to increased problems for the disabled person in the social environment.

Culture should also be considered in the assessment process. In the assessment of intellectual functioning, one should consider the suitability of the instrument to the person's sociocultural background, education, associated handicaps, motivation, and cooperation (American Psychiatric Association, 2013). In an educational environment, an assessor must be careful not to misdiagnose one with a learning disability when there could simply be a language barrier. Functional academic skills include a student's ability to acquire knowledge. Students with intellectual disability may have difficulty in learning basic reading and math skills. These students may need to access support services within a school environment. Bringing support services to children in the general education classroom is known as inclusion, and it is a common practice in today's classrooms (Brisendine, Lentjes, Morgan, Purdy, Wagnon, Woods, & Notar, 2008). According to Individuals with Disabilities Education Act, students identified as having intellectual disability must be provided with a free and appropriate public education in inclusive settings involving same aged peers. Ideally, this inclusive setting should provide this population with the opportunity to reach their full potential.

Sometimes, those with mental disabilities make poor choices due to cognitive deficits. They may be thought of by clinical staff as having impulsive personalities or lacking self-control. (Benedick & Dixon, 2009). This portion of those with intellectual disability may present as being angry and they may have difficulties in their interactions with others. Their coping skills may lack in development due to cognitive difficulties and the inability to implement skills learned. It may be difficult for those with intellectual development disabilities to learn coping skills to change their behavior. Some may lack the ability to interact in a friendly manner with their peers on a consistent basis. Relationships may become damaged and interventions may be needed. It has been argued that the most developed and publicly recognized area of work with those who have developmental disabilities is applied behavior analysis (Gadaire, Kelly & DeRosa, 2010). Applied behavior analysis is an intervention that targets problem behavior in relationship with the social and physical environment.

Psychosocial, Cultural and Environmental influences:

Culture impacts how those with intellectual disability are perceived. This is often evidenced by the kinds of roles accessible to people with disabilities within a culture (Rao, 2006). In some cultures, one with intellectual disability may be able to assume vital roles within their tribe or community. This participation in one's culture has the ability to increase life satisfaction. In cultures where independence is not highly valued, those with intellectual disability may be a greater part of their individual families and communities. In the United States, those with intellectual disabilities often assume supervised roles and may be isolated to group homes. It may be difficult for this population to develop satisfying life goals, as independence is a valued goal in U.S. culture. Having a more prominent role in their community might lead to a more fulfilled and satisfying life.

In the educational system, inclusion in the school environment is a common practice in the United States (Brisendine, et. al, 2008). In a classroom, one with intellectual disability may be treated differently by administrators, teachers, and students. It is common for peers to dictate how people with intellectual disability are perceived. It is now more important than ever to strive for equality, fairness, and respectful treatment of those with disabilities. Inclusion of the disabled in the regular education environment is an attempt to achieve that. Inclusion gives students with disabilities a chance to integrate into mainstream society through social interaction and joining a community. Since the Individuals with Disabilities Education Act says that students must be provided with free and appropriate public education with same-aged peers, this has led to greater cultural exposure. The hope is that this inclusive setting will provide those with intellectual disability with the opportunity to be included in society.

Those with intellectual disability may live with family, in their own apartment, or in a group home. There are services that can provide housing and basic life support for this population, and education in interpersonal skills and everyday activities like self-care and housekeeping can be provided. In some cases, family interventions are included. Vocational rehabilitation and daytime activities are other common services (Gustafsson, et al., 2009). Unfortunately, with governmental budget shortfalls, these needed services are often some of the first to get cut. The most vulnerable of our population is then left without the necessary support. It has been shown that the number of environmental factors that increase risk for intellectual disability have increased over time. Various environmental conditions can increase risk for prenatal birth defects According to Schroeder, environmental neurotoxicology should be included in any risk assessment for goal of prevention and environmental regulation (2000). Intervention is then aimed at primary, secondary, and tertiary prevention.

In a controversial 2010 study, the impact of cochlear implantation was observed with children with intellectual disability. It was discovered that children may receive benefit from the cochlear implants, and their postoperative performance was impacted by the degree of intellectual disability. Although the language development of children with mild intellectual disability was slow, they were able to communicate verbally 3 years after implantation. The children with moderate intellectual disability had slower progress and had limitations in speech and language development (Lee, Kim, Jeong, Kim, & Chung, 2010). This research shows that the degree of intellectual disability influences the amount of benefit one would receive from this implant.

Common Co-occurring disorders:

When evaluating a person with intellectual disability, it is important for the professional to evaluate and treat the person for other affective disorders. It is reported that mental health problems are approximately 2 to 3 times greater in people with intellectual disability compared to the general population (Gustafsson, Öjehagen, Hansson, Sandlund, Nyström, Glad, & Fredriksson, 2009). Those with mental illness and intellectual disability are known as having dual diagnosis, in which they have symptoms for both. It is common for those in this category to have affective disorders that make it difficult to achieve satisfactory social relationships.

Dual diagnosis and co-occurring disorders present unique challenges for this population. They often have numerous challenges to overcome. Not only may they have to deal with intellectual deficiencies, but they may also have depression symptoms which can make it difficult to function (Matson, Lott, Mayville, Swender, & Moscow, 2006). A portion of the dually diagnosed population lives in group homes with other residents. It can be challenging to work in these homes with the unique mix of roommates and those with possible dual diagnosis. Those who work with the dually diagnosed need special training. Those employed in group homes commonly take classes in order to become better equipped to work with this challenging population. Those with developmental disability services and mental health services may have multiple caseworkers and service providers know as the treatment team.

