VOLUME 2 ISSUE 1

ISSN 2395-5570

International Journal of

Contemporary Issues in Behavioural Sciences

Hon. Editor
Vibha Sharma, Ph. D

UPS

International Journal of
Contemporary Issues in Behavioral Sciences
Journal of Unique Psychological Society

uibsdel.org, ISSN 2395-5570
Jan to June 2016, Vol. 2 No. 1

OWNERSHIP

International Journal of Contemporary Issues in Behavioural Sciences is owned by the Unique Psychological Society, 101, First Floor, Bharat Nagar, New Friends Colony, New Delhi-110025-India, Phone: +91-11-65653070. EDITOR: DR. Vibha Sharma, Ph.D. Department of Clinical Psychology IHBAS, Delhi, India-110062. Email: upsjournal@gmail.com Email: upsjournal@gmail.com. PUBLISHER: Unique Psychological Society, 101, First Floor, Bharat Nagar, New Friends Colony, New Delhi-110025-India, e-mail: upsjournal@gmail.com. International Journal of Contemporary Issues in Behavioural Sciences's purpose is to help to strengthen the research and educational base of psychology. It does not assume any responsibility for the written content of articles. The Unique Psychological Society, founded in 2013 as a trust, aims to spread awareness and provide training programs about various mental health concerns either on its own or in association with similar agencies working for the all-round development of the society.

BULK REPRINTS

Reprints of International Journal of Contemporary Issues in Behavioural Sciences articles are available. To order, please contact Unique Psychological Society, 101-First Floor, Bharat Nagar, New Friends Colony New Delhi-110025 India. +91-11-65653070.

International Journal of
Contemporary Issues in Behavioral Sciences
Journal of Unique Psychological Society

uibsdel.org, ISSN 2395-5570
Jan to June 2016, Vol. 2 No. 1

Volume 2 Issue 1,Jan to June 2016

EDITORIAL

Depression: let's talk

Depression has now become a common illness worldwide, with more than 300 million people affected. It is not short-lived emotional reaction rather than it challenges all spheres of everyday life. Especially when long-lasting and with moderate or severe intensity, depression may become a serious health concerns, and results may be from performing poorly at work, school and in other social commitments. At its worst, it can lead to suicide. Close to 8 lakhs people die due to suicide every year as per WHO report released recently. Suicide is the second leading cause of death in 15-29-year-olds. Over five crore Indians suffered from depression, which is an increase of 18 % from the previous decade, which is around 4.5 % of the total population. A striking finding shows that a two third of the global suicide are from countries with middle income like India. WHO Campaign slogan is: Depression: let's talk. Depression can be effectively prevented and treated. Treatment involves either a taking psychotherapy or antidepressant medication or a combination of these. Talking with people you trust, can be a first step towards recovery from depression.

Vijander Singh

Editor

Volume 2 Issue 1,Jan to June 2016

Is Obesity taking toll on Cognitive Functions of Children and Adolescents?

***Gupta, T (M.Phil, PhD)**

*M.Phil, PhD Clinical Psychology

Letter to the Editor

Dear Sir,

The prevalence of childhood obesity has been rising continuously over the past two decades and it has become a major health problem both in developed and developing countries including India (Ebbeling, Pawlak, & Ludwig, 2002). Traditional Indian culture upholds certain myths and misconceptions about childhood obesity such as a fat child is a healthy child, plumpness passes away with growth spurt over the years, fatness in an offspring is indicative of the prosperity of his or her family, and childhood is the age to eat and relax. But unlike the past, today obesity is recognized as a major health risk condition. Childhood is a time of constant cognitive development for children so it becomes imperative to provide adequate stimulation to children in their early years of life. However, rapid urbanization and lifestyle changes have significantly increased the popularity of fast foods, soft drinks and sedentary way of living. Physical inactivity in the form of increased television viewing and computer use are the common lifestyle trends adopted by the children in present-day India and frequently turn out to be the causative or maintaining factors of childhood obesity. Childhood obesity has come up as an epidemic in today's world but the major concern lies in its affect on physical, emotional and cognitive development of children. Recent literature reported negative association of childhood obesity with cognitive functions of children

The association of higher body mass index (BMI) and reduced performance on various cognitive tests has been relatively well established in adults (Elias, Elias, Sullivan, Wolf, & D'Agostino, 2003; Fagundo et al., 2012). Recent work suggests that the relationship of obesity and cognitive functioning may not be limited to grown-ups only. It can also be observed in children and adolescents.