When presented with various options, those with dual diagnosis may appear to have impulsive personalities. Some clinical staff may dismiss those with dual diagnosis as lacking self-control and making poor choices (Benedick & Dixon, 2009). When providers are impatient and have short fuses, this can lead to ineffective treatment. It is common for developmental disability employment to have high turnover, which can be difficult for those with disabilities to adjust to.

It can be challenging for one with a dual diagnosis to learn coping skills to change behavior associated with mental illness. Research has shown that it is possible for those with dual diagnosis of intellectual disability

and mental illness to be taught self-control, and they can implement these skills rather quickly (Benedick & Dixon, 2009). Using the principles of behavior analysis, those with dual diagnosis can apply these skills to daily life. Most behavior analysts would agree that these behavior-analytic services require problem identification, establishing operational definitions, establishing assessment and treatments goals, achieving accurate data collection, and evaluating treatment in a conservative experimental design (Gadaire, Kelley & DeRosa, 2010). Practitioners must be careful not to classify all with intellectual disability into the same group. Every person is unique with their own strengths and challenges. All people with disabilities should be treated with respect, dignity, and empathy. A practitioner's view of one person who has social deficits should not impact the practitioner's view of another. It is important to evaluate each person openly and on their own merit in order to help ensure that all reach their potential.

Treatment Modalities:

Ideally, the primary goal of treatment in cases of intellectual disability is to develop the person's full potential. This can be difficult with Medicaid and Medicare cuts. In some states, those receiving developmental disability services can no longer receive mental health services. These cuts impact the quality of life of the most vulnerable in our society. This is especially troublesome when research has suggested that the mono-disciplinary treatment approach to behavioral and psychiatric problems in those with intellectual disability, such as psychotropic medication or behavior modification programs has led to limited success (Dosen A.A., 2007). Although behavioral approaches of treatment can be beneficial for people with intellectual disability, it makes treatment more effective to look at all aspects of a person's life. This allows the counselor to develop treatment appropriately using a holistic approach.

Due to the complexity of behavioral and psychiatric problems, it may be helpful to apply varying treatment methods from different perspectives. Including treatment members from various domains can be effective in helping this population reach their potential. Biological, psychological, social, and developmental aspects should be addressed in treatment. Different professionals should be incorporated as well like a psychiatrist, psychologist, social worker, nurse, and the person's caretakers (Dosen A.A., 2007). It may be difficult to get all of these professionals to engage in a single meeting, so a case manager should be included on the team. It can become increasingly important to foster communication between the treatment team members. The integrative treatment should not be primarily directed towards the symptoms of the disorder but towards restoring a person's mental well-being. Social functioning for individuals with intellectual disabilities impacts an individual's quality of life (Cook & Oliver, 2011). Social skill development may also be included since there are often functional deficits impacting a person in their

relationships. This may be accomplished through role-playing social situations in which a person can practice interacting in various circumstances and with a wide variety of people. It is possible for successful treatment in the social skills domain to improve one's life interactions and increase one's happiness. Treatment in the psychiatric domain often includes working on skills related to managing symptoms. This can include controlling anger outbursts though developing various coping skills. Decision-making can be improved through developing problem-solving skills. Cognitive difficulties can make it difficult for those with intellectual disability to learn skills, but this can be helped with repetition. In the domain of basic living skills, it is common to teach basic household skills like cooking and cleaning. This domain can also include basic hygiene skills such as bathing and brushing teeth. Long-term levels of continued support may be needed in this area to assist with safety and basic needs. It can be empowering and fulfilling for a person to learn and participate in their self-care. Practitioners must be careful to treat those with intellectual disability with respect and dignity. They must strive to treat each person as unique with their own strengths and challenges. Each person should be evaluated and treated as unique individuals in order to help ensure that they reach their potential.

World Health Organization Disability Assessment Schedule 2.0

When conducting the WHODAS 2.0 with the intellectual disability population, one must consider the following areas: understanding and communicating, getting around, self-care, getting along with people, life activities, and participation in society (American Psychiatric Association, 2013). The WHODAS 2.0 asks individuals to rate their difficulty with each area of functioning over the last month. There are 36 questions on the assessment and two ways of scoring. The simple version scores items from 1-5 (no difficulty-extreme difficulty) while the complex version is based on item-response theory. The complex version uses a computer to determine a score ranging from 0-100 (0 = no disability; 100 = full disability). The scores produced from the complex version are the result of a fusion of six different domains (cognition, mobility, self-care, getting along, life activities, and participation). Over time, this measure could be completed regularly to understand the client's stability of symptoms and treatment status. If someone continues to score high in one area, it might indicate a need for further assessment and intervention.

Conclusion:

Those with intellectual disabilities experience unique challenges. These may be difficult to overcome, as resources may not be available. They face symptoms that might be difficult for themselves and their families. This population may struggle to access appropriate treatment to overcome challenges. Behavior interventions are often incomplete and do not consider the person as a whole. Various social and environmental factors can lead to an increase in a person's symptoms. Properly trained

professionals must be able to accurately assess and develop treatment plans that incorporate holistic treatment approaches

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Case study:

Axis II 318 moderate intellectual disability

Joe meets criteria A, B, and C as stated below. He appears to meet criteria of sub average general intellectual functioning criteria A, He deficits with communication, self-care, home living, Social/ interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B). The onset must occur before age 18 years (Criterion C).

Joe had difficulty with self-care evidence by not bathing on his own. There are times when Joe does not bath for days at a time unless he is bathed. His brother, John is his caretaker as his Mother is unable to handle the responsibility.

There are family stressors impacting the home environment, including arguing and aggressive behavior. Joe is frustrated at not being able to take care of self. Safety issues were evident with Joe riding the lawnmower through town and being arrested. Joe appeared to have difficulty with interpersonal skills and communication skills throughout the interview. Joe meets the diagnostic criteria in the DSM-IV for moderate intellectual disability.

Multiaxial Evaluation Report Form:

Axis I: Clinical Disorders
Other Conditions That May Be a Focus of Clinical Attention

Diagnostic Code DSM-IV Name

_____
_____

_____
_____

_____
_____

Axis II: Personality Disorders
Intellectual Disability

Diagnostic Code DSM-IV Name

__318 moderate intellectual disability_____

_____

_____

Axis III: General Medical Conditions

ICD-9-CM Code ICD-9-CM Name

_____

none_____

_____

_____

_____

_____

Axis IV: Psychosocial and Environmental Problems

Check:

□□Problems with primary support group specify: Mother unable to care for Jim. Caretaker is older brother.

□□Problems related to the social environment specify: _____

_____

_____

□□Educational problems specify: Not attending school._____

_____

□□Occupational problems specify: _____

_____

_____

□□Housing problems specify: Staying with relatives. Mother, older brother homeless.

_____

_____

□Economic problems specify: Income.

_____

__

□□Problems with access to health care services specify: _____

_____

_____

□□Problems related to interaction with the legal system/crime specify: safety issues._____

_____

_____

Treatment Plan:

GOAL: Joe would like assistance getting along with others and to manage symptoms more effectively.

OBJECTIVE: Joe will learn two new strategies to better cope with symptoms.

Strategy: Joe will learn relaxation techniques.

Strategy: Joe will learn to recognize anger.

Strategy: Joe will learn healthy coping skills.

OBJECTIVE: Joe would like to reduce outbursts and crisis.

Strategy: Joe will learn to express feeling appropriately.

Strategy: Joe will learn to self initiate using coping skills.

GOAL: Joe would like to better communicate with family.

OBJECTIVE: Joe would like to better communicate with family while managing symptoms.

Strategy: Joe will learn to understand others point of view.

GOAL: Joe would like to make more friends and not be lonely.

OBJECTIVE: Joe will learn social and communication skills.

Strategy: Joe will learn positive peer interactions as well as empathy.

Strategy: Joe will learn characteristics of healthy relationships.

OBJECTIVE: Joe will learn how hygiene impacts him socially.

Strategy: Joe will learn others view points on grooming and hygiene.

Strategy: Joe will better learn to implement hygiene and grooming schedule.

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Views of rural young adults regarding marriage and mate selection

Madhu Asthana*

The present study was conducted on a sample of 60 unmarried young adults from rural areas of Varanasi, U.P. Same number of male and female respondents was taken in the study. The objective of the study was to have views of rural young adults regarding marriage and mate selection. An interview schedule with 12 statements was used for the same. Findings show that most of the respondents consider marriage as an eternal relation and necessity of life. Choice marriages within the caste with parents' consent and with traditional rituals were preferred. Matching of horoscopes was favoured while dowry was considered as an evil of society. 19-22 years for girls and 22-25 years for boys were considered as the ideal minimum age of marriage. 2-3 years of age difference between couples was found ideal

Key words: *young adults,marriage,mate selection.*

INTRODUCTION

Marriage is an important institution in almost every society. It has far reaching effects on the lives of not only the couples but also of the family members. In the earlier Hindu conception of marriage little attention was paid to the wishes of the young persons. Marriage was regarded as compulsory. The parents were morally obligated to find mates for their children and the children to accept the parental choice. In an intricate system of religious beliefs, caste restrictions and communal controls, the parents would exert extreme effort to marry their children. Indeed they often married them at a very early age, in infancy or childhood. The marriage contract was regarded as an agreement between two joint families rather than between two young people (Davis, 1942). In such circumstances there was no room for romantic love as a basis of marital selection. The Hindu ideal of marriage had no regard for individual taste or inclination - it was rather afraid of them (Tagore, 1920). But when the modern nation began to evolve, bringing millions of strangers in a common milieu, fostering a dynamic technology, a mobile class structure, a complex division of labour, and a dominant urbanism, the old and rigid concept of Hindu marriage began to lose. The rapid spread of education, the increasing influence of forces of modernization, and increasing emphasis on the freedom of individuals have brought about some changes in the institution of marriage in India. Now marriage has become increasingly a private matter beyond the control of parents (Davis, 1981). The most striking change has been observed in the area of mate selection. While parental influence in decisions related to mate selection is still dominant, premarital attitudes show gradual but definite change. The moment is shifting away from marriage arranged by parents

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to more freedom of choice (Saroja and Surender, 1990).