A relatively recent surge of interest has been seen in researchers to examine neuro-

cognitive aspects of childhood obesity. As it is important to understand the role of underlying brain mechanisms of eating and exercise behaviors of children with obesity and, how does brain respond to food cues in these children which affect their eating behavior. Number of recent cross-sectional and prospective studies has attempted to look at the structural and functional differences in brain of obese and non-obese children. These studies have used various cognitive/neuro-psychological tests and different imaging techniques to understand the neuro-cognitive basis of childhood obesity. Some of the recent cross-sectional studies stated inverse association of cognitive functions and childhood obesity specifically in the realm of intelligence (Miller et al., 2006; Yu et al., 2009), executive functions (Verdejo- Garcia et al., 2010; Lokeen et al., 2009; Schwartz et al., (2013) and memory (Li et al., 2008; Abdel-Nabi et al., 2010).

Researchers have also proposed different mechanisms to explain this association. One such proposition is that the neural centres of impulsivity may foster impaired control of food intake in obese children and lead to overeating and subsequent weight gain (Cortese et al., 2008). The effect of overweight/obesity on the brain has also been observed in the form of subclinical inflammation and vascular changes that may also impair the performance on some of the cognitive function tests (Gustafson , Rothenberg, Blennow, et al., 2003; Gustafson, Lissner, Bengtsson, Björkelund, & Skoog, 2004). Alternatively, Joseph and colleagues (2011) observed and pointed out the shared neuro-cognitive connections between eating behaviour and physical activity. Physical exercise improves executive functions and indirectly influences the eating behavior through executive functions.

Why obese individuals perform poorly on cognitive function tests?

The inverse association of childhood obesity and cognitive function has been supported by ample western literary evidence, available from a variety of cross-sectional and longitudinal studies, and additionally substantiated by recent systematic reviews and meta-analysis. However, the underlying mechanism of this association of obesity and lower cognitive functions are uncertain. Some of the postulated mechanisms are:

Literature report similarities in underlying brain mechanisms of drug addiction and obesity (Volkow & Wise., 2005; Wang et al., 2001) and substance users were found to

have poorer performance on executive functions task (response inhibition, mental flexibility) relying mainly on the neural circuits within the prefrontal cortex (Vardejo-Garcia et al., 2006). These similarities could be a possible reason for the similar cognitive deficits in individuals with obesity and substance use.

Alternatively, in an MRI study, group of obese adolescents showed significant decrease in grey matter volume of orbitofrontal cortex (a brain region responsible for behavioral inhibition and impulse control) compared to their lean counterparts. The reason for this finding was attributed to the obesity as well as associated insulin resistance in obese adolescents (Maayan et al., 2011).

Smith et al. (2011) explained the bi-directional association of obesity and neuro-cognition, wherein obesity can be a cause or consequence of these cognitive deficits. Children having deficits in executive function are predisposed to engage in lifestyle behaviors that lead to obesity. In another way, obesity can be a cause of these deficits as it impacts the brain in the form of low-grade systemic inflammation, elevated lipid levels and insulin resistance in obese individuals.

Overall the literature supports inverse association between obesity and cognitive functions in children and adolescents specifically in the realm of executive functioning. However, the evidence is mixed in the areas of general intellectual functioning, learning, memory, and language. Although these studies do not provide causal explanations for their findings but the inverse association of childhood obesity and cognitive functions is a cause of considerable concern as it can also affect academic performance and attainment of other skills by obese children (Mond, Stich, Hay, Kraemer, & Baune, 2007; Sigfusdottir, Kristjansson, & Allegrante, 2007). So it becomes imperative to assess the obese children comprehensively to understand the sequel of obesity on cognitive, behavioral and emotional development of children.

References

Abdel-Nabi, I. M., Kalifa, A. G., Ahmed, H. H., Eskander, E. F., & Sayed, A. H. (2010). The impact of obesity on some

hormones and cognitive function among school girls. *New York Sci. J, 3(4)*, 66–71.

Ebbeling, C. B., Pawlak, D. B., & Ludwig, D. S. (2002). Childhood obesity: public-health crisis, common sense cure. *Lancet, 360(9331)*, 473–482.

Elias, M. F., Elias, P. K., Sullivan, L. M., Wolf, P. A., & D'Agostino, R. B. (2003). Lower cognitive function in the presence of obesity and hypertension: the Framingham heart study. *International Journal of Obesity, 27(2)*, 260–268.

Fagundo, A. B., de la Torre, R., Jiménez-Murcia, S., Agüera, Z., Granero, R., Tárrega, S., … Fernández-Aranda, F. (2012). Executive functions profile in extreme eating/weight conditions: From Anorexia Nervosa to Obesity. *PLoS ONE*, 7(8), e43382.

Gustafson, D., Lissner, L., Bengtsson, C., Björkelund, C., & Skoog, I. (2004). A 24-year follow-up of body mass index and cerebral atrophy. *Neurology, 63(10)*, 1876–1881.

Gustafson, D., Rothenberg, E., Blennow, K., Steen, B., & Skoog, I. (2003). An 18-year follow-up of overweight and risk of Alzheimer disease. *Archives of Internal Medicine, 163(13)*, 1524–1528.