Since, the selection of a partner in a marriage is one of the important decisions in an individual's life, the factors contributing to this decision have continuously attracted the researchers. Education has been found to be associated with liberal attitudes towards mate selection (Gore, 1968; Shaw,1961; and Katti & Saroja, 1988). Increasing level of education has decreased the percentage of respondents supporting arranged marriage (Gore, 1969; and Raman, 1983). Education was not only found to be associated with the desire of more freedom in mate selection but also with the desire of more sexual contacts especially with the future spouse (Ross, 1961). In a study Devi (2003) observed that regardless of education, youth still prefer ritualistic marriage within the same caste, with boys preferring choice marriage with consent of parents and girls preferring arranged marriage with consent of youth. Medora (2003) had discussed at large about factors influencing mate selection and love marriages and arranged marriages in India. Asthana (2007) found that choice marriages within the caste with parents' consent and with traditional rituals were preferred by young adults. Khodarahimi and Fathi (2017) found significant effects of ethnicity and educational level in the meaning of marriage and hope respectively in a study of 632 Iranian individuals. They observed no gender influence on these cognitive constructs. Gupta (2021) studying various age differences for successful marriage observed that many people believe that 5 to 7 years difference between spouses was ideal for marriage. But Forever (2021) found it to be 2 to 3 years. The ideal age of marriage for boys and girls was found to be 26 and 22.2 years.(Kaur, 2014). Pathak (2018) found it to be 26 years for boys and 22 years for girls in India. In the United States it is 25 yrs. for girls and 27 yrs. For boys (Gallup poll, 2006)

Aim:

Keeping the above background in view, the present work was aimed to study the views of male and female rural young adults regarding marriage and mate selection.

Sample:

60 young adults of Varanasi were taken for the present study. Equal number of male and female subjects was taken from rural background. The age range of the sample was 17 to 25 years. All the respondents were unmarried Hindus.

Tool:

An interview schedule was used to collect relevant information about views of rural young adults regarding marriage and mate selection. Twelve statements were prepared regarding ideology of marriage, necessity of marriage in life, types of marriage preferred, suitable age of boys and girls at the time of marriage, their age difference, matching of horoscope, dowry, qualities in life partner, and preference for arranged or choice marriage. Some statements had three alternatives and some had

four alternatives to respond to. Each respondent was contacted individually to collect the data.

RESULTS AND DISCUSSION

The obtained data were analyzed in terms of frequencies and percentages. As stated above twelve statements were prepared in the interview schedule. The findings are being presented through table 1 to 12. The values presented in bold show the frequencies while the values presented in parenthesis are the percentages.

Table 1: *Views of rural young adults regarding ideology of marriage*

S. No.	Alternatives	Rural Young Adults (N=60)	Males (N=30)	Females (N=30)
1	Eternal Relation	23 (38.3)	11 (36.6)	12 (40.0)
2	Social Contract	15 (25.0)	4 (13.3)	11 (36.6)
3	Biological Need	15 (25.0)	10 (33.3)	5 (16.6)
4	Maintains race	7 (11.6)	5 (16.6)	2 (6.6)

The first statement was regarding the ideology of marriage. Views of the respondents about this aspect of marriage are being presented in table 1.

Table 1 reveals that most of the rural respondents consider it as a bond of life and beyond life. When we concentrate upon the responses of boys and girls we find that both of them (36.6 percent boys and 40 percent girls) consider it as a bond of life and beyond life. However, 36.6percent girls consider it as a social contract.

Table 2: *Views of rural young adults regarding necessity of marriage*

S. No.	Alternatives	Rural Young Adults (N=60)	Rural Males (N=30)	Rural Females (N=30)
1	Yes	36 (60.0)	18 (60.0)	18 (60.0)
2	No	17 (28.3)	11 (36.6)	6 (20.0)
3	Undecided	7 (11.6)	1 (3.3)	6 (20.0)

The second statement was regarding the necessity of marriage in life. The frequencies and percentages of the responses are being presented in table 2.It is clear from the table that maximum respondents feel marriage necessary for life. Only 36.6% boys and 20% girls feel it is not necessary.

The third statement was about arranged and choice marriage. The responses are presented in table 3, which show that most of the respondents whether they were male or female, preferred the marriage of their own choice with the consent of parents. The second preference of all subgroups was for arranged marriage with their own consent. No one was ready to marry without his/her consent or without parent's consent.

Table 3: *Views of rural young adults regarding arranged and choice marriage*

S. No.	Alternatives	Rural young Adults (N=60)	Males (N=30)	Females (N=30)
1	Arranged marriage with your consent	20 (33.3)	10 (33.3)	10 (33.3)
2	Arranged marriage without your consent	0 (0.0)	0 (0.0)	0 (0.0)
3	Choice marriage with parents' consent	40 (66.6)	20 (66.6)	20 (66.6)
4	Choice marriage without parents' consent	0 (0.0)	0 (0.0)	0 (0.0)

Fourth statement was related to intra-caste, inter-caste and inter-religion marriage. All respondents whether they were male or female preferred to marry in their own caste (Table-4).

Table 4: *Views of rural young adults regarding consideration of caste in marriage*

S. No.	Alternatives	Rural Young Adults (N=60)	Rural Males (N=30)	Rural Females (N=30)
1	Intra-caste	47 (78.3)	24 (80.0)	23 (76.6)
2	Inter-caste	9 (15.0)	3 (10.0)	6 (20.0)
3	Inter-religion	4 (6.6)	3 (10.0)	1 (3.3)

When the respondents were asked about their liking for traditional and nontraditional modes of marriage, each group of them preferred the traditional mode (Table-5).