Joseph, R. J., Alonso-Alonso, M., Bond, D. S., Pascual-Leone, A., & Blackburn, G. L. (2011). The neurocognitive connection between physical activity and eating behavior. *Obesity Reviews, 12(10)*, 800–812.

Li, Y., Dai, Q., Jackson, J. C., & Zhang, J. (2008). Overweight is

associated with decreased cognitive functioning among school-age children and adolescents. *Obesity*, *16(8)*, 1809–1815.

Lokken, K. L., Boeka, A. G., Austin, H. M., Gunstad, J., & Harmon, C. M. (2009). Evidence of executive dysfunction in extremely obese adolescents: a pilot study. *Surgery for Obesity and Related Diseases*, *5(5)*, 547–552.

Maayan, L., Hoogendoorn, C., Sweat, V., & Convit, A. (2011). Disinhibited eating in obese adolescents is associated with orbitofrontal volume reductions and executive dysfunction. *Obesity*, *19(7)*, 1382–1387.

Miller, J., Kranzler, J., Liu, Y., Schmalfuss, I., Theriaque, D. W., Shuster, J. J. and Driscoll, D. J. (2006). Neurocognitive findings in Prader-Willi syndrome and early-onset morbid obesity. *The Journal of Pediatrics*, *149(2)*, 192–198.e3.

Mond, J. M., Stich, H., Hay, P. J., Kraemer, A., & Baune, B. T. (2007). Associations between obesity and developmental functioning in pre-school children: a population-based study. *International Journal of Obesity*, *31(7)*, 1068–1073.

Schwartz, D. H., Leonard, G., Perron, M., Richer, L., Syme, C., Veillette, S. and Paus, T. (2013). Visceral fat is associated with lower executive functioning in adolescents. *International Journal of Obesity*, *37(10)*, 1336–1343.

Shah, C., Diwan, J., Rao, P., Bhabhor, M., Gokhle, P. and Mehta, H. (2008). Assessment of obesity in

school children. *Calicut Medical Journal, 6(3),* e2.

Sigfusdottir, I. D., Kristjansson, A. L., & Allegrante, J. P. (2007). Health behaviour and academic achievement in Icelandic school children. *Health Education Research, 22(1),* 70–80.

Smith, E., Hay, P., Campbell, L., & Trollor, J. N. (2011). A review of the association between obesity and cognitive function across the lifespan: implications for novel approaches to prevention and treatment. *Obesity Reviews, 12(9),* 740–755.

Verdejo-García, A., Pérez-Expósito, M., Schmidt-Río-Valle, J., Fernández-Serrano, M. J., Cruz, F., Pérez-García, M., … Campoy, C. (2010). Selective alterations within executive functions in adolescents with excess weight. *Obesity, 18(8),* 1572–1578.

Volkow, N. D., & Wise, R. A. (2005). How can drug addiction help us understand obesity? *Nature Neuroscience, 8(5),* 555–560.

Wang, G. J., Volkow, N. D., Logan, J., Pappas, N. R., Wong, C. T., Zhu, W., … Fowler, J. S. (2001). Brain dopamine and obesity. *Lancet, 357(9253),* 354–357.

Yu, Z. B., Han, S. P., Cao, X. G., & Guo, X. R. (2010). Intelligence in relation to obesity: a systematic review and meta-analysis. *Obesity Reviews, 11(9),* 656–670.

Volume 2 Issue 1,Jan to June 2016

Transformational Leadership Style: An Innovative Approach to Enhance Employee Engagement

Gangai, K. N* & Agrawal, S**

*Bharatiya Vidya Bhavan's Usha & Lakshmi Mittal Institute of Management (BULMIM), New Delhi.

**Professor (HR/OB), Jaipuria Institute of Management, Noida

Abstract

Leadership is an important area of both as far as the academic and business orgnisations for a long time. The Leader is a person who encourages, and drives many individuals to execute particular every day jobs what's more move his/her subordinates to make profitable in their performance in the achievement of business goals. The great leaders are always looking like a wall in the house, who lead in the front and work with the organisation and employees for their benefits and bring orgnisational goal closer to reality. The employees are having a critical part to play in the business organisation , sometimes they disconnect from being as an employee. Thus a leader who creates a special environment and feel them, they are part of incredible support in doing the business. The leader behaviour and communication ways makes truth to the employees, whether the employee to stay or quit the organisation. Similarly, employees are leaving the supervisors not the organisation. Therefore, it demonstrates that the employee engagement is more related to the leadership style components. The present paper is theoretical inside from secondary data; the data aggregation got is for discretionary data from the evaluating study from various sources. The objective of this exploratory paper to investigate how leadership style is a creative way to deal with improving employee engagement in the organization. The result shows by many researchers that transformational leadership style is more important than transactional leadership style to increase employee engagement in the organization (Tims, Bakker, Xanthopoulou, 2011; Metzler,2006; Raja ,2012).

Keywords: Transfromational leadership, Transactional leadership, Laissez-faire leadership, Employee engagement

The business universe of today's, fantastic initiative is key because of money related turmoil, overall contention, cutting back business sectors, cutbacks, expanding skepticism and doubt etc. So, now-a- days business pioneers, they need to stay predictable with their own particular assurance that to be in charge of their business, meanwhile moving their subordinates needs an astounding style of administration that deals with each one of these solicitations. The review highlighted and examines probably the most successful style and suggested model display the expectations of the

needs and challenges of particular business with the leadership style which is helping them update of the employees haunted with the work. Most organization today comprehended that a satisfied employee is not by any means the best workers to the extent relentlessness and productivity. This is only an associated within the employees that are rational and genuinely create to affiliation and feels enthusiastic about its objectives and is given towards its qualities thus he goes the additional mile of his her main occupation. Employee engagement is the exhaustively inspected thought into the corporate organisation that is portrayed complicatedly by different creators. Scarlett Surveys described, "Employee Engagement is a quantifiable level of an employee's certain or negative emotional attachment to their occupation, associates and organization which significantly impact their readiness to learn and perform at work". Employee engagement in additionally known as work engagement in a business organization. A "connected with employees" that are totally required in, and on edge about his work, and along with these lines it will develop the engages and advantage to the organization. Employee engagement is determined by how many employees taking responsibility, both passionate and intellectually, that has been existed in organizations with satisfying the works and leads to achieve mission, and vision of the organization. Leadership has been persuaded in enhancing employees' performance and expanding the opportunity to accomplish organizations' objectives, and also expanding employees" engagement with the organization (Daft and Marcic, 2006).

Defining Employee Engagement

Employee engagement has described as an extensive variety of ways and the definitions and measures frequently stable like other better known and setup assembles like organizational commitment and organizational citizenship behavior (OBC) (Robinson et al., 2004). Most as every now and again as would be judicious, it has been depicted as wholehearted and insightful obligation to the organizations (Shaw, 2005; Richman, 2006; Baumruk, 2004), the measure of discretionary effort

appeared by masters in their jobs (Frank et al., 2004). Kahn (1990;1992) describes employee engagement as "the harnessing of organization members' selves to their work roles; in engagement, people employ and express themselves physically, cognitively, and emotionally during role performances." Individual detachment implies "the uncoupling of selves from work roles; in disengagement, people withdraw and defend themselves physically, cognitively, or emotionally during role performances". In this context, Rothbard (2001) "psychological accessibility and the measure of time one spends considering a part" while retention "means being charmed in a part and alludes to the force of one's concentrate on a part." Similar concept defined (Schaufeli et al. 2002; Maslach et al., 2001; Gonzalez-Roma et al., 2006) that employee engagement "as a positive, fulfilling, work-related state of mind that is characterized by vigor, dedication, and absorption".

Defining Leadership Styles

The present review is one of a kind in that it utilizes an inside individual way to deal with leadership as well as between-individual perspective of leadership, highlighting a singular contrasts in leadership "styles" or leader practices all things considered, the researcher receives the view that leadership practices may vacillate inside people from everyday. Leadership style is major outcomes of an achievement or a failure of the organization. This is the way and approach of generous to give direction, realizing courses of action, and inducing people (Lee and Chang, 2006).

Transformational leadership: Research since the 1990s recommends that transformational leadership is identified with numerous positive results inside organizations. Transformational leadership decidedly impacts employee performance in the military (Dvir et al., 2002) and has a positive connection to follower commitment. The particular leadership style with the goal of changing subordinates into pioneers themselves (Bass and Avolio, 2004). The transformational leader grabs trust and respect from his/her adherents by giving a fantasy and sentiment pride (Bass, 1998). The center of transformational leadership is sustaining

the commitment of the staff and creating them by lifting their destinations (Mulford, 2008). There are four basic parts of transformational leadership as doled out by Bass (1999, 1985) Transformational pioneers indicate rehearses that can be requested into four particular styles, for example, inspirational motivation, idealized influence, intellectual stimulation, and individualized consideration. The transformational leadership, these four styles have been recognized oftentimes insinuated as the 'Four I's'.

Transactional leadership: As indicated by Kirkbride, (2006) transactional leadership gets certain endeavors to perform and give prizes or trains to peers in light of execution results. Supervisors and colleagues set fated destinations together, and employees agree to take over the bearing and leadership of the supervisors to satisfy those goals. Leaders who are guide or spur their followers toward setting up objectives by clearing up part and assignment necessities. Transactional leaders and adherents coordinate and orchestrate understandings, that is, they partake in 'trades'. Thusly, it is essential for the pioneer to have the capacity to reward supporters (Bass and Avolio, 1994). Distinctive trades require helping supporters are getting included just with issues that need the pioneer's thought, which is called management-by-exception (Bass, 1985; Avery, 2004). The transactional leadership and subordinates agree with, recognize, or concur with the pioneer to exchange cash related prizes, praise, and resources, or to evade disciplinary exercises (Avery, 2004; Bass, Jung, Avolio, and Berson, 2003).