Table 5: *Views of rural young adults regarding traditional/nontraditional marriage*

S. No.	Alternatives	Rural Young Adults (N=60)	Males (N=30)	Females (N=30)
1	Traditional	51 (85.0)	23 (76.6)	28 (93.3)
2	Non-traditional	3 (5.0)	2 (6.6)	1 (3.3)
3	Both	6 (10.0)	5 (16.6)	1 (3.3)

The next statement was regarding the matching of horoscopes in the marriage. Table 6 shows the responses. Most of the respondents find it necessary to match the horoscope. 15 (50%) of the boys and 16 (53.3%) of the girls agree for matching horoscopes, but 12 (40%) boys and 11 (36.6%) girls do not agree to match horoscopes in marriage.

Table 6*: Views of rural young adults regarding matching horoscope in marriage*

S. No.	Alternatives	Rural Young Adults (N=60)	Rural Males (N=30)	Rural Females (N=30)
1	Yes	31 (51.6)	15 (50.0)	16 (53.3)
2	No	23 (38.3)	12 (40.0)	11 (36.6)
3	Indefinite	6 (10.0)	3 (10.0)	3 (10.0)

Regarding the minimum age of girls at marriage, most of the respondents said that it should be 19 to 22 years. None of them felt that it should be 26 to 28 years (Table-7).

Table 7: *Views of rural young adults regarding minimum age of girl at marriage*

S. No.	Alternatives	Rural Young Adults (N=60)	Males (N=30)	Females (N=30)
1	15-18 years	7 (11.6)	4 (13.3)	3 (10.0)
2	19-22 years	45 (75.0)	24 (80.0)	21 (70.0)
3	23-25 years	8 (13.3)	2 (6.6)	6 (20.0)
4	26-28 years	0 (0.0)	0 (0.0)	0 (0.0)

When the views regarding the minimum age of boys at marriage were asked, all the respondents said that it should be 22 to 25 years. 83.3% boys and 73.3% girls accepted the above option. Some girls (20%) said that it should be 26 to 29 years, but none of the respondents felt that the age of 30-32 years was ideal for boys at marriage (Table-8).

Table 8: *Views of rural young adults regarding minimum age of boy at marriage*

S. No.	Alternatives	Rural young Adults (N=60)	Rural Males (N=30)	Rural Females (N=30)
1	18-21 years	5 (8.3)	3 (10.0)	2 (6.6)
2	22-25 years	47 (78.3)	25 (83.3)	22 (73.3)
3	26-29 years	8 (13.3)	2 (6.6)	6 (20.0)
4	30-32 years	0 (0.0)	0 (0.0)	0 (0.0)

Table 9 shows the responses of rural boys and girls regarding the age difference between bride and bridegroom. Most of the respondents of both subgroups consider it to be 2 to 3 years. Only 7 (23.3%) boys and 3 (10%) girls thought that the difference should be 4-5 years, but the difference of more than 6 years was not accepted by any subgroup of respondents.

Table 9: *Views of young adults regarding age difference in bride and bridegroom*

S. No.	Alternatives	Rural Young Adults (N=60)	Males (N=30)	Females (N=30)
1	1year	2 (3.3)	1(3.3)	1(3.3)
2	2-3 years	48 (80.0)	22 (73.3)	26 (86.6)
3	4-5 years	10 (16.6)	7 (23.3)	3 (10.0)
4	More than 6 years	0 (0.0)	0 (0.0)	0 (0.0)

Statement 10 of the interview schedule was related to the qualities preferred in mate selection. The responses are presented in table 10. The quality preferred in life partners by most of the respondents was good behaviour. All respondents preferred good behaviour followed by education. Boys preferred good behaviour followed by education and physical beauty, while girls preferred good behaviour followed by education and high level of service. No girl preferred physical beauty in her future life partner while no boy preferred high level service in his bride.

Table 10: *Views of young adults regarding qualities preferred in future life partner*

S. No.	Alternatives	Rural Young Adults (N=60)	Males (N=30)	Females (N=30)
1	Well Behaved	43 (71.6)	21 (70.0)	22 (73.3)
2	Physical Beauty	3 (5.0)	3 (10.0)	0 (0.0)
3	Education	12 (20.0)	6 (20.0)	6 (20.0)
4	High level of Service	2 (3.3)	0 (0.0)	2 (6.6)

Last two statements were regarding dowry in the marriage. In all subgroups most of the respondents considered dowry as an evil of the society. Some boys (20%) considered it as a gift (Table-11).

Table 11: *Views of young adults regarding dowry in marriage*

S.No.	Alternatives	Rural Young Adults (N=60)	Males (N=30)	Females (N=30)
1	A Gift	8 (13.3)	6 (20.0)	2 (6.6)
2	An evil of society	50 (83.3)	23 (76.6)	27 (90.0)
3	Necessary condition for marriage	2 (3.3)	1 (3.3)	1 (1.6)

Liking for giving or accepting dowry was asked in statement no. 12. Most of the respondents deny to accept or to give dowry. The findings are presented in table 12.

Table 12: *Views of rural young adults regarding liking for giving or accepting dowry.*

S. No.	Alternatives	Rural Young Adults (N=60)	Males (N=30)	Females (N=30)
1	Yes	3 (5.0)	2 (6.6)	1 (3.3)
2	No	32 (53.3)	17 (56.6)	15 (50.0)
3	As the Family Wish	11 (18.3)	2 (6.6)	9 (30.0)
4	Oppose against the family	14 (23.3)	9 (30.0)	5 (16.6)

30% rural girls set it on the family will, but 30% rural boys told that they would oppose dowry against the will of their family members.