Laissez-Faire leadership: Laissez-faire leadership is for the most part called "delegative leadership style". This is a kind of leadership style in which leaders behaves unautocratic and permit to gather individuals to settle on the choices. The leadership style is more uncomplicated and approachable. Bass and Avolio, (2004) said that "Latent leadership abstain from indicating understandings, elucidating desires, and giving objectives and models to be accomplished by supporters". The similar leadership style is called as "no specific leadership style" (Bass and Avolio, 2004).

Methodology

Since this research paper is a theoretical based paper in light of writing review, the technique turns principally on the assurance furthermore, rejection of each article; the crucial system is subjective and qualitative examination of research paper. The researcher did examination of each article look for in different steps. Going before last decision, the uniqueness of each article was investigated so that elite the related articles were kept in the picked pool. Correlated articles, which fulfilled the chase need, whether subjective or quantitative, were kept in the pool. Generally, a thumb standard was used which viewed employee engagement as a predictive factor, and leadership style is an independent factor. All the model articles have been investigated to unequivocally place them in classes in perspective of the orientation of inter-relationship among the factors as determined in the written compilation work. The collecting period of research articles were January, 2014 to December, 2016.

Review of Literature

Leadership is a completely the important topics in research fields of management. Its forerunners and results have all the more broadly significant impact on organisational results and performance of the employees. Numerous researchers, similar to (Hartog et al., 1997; Bass, 1988, 1990) additional research of management in the area of leadership. Further, it has been classified such as transformational, transnational and laissez-faire leadership style. The transnational leadership style for the most part is depicted as the trades of prizes and focuses amongst employees and the organization (Howell and Avolio,1993). The transactional leaders fulfil worker's needs and assistance of reward when targets are completed by employees (Howell and Avolio, 1993, Bass, 1990; Humphreys, 2002). This delineated as the exchanging of necessities fulfillment of win win situations from both sides (Pounder, 2002). The transformational leadership style focuses on career development and change of subordinates as per their prerequisites. The super practicing transformational leadership concentrates on the change of gigantic worth game-plan of employees, their motivation level and moralities with the change of their

aptitudes (Ismail et al., 2009). Transformational leadership goes about as a structure among pioneers and subordinates to clarify perception of supporters' interests, values and motivational level (Bass, 1994). The transformational theory (Burn, 1978) and transformational leadership theory (Bass, 1985) cleared up these attributes of leadership style. similarly, Burns (1978) clarifies that transformational Leadership style bolsters shared comprehension among employees and organizations while Burn's (1985) theory enlightened the relationship among employees and organization are coordinated in courses that over the long haul drives employees their individual enthusiasm in support of organizational outcomes. The transformational leadership style offer inspiration to his/her employees increase the reality of work, overhaul hoard union, and confer trust in their workers (e.g., Jung and Sosik, 2002; Dirks and Ferrin, 2002; Arnold, Turner, Barling, Kelloway, and McKee, 2007).

Liao and Chuang (2007) surmise the transformational leadership is recognized with social recognizable proof with the supervisor, on the grounds that such leaders serve as commendable good examples, express a convincing vision, and impart elite desires (charisma), give enthusiastic interest, which means, and test to their subordinates (Inspirational motivation), give careful consideration to his /her supporters' needs, desires, and improvement (individualized consideration) while likewise difficult their subordinates to take a gander at problems from alternate points of view (Intellectual stimulation) and the outcomes additionally affirmed their research.

Transformational leadership style develops the change of employee engagement in the organization. Kaiser, Hogan, and Craig (2008) described transformational leadership style changes the way subordinates observe themselves from isolated individuals to people from a greater social affair. Exactly when subordinates view themselves as to be people from a total get-together, they tend to continue on gather qualities and goals, and this enhances their motivation to add to more important advantage. Transformational

leaders give an awakening vision of destinations that can help overcome self-interest and thin factionalism in business organisations. Transformational leaders call upon new and broad energies among subordinates. Raja (2012) investigated how transformational leadership prompts to higher employee work engagement in the service sector firms of Pakistan. The outcome demonstrates, the transformational leadership factors like idealized influence, inspirational motivation, individual consideration and lastly intellectual stimulation, when every one of these parts of transformational leadership style is honed by the mangers likely prompts to higher work engagement.

Metzler (2006) investigated the association between leadership style (transformational, transactional) and employee engagement among 251 respondents. The disclosures of this review uncovered that there is a positive relationship between transformational leadership style and employee engagement. The transactional leadership style identified a negative relationship with employee engagement.