Conclusion:

As a whole we can conclude that in general rural young adults consider marriage as an eternal relation, and they find it necessary for life. Choice marriages with the consent of parents were preferred by the majority of the sample. They preferred marriage within the same caste

with ritualistic traditional mode. Matching horoscope was favoured by most of the respondents. In general, they considered 19-22 years as an ideal minimum age of marriage for girls, 22-25 years for boys, and 2-3 years as ideal age difference between bride and bridegroom.

The quality preferred in a future life partner was his/her good behaviour. Education, physical beauty and high level of service were the qualities for which different views had been obtained. All the respondents considered dowry as an evil of society.

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Study of music as an activity in people with dementia in long term care facility in India: A pilot study

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Dementia is a syndrome marked with significant deterioration in memory, thinking, behaviour and the ability to perform everyday activities (World Health Organization, 2019). Music therapy has been researched in the past as a possible viable alternative to pharmacological interventions. The present study uses music activities to treat behavioural and psychological symptoms of Dementia (BPSD) and seeks to understand the efficacy and success of the intervention as a non-pharmacological approach

Personality could be defined as those characteristics of the individual that accounts for consistent pattern of feeling, thinking and behaviors that makes him unique. The word personality originated from the latin word 'persona' meaning mask. The field of personality typically addresses three issues, namely, Human universal, Individual differences, and Individual uniqueness. The personality arises from within the individual that remain fairly consistent throughout the life. The research suggested that Personality as a psychological constructbeing influenced by biological processes and needs believed to have an impacton behavior and actions.

The current study attempted to look at the implementation of music as an intervention in a long-term care facility for persons with dementia (PwD) in various stages of the disease.

Twenty participants (n = 20) with Dementia were recruited from Nightingale's Medical Trust for this study. Participants cognitive and social behaviours were tested pre- and post-intervention using the Mini-Mental State Examination. Participants received forty-minutes group therapy sessions provided by a music therapist once a week.

The results of the study show that the social behaviours had considerably improved in majority of the participants as part of the intervention. However, the mean value of the MMSE scores decreased from pre- to post-intervention. Furthermore, the effect size of the intervention was small. This study showed promising results for the efficacy of music activities as a therapeutic intervention, but further in-depth research is required to generalise the results. centre for disease control and prevention(CDC,2010),states that by the year of 2010, there is an expectancy rate of 1 in 110,being victims of Introduction

Key words: *Autism, Mental stress, communication problems, behavioural changes, outburst of behaviour, coping strategies.*

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INTRODUCTION

The world and India is in a stage of swift demographic ageing. By 2050, the ageing population of people who are 60 years and older is expected to increase drastically by approximately 2.1 billion individuals worldwide (United Nations, 2015). Automatically, the number of people diagnosed with various mental health problems related to senility and disorders like dementia are bound to increase in the forthcoming years. Dementia is clinical syndrome which is caused by various factors and results in a progressive decline in cognitive, behavioural, communication, social and emotional functions. Once diagnosed there is an immediate need for intervention. Various different intervention methods have been used to combat the progression of symptoms in Dementia patients. Majorly from the medical point of view, pharmacological interventions are at one's disposal but however have proven to have limited effectiveness for the management of the various features of syndrome. There has been very less research carried out on various non-medical or the non-pharmacological treatments. Non-pharmacological treatments are non-invasive and can include light massage and aromatherapy, music and dance therapy, animal assisted therapy, multi-sensory therapy. Music intervention uses music activities to aid in the management of psychological and behavioural symptoms of Dementia. Music therapy has been found to be a more economical intervention with minor adverse effects for persons with Dementia (Guetin et al., 2013). Musical intervention can set in a pattern for meaningful and purposeful engagement and has been found to increase neuroplasticity and neural connections in the brain (Hyde et al., 2009).

Literature states that there are benefits of music intervention for PwD in terms of reducing anxiety and depressive symptoms (Svansdottir & Snaedal, 2006), and agitation and challenging behaviours (Vink et al., 2013). Music that was familiar to those with Alzheimer's disorder are still recognisable to the former (Cuddy and Duffy, 2005). This was found to be true due to early bond formation between tunes and lyrics. In terms of cognitive symptoms, research has shown cognitive training to improve cognition and abilities among persons with Alzheimer's disorder (Sitzer, Twamley, & Jeste, 2006). Särkämö et al. (2014) had similar findings on the effects of singing and listening to music. Additionally, training various domains of cognition at the same time with ascending intensity aids in improving quality of life (Kumar, 2013).

Furthermore, Dyer et al. (2018) found music interventions were effective in improving behavioural and psychological symptoms. Although, the review was inconclusive about music therapy due to low quality of evidence. But, music interventions have shown potential as a possible non-pharmacological treatment for Dementia, but further research must be done to understand the extent of its effectiveness.

Literature also states that the length of the music intervention itself may play an important role for positive results (Carr, Odell-Miller, and Priebe, 2013). Leubner and Hinterberger (2017) found continuous interventions to produce the most effective results. Research in this area is heterogenous and requires more data to draw any further conclusions on effective length and duration of the intervention. Vink and Hanser, (2018) found that there is lack of sufficient data available in regard to music therapy as there is lack of protocols and research lack sufficient detail to enable researchers to compare and replicate studies, and clinicians to apply techniques. Hence, there is a need to draw conclusive results regarding the efficacy of music therapy as a viable option in treating individuals with dementia.

Aim of the study:

The study aimed to understand the efficacy of music activities as a viable group therapy option for people with dementia (PwD) living in long term care facilities in South India.

Objectives of the study:

1. To evaluate the impact of music activities as a group on behavioural and psychological symptoms in people with Dementia (PwD)
2. To determine whether the music activity is a safe, tolerable and feasible activity which could be considered as a therapeutic intervention.
3. To assess whether there is a need to undertake a larger study to look at music activities as an intervention for PwD.

METHOD

Participant characteristics:

This study was conducted in Bangalore, Karnataka. Participants were required to comprehend and respond to English, Hindi, or Kannada. Participants with consent or assent from family members were chosen randomly to participate in the music sessions and modules. The authors sampled participants from Nightingales Centre for Ageing and Alzheimer's in Kasturi Nagar, Bangalore, a long-term care facility for people with Alzheimer's and Dementia.

The study employed a convenient sampling method with a single subject design where in the subjects were their own control subjects. The participants were required to meet specific inclusion and exclusion criteria. Inclusion criteria consisted of the following: The participant had to be a resident of a long-term care facility, and the age of the participants being over 65 years, having a diagnosis of Dementia. One of the important criteria was that that music had to be one of their interests.

Any participant with known hearing difficulties or diagnosed with hearing impairment were excluded from the study. All participant's medical history was documented including all psychological and social behaviours. Cognitive impairments were tested using Mini-Mental State

Examination (MMSE) developed by Folstein, Folstein, & McHugh (1975).

Altogether, twenty participants were recruited for the study (n = 20). All participants were included in the study as MMSE scores of all the participants were within the range.

All the researchers working on the project were expected to be trained in Good Clinical Practice (GCP) for research. Data integrity was maintained, and anonymized. Data was transferred confidentially to the computer for synthesis and analysis. The study followed all the ethical guidelines under the local governance.

Material:

The MMSE was used for assessment of psychological and social behaviours and also to assess the cognitive abilities. The Menorah Park Engagement Scale (MPES) developed by Camp, Intrieri, & Hyer (2006) was also used to rate the participant's engagement in the activities. Both the scales were used pre- and post-intervention. Music activities as mentioned below were used to implement the intervention.

Procedure:

Participants were introduced to the music and its related activities. The music activities consisted of the following:

- Music and greetings: A simple tune was used to acknowledge and say hello to every member of the group including staff and ask the rest of the group to name the person we were singing to. If the group couldn't remember, we encouraged them to ask the person what their name was instead of withdrawing due to the awareness they had about their own condition and their inability to remember.
- Music and movement: Participant preferred music (based on the songs that different group members suggested for every session) were played. Different kinds of bodily movement were encouraged as a sign of delightment. Upper body movement like clapping while raising their hands, stretching, lower body movements of tapping their feet, stretching and relaxing their legs by swinging it to the rhythm were encouraged.
- Music and memory: While the music was played, various memories were recollected by the participants according to the song played. Conversations were initiated and supported. An example is Kabhi Kabhi Mere Dil Mein which started a conversation about memories of relationships and people they have in their lives where each client in the group named someone in their life that they have a special memory with and shared that memory.
- Music and singing: Whenever a lyrical song is played, it is a tendency to sing the lyrics along and becomes a way to engage themselves. During the activity, when a participant picked up a song, everyone in the group may or may not have known the song. Therefore, we picked 4 lines from the lyrics to sing over and over again. This allows for

new information to be cognitively processed and gives the participant the opportunity to be engaged. These songs were revised in the following sessions to strengthen their short-term memory and learning capacity.

These activities were guided by a licensed music therapist for forty-minutes in a group setting. The intervention was conducted for a period of two months. At the end of the intervention period, a period of ten days followed where no intervention was provided. Post intervention data was collected using the MMSE, performed by staff members who were blinded to the aim of the study. Data collection was done in an organised and systematic way where a common identifier was set up for each data set and the participant's identity was kept confidential. The researcher tried to minimise the inherent risks associated with the disclosure. Finally, the data was subjected to statistical analysis

Statistical Analysis:

All analysis had been carried out using Statistical Package for Social Sciences (SPSS) 15.0 for Windows. Quantitative analysis was employed for all the measures. Descriptive statistics such as mean, standard deviation were obtained to analyse the data. The data followed normal distribution and hence, paired t test was employed to find the significant differences between the pre- and post- intervention data.

RESULTS

The sample size for the study was 20. The mean result of MMSE scores was 15.3 before the intervention and 14.6 after the intervention. This decrease may be attributed to the gradual cognitive

decline in the person with dementia. When looking at the results, all participants had been found to have severe cognitive impairment as most scores tended to be below 20. Although, one patient had a score that indicated normal cognitive function (MMSE 27-30).

Most participants who scored lower on the MMSE tended to have more passive engagement according to MPES scale initially. After the intervention, participant's psychological and behavioural symptoms improved slightly while engaging in the music activity. Results for the MPES after the intervention showed most participants were actively engaging in the activity and an overall positive outcome. Results has been presented in table 1 and 2.

Using the Paired t-test, the means of the MMSE scores were analysed for statistical significance. The statistical analysis showed there was no significant differences between the two sets of MMSE data as the value of p was greater than .05. Furthermore, Shapiro wilk's $w = .98$, $p > .05$ and Cohen's d value (0.16) show that the effect size of the intervention is small. This could be due to the small sample size and as a result the data cannot be generalised. Therefore, the null hypothesis cannot be rejected.