Tims, Bakker, Xanthopoulou (2011) examined how transformational leadership style upgrades subordinates every day employee engagement. The propose, among that different measurements of employee engagement, commitment, absorption and lastly social persuasion are firmly corresponded with successful adjustment of transformational leadership style.

Vidyakala & Ram (2016) examined leadership style such as transformational, transactional and Laissez-faire leadership & employee engagement over demographic factors in Coimbatore city among 369 respondents in various sectors. The demographic factors, i.e., gender, age, experience, position, sectors and industries had a significant relationship leadership style and employee engagement.

Employee engagement and leadership, investigating the union of two structures and suggestions for leadership improvement in human resources development (HRD) by Shuck and Herd (2012). The Result exhibits that using a single style transactional or transformational style does not suit changing worker engagement needs. So

the blend of both styles will suit particular levels of representative in the cosmopolitan organizations.

Ghafoor, Qureshi, Khan, and Hijazi (2011) reviewed and found out that the association between transformational leadership style, employee engagement. The observational revelations of information, amassed through studies from test of 270 respondents of telecom industry showed the association between transformational leadership style, employee engagement practices.

Theoretical Framework

The theoretical framework of leadership and engagement highlights the way that a large number of the reviews concentrate on to a great extent the visionary and transformational leadership while examining engagement. As proposed in the theoretical structure given by Shuck and Herd (2012), transactional leadership may likewise add to the expansion of employee engagement next to transformational leadership, however has not been researched much. In the Indian setting, there is a reasonable absence of such reviews. This study has been reviewed along these lines goes for investigating the leadership and engagement relationship in this unique situation. The review tries to extend a portion of the exploration crevices by utilizing the full-range leadership model (Avolio & Bass, 1991) that consolidates each of the three leadership styles such as transformational, transactional and passive-avoidant. Disregarding tending to the puncture in the transactional and employee engagement relationship, the research furthermore plans to think the negative relationship of passive-avoidant leadership. The consequence of leadership style on behavioral results like employee engagement as can be measured in further research will add to the pool of research in the leadership and behavioral results domain. The empirical proof of leadership style and employee engagement relationship in the Indian setting is somewhat restricted; the exploration would like to add to this assemblage of research.

Discussion

Transformational leadership style is generally utilized as a part of organizations today. Past reviews uncover useful result of transformational leadership style which individual

practices on the business outcomes. Transformational leadership is unwaveringly identified with the carrying out of the employee to the degree redesigned nature of the consequence (Ismail et al., 2009). The transformational leadership style is identified with other positive consequences, for example, creativity at long last enhancing execution of the workers (Shin and Zhou, 2003). The Transformational leadership style strongly connected with obligation of worker to work and business orgnisations in spite of that when they are at division from their mangers and leaders. The valuable result of strengthening backing, this relationship (Avolio, Zhu, Koh and Bhatia, 2004) this demonstrates the movement of authority conduct happens when transformational administration is infiltrated and representatives are given a tasteful level of bracing in their work to secure. Transformational leadership style and its particular practices are additionally considered at the idea to lessen the feedback in the business practices. The Transformational leadership style which the overhaul of reinforcing similarly as more imperative incorporation in errands movement of workers decreases the negative factors that may impact execution, furthermore, that the vitality builds worker execution (Avey, Hughes, Norman and Luthans, 2008).

The transformational leadership lessens the negative impacts of work worry in the workplace situation that at any rate updates the execution (Ferguson ,2009). Precisely when business associations practice powerful reinforcing among entire staffs the point of view of laborer makes solid since the employees are more drawn in work environment. In business environment practices, leadership and perspective of employees works towards a commitment to make stimulating motivation and inspiration among the employees (Yulk and Becker, 2006). Same times the organization always reinforcing to workers and builds up their capability towards the attempts that he/she performs. This has been shown when an employee is took responsibility with his/her assignments according to their level and feeling reinforcing in any event upgrades the practicality of the business organizations

in light of an individual's execution. Past review bolsters that positive relationship among worker strengthening, commitment, execution, center and accuracy and that things are possible when the employees are agreed stimulating that he/she plays out his attempts with more meticulousness with deliberation (Fandt,1991).

The transformational leadership style has a positive association with various outcomes and employee engagement is an overall form and is considered in the relationship of employee responsibility, implementation (Ferguson, 2009). This has been redesigned work engages in organizations that decrease's push employees sides (Gill, Flaschner, and Bhutani, 2010). This is not only worry in the work setting acknowledges and a negative part in the change of work engagement. Employee engagement and transformational administration style are emphatically contemplated concerning the workplace and studies drove on hierarchical settings. Relationship of transformational leadership style and worker engagement are besides kept up in the audited with to a great degree positive outcome. Transformational leadership makes and improves employees relationship, brining mutual trust in the organisation (Avey, Hughes, Norman, and Luthans, 2008).