Table 1: *Pre - and Post- Mini-Mental State Examination and Menorah Park Engagement Scores*

Age	MMSE /30 (Pre)	MMSE /30 (Post)	Menorah Park engagement (Pre)	Menorah Park engagement (Post)
75	22	17	Passive, not distracted, no self-stimulating behavior (ssb) seen.	Active engagement, Adequate response, No ssbseen
80	20	19	Passive, responds if directed, No ssb	Active, Quick response, No ssb
76	5	4	Disengaged, No response even if directed	Delayed response and clapping
80	30	27	Active engagement, happy	Active engagement, Quick responses, Independently sings
65	17	17	Active engagement, excited, spontaneous responses	Active engagement
73	23	17	Motor and verbal responses present, relaxed	Active full engagement, Quick responses
76	25	28	Passive engagement, responds if directed	Active engagement, Adequate response
76	7	15	Active engagement, Calm	Passive engagement, Motor responses
74	19	12	Passive engagement, No response	Passive engagement, Clapping in the last 3 sessions
86	20	18	Disengaged and distracted	Active engagement and self-encouraged singing
84	0	3	Passive engagement, relaxed, not distracted	Active engagement, Slow motor response
86	17	21	Active engagement, verbal and motor responses present, not distracted	Active engagement, Quick responses
80	20	25	Active engagement, verbal response, often distracted	Active engagement, Quick responses
88	3	7	Passive engagement, highly distracted	Passive engagement, responds if directed
86	14	5	Active engagement, spontaneous in responses	Active engagement, No distractions
90	20	17	Active engagement, verbal responses present, social interaction was present	Active engagement, happy, quick responses
85	12	9	Engagement through listening and observation, no singing,	Active engagement, singing and comfortable
80	1	0	Active engagement, enjoyed	Passive engagement, directed responses
73	14	15	Active engagement, quick response	Active engagement, quick response
71	16	15	Disengaged	Passive engagement by listening

DISCUSSION

The study aimed to understand the efficacy of music activities for people with dementia (PwD). Past research has shown that cognitive symptoms and BPSD are very stressful for persons with dementia as well as caregivers (Carrion et al, 2018). Hence, it is necessary to reduce the pressure over persons with dementia and care givers. In the present study it was seen that post intervention, participant's psychological and behavioural symptoms improved slightly and were actively engaged. A comprehensive review by Wall and Duffy (2013) found that music therapy can make a change in the behaviour positively in individuals with dementia as the levels of agitation reduced. They also reported that the activities in terms of socialization was more with carers and their mood was better than before as seen in our study. A systematic review (Morales, Calero, Morales and Pintado, 2020) found that music intervention can improve cognition and quality of life and the long standing depression.

On other hand, a meta analyses (Steen et al., 2018) of 22 studies found that when persons with dementia placed in institutional care, the behaviors reduced majorly at the end of therapy sessions with a reduction in depressive symptoms. The emotional well-being and overall quality of life also improved. But there was hardly any change or almost no effect on agitation, aggression and on cognition. The current literature about music intervention has vast amounts of gaps on the efficacy of music therapy and the longevity of its effects.

Various studies have used different durations and used different protocols. There is a gap in research about specific timing and duration requirements for the interventions to have a significant effect. There is a need for further research to fill the gap in this area. This leads us to possibly providing a newer intervention with flexible timings and durations. In this study, interventions were only done once a week for a duration of two months. Based on the results, it is probable that the lack of a significant effect is due to the infrequency of the intervention. Further research must be undertaken to analyse the true effectiveness of this therapy when used more frequently.

According to the results, interruptions in the intervention did not seem to contribute to the challenges of being attuned. Although, small effect size suggests that the sample size of this study was too small, further research must be done to understand the efficacy levels of this intervention specifically in long term care facilities.

Additionally, when patients were to sing a song that they were familiar with, they were more likely to engage in conversation about a memory related to that song. This provides further evidence to support research as suggested by Cuddy and Duffin (2005) on familiar music still being recognized by individuals with dementia of Alzheimer's type due to the link between tunes and lyrics. Music may have formed specific sensory

memories that makes it easier for patients to recall. Thus, proving that music can be used as a beneficial intervention for persons with dementia.

Table 2: *Mean, standard deviation (S.D), 't' value and effect size for the participants Shapiro wilk's w = 0.98, p > .05*

	N	Mean	S.D	t	P	Cohen'd
MMSE/30 - Pre	20	15.3	8.28	0.723	0.478	0.16
MMSE/30 - Post		14.6	7.9			
	N	Mean	S.D	t	P	Cohen'd
MMSE/30 - Pre	20	15.3	8.28	0.723	0.478	0.16
MMSE/30 - Post		14.6	7.9			

Conclusions and Future Research:

Although results were somewhat inconclusive, evidence does point towards a probable link between the intervention and an improvement in behavioural and psychological symptoms of Dementia. Further research into the possible effects on cognition must be done to understand the overall efficacy of the intervention and its ability to be an alternative to pharmacological interventions. Additionally, the frequency and length of the intervention was found to be an important aspect. With an in-depth study on the effect of frequency differences on the success of music therapy as a non-pharmacological intervention might be necessary to fill the gap in the research on this topic. Hence, it is necessary to develop clinical trials aimed to design standardized protocols depending on the nature or stage of dementia so that they can be applied together with current cognitive-behavioural and pharmacological therapies.

Finally, Musical intervention was found to be a cost effective non-pharmacological intervention that could be facilitated in long term care facilities for person with dementia as only minimal resources are required to effectively implement this intervention.

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