Conclusion

On the premise of reviewed literature shows that transformational leadership has a positive relationship with employee engagement. This style enthuses, rouses and propels employees work towards the organizational objectives and the leaders can draw out the best in the subordinates by communicating trust in their capacities. Transactional leadership style likewise has a positive relationship with an employee engagement and utilizing this style leadership propels subordinates by fulfilling and valuing their supporters in lieu of undertaking achievement. The past review not just revealed hold up for already established transformational leadership and employee engagement affiliation, however more significantly it builds up the transactional leadership and employee engagement affiliation, particularly amid early phases of vocation and among youthful workers. One of the remarkable commitments of the review is the significance of both

transactional and transformational leadership in enabling engagement. The hypothetical establishment of work is maintained in research by Bass (1985) who had seen both transactional and transformational leadership style as positive and recommended a perfect usage of the styles for most noteworthy feasibility. Bass and Avolio (1997) awere of the feeling that in spite of the fact that transformational leadership style might be more powerful in evolving times, the transactional procedure of clearing up specific hopes for a reward is a fundamental segment of the full scope of successful leadership. These thoughts of the advocates of the transformational and transactional leadership have shown to have been out of core with emphasis around the transformational leadership make inquiries about as of late. In the previous couple of years, be that as it may, a few reviews have begun assessing and prescribing a leadership style that utilizations both transactional and transformational styles for particular results (Deichmann and Stam, 2015; Shuck and Herd, 2012). Passive-avoidant behaviours, for example, 'neglecting to meddle until problem turned into genuine and 'postponing or staying away from choices', have a negative relationship with employee engagement. Leaders need to look for such practices and should be equipped to have the competence to modify these practices and have the capability to contribute productively to employee engagement.

References

- Arnold, K. A., Turner, N., Barling, J., Kelloway, E. K., & McKee, M. C. (2007). Transformational leadership and psychological well-being: the mediating role of meaningful work. *Journal of occupational health psychology, 12*(3), 193.
- Avery, G. C. (2004). *Understanding leadership: Paradigms and cases*. Sage.
- Avey, J. B., Hughes, L. W., Norman, S. M., Luthans, K. W. (2008). Using positivity, transformational leadership and empowerment to combat employee negativity. *Leadersh. Organ. Dev. J., 29(2)*:110-126.
- Avolio, B. J., Zhu, W., Koh, W., Bhatia, P. (2004). Transformational

Leadership and Organizational Commitment: Mediating role of Psychological Empowerment and Moderating Role of Structural Distance. *J. Organ. Behav*., *25*: 951-968.

- Avolio, B.J., & Bass, B.M. (1991). *The full range leadership development programs: Basic and advanced manuals*. Binghamton, NY: Bass, Avolio & Associates.
- Bass, B. M. (1998). The ethics of transformational leadership. *Ethics, the heart of leadership*, 169-192.
- Bass, B. M. (1999). Two decades of research and development in transformational leadership. *European journal of work and organizational psychology*, *8(1)*, 9-32.
- Bass, B. M., & Avolio, B. J. (1994). *Improving organizational effectiveness through transformational leadership*. Sage.
- Bass, B. M., & Avolio, B. J. (2004). *Manual for the Multifactor leadership questionnaire*. Palo Alto, CA: consulting psychologist press.
- Bass, B. M., Avolio, B. J., Jung, D. I., & Berson, Y. (2003). Predicting unit performance by assessing transformational and transactional leadership. *Journal of applied psychology*, *88(2)*, 207.
- Bass, B.M. (1985). *Leadership and performance beyond expectation.* New York, NY: Free Press.
- Bass, B.M. (1988). The inspirational process of leadership. *J. Manage. Dev*. 21-31.
- Bass, B.M. (1990). Bass and Stogdill's handbook of leadership: theory research and managerial applications 3rd edition. NY: Free Press.
- Bass, B.M. (1994). Transformational Leadership and Team and organizational Decision Making. Sage Thousand Oaks .
- Bass, B.M., & Avolio, B. (1997). *Full range leadership development: Manual for the multi-factor leadership questionnaire*. Palo Alto, CA: Mindgreen.
- Baumruk, R. (2004).The missing link: the role of employee engagement in business success, *Workspan*, *47*, 48-52.
- Burns JM (1978). Leadership. New York: Harper & Row.

- Daft, R. L., & Marcic, D. (2006). *Understanding management*. Cengage Learning.
- Deichmann, D., & Stam, D. (2015). Leveraging transformational and transactional leadership to cultivate the generation of organization-focused ideas. *The Leadership Quarterly, 26(2),* 204–219.
- Dirks, K. T., & Ferrin, D. L. (2002). Trust in leadership: meta-analytic findings and implications for research and practice, 87*(4),* 611-628.
- Dvir, T., Eden, D., Avolio, B. J., & Shamir, B. (2002). Impact of transformational leadership on follower development and performance: A field experiment. *Academy of management journal, 45(4),* 735-744.
- Fandt, P. M. (1991). The relationship of accountability and interdependence behavior to enhancing team consequences. *Group. Organ. Stud.*300-312.
- Ferguson, A. (2009). 'Employee engagement': does it exist, and if so, how does it relate to performance, other constructs and individual differences?
- Frank, F.D., Finnegan, R.P. and Taylor, C.R. (2004), "The race for talent: retaining and engaging workers in the 21st century", *Human Resource Planning, 27 (3),* 12-25.
- Ghafoor, A., Qureshi, T. M., Khan, M. A., & Hijazi, S. T. (2011). Transformational leadership, employee engagement and performance: Mediating effect of psychological ownership. *African journal of business management, 5(17),* 7391.
- Gill , A., Flaschner, A. B., Bhutani, S. (2010). The Impact of Transformational Leadership and Empowerment on Employee Job Stress. *Bus. Econ*. J., pp. 1-11.
- Gonzalez-Roma, V., Schaufeli, W.B., Bakker, A.B. and Lloret, S. (2006), "Burnout and work engagement: independent factors or opposite poles?" *Journal of Vocational Behavior, 68,* 165-74.
- Hartog, D., Muijen, J.J., Koopman, V. (1997). Transactional vs.Transformational leadership: An

analysis of the ML Q. J. Occup. Organ. Psychol, *70*: 19-34.

- Howell, J.M., & Avolio, B.J. (1993). Transformational leadership, transactional leadership, locus of control and support for innovation: Key predictors of consolidated-business unit performance. *J. Serv. Mark., 16*: 487-502.
- Humphreys, J.H. (2002). Transformational leader behavior, proximity and successful service marketing. J. Serv. Mark., 16(6): 487-502.
- Ismail, A., Halim, F.A., Munna, D.N., Abdullah, A., Shminan, A.S., Muda, A.L., et al (2009). The Mediating Effect of Empowerment in the Relationship between Transformational Leadership and Service Quality. *J. Bus. Manage*., 4(4): 3-12.
- Jung, D. I., & Sosik, J. J. (2002). Transformational leadership in work groups: The role of empowerment, cohesiveness, and collective-efficacy on perceived group performance. *Small group research, 33(3),* 313-336.
- Kahn, W.A. (1990), "Psychological conditions of personal engagement and disengagement at work", *Academy of Management Journal*, *33*, 692-724.
- Kahn, W.A. (1992), "To be full there: psychological presence at work", *Human Relations*, *45*, 321-49.
- Kaiser, R. B., Hogan, R., & Craig, S. B. (2008). Leadership and the fate of organizations. *American Psychologist*, *63(2)*, 96.
- Kirkbride, P. (2006). Developing transformational leaders: the full range leadership model in action. *Industrial and commercial training*, *38(1)*, 23-32.
- Lee, Y. D., & Chang, H. M. (2006). Leadership style and innovation ability: An empirical study of Taiwanese wire and cable companies.
- Liao, H., & Chuang, A. (2007). Transforming service employees and climate: A multilevel, multi source examination of transformational leadership in building long-term service relationships. *Journal of Applied Psychology*, *92*, 1006–1119.

- Maslach, C., Schaufelli, W.B. and Leiter, M.P. (2001), "Job burnout", *Annual Review of Psychology, 52,* 397-422.
- Metzler, Joshua M., "The relationships between leadership styles and employee engagement" (2006). Master's Theses. Paper 2967.
- Mulford, B. (2008). The leadership challenge: Improving learning in schools.
- Pounder, J.S. (2002). Employing Transformational Leadership to enhance the Quality of Management Development Instruction. *J. Manag. Dev., 22(1)*: 6-13.
- Raja, M. W. (2012). Does transformational leadership leads to higher employee work engagement. A study of Pakistani service sector firms. *International Journal of Academic Research in Business and Social Sciences, 2(1),* 160.
- Richman, A. (2006), "Everyone wants an engaged workforce how can you create it?", *Workspan, 49,* 36-9.
- Robinson, D., Perryman, S. and Hayday, S. (2004), The Drivers of Employee Engagement, Institute for Employment Studies, Brighton.
- Rothbard, N.P. (2001), "Enriching or depleting? The dynamics of engagement in work and family roles", *Administrative Science Quarterly, 46,* 655-84.
- Schaufeli, W.B., Salanova, M., Gonzalez-Roma, V. and Bakker, A.B. (2002), "The measurement of engagement and burnout: a two sample confirmatory factor analytic approach", *Journal of Happiness Studies, 3,* 71-92.
- Shaw, K. (2005), "An engagement strategy process for communicators", *Strategic Communication Management,* 9(*3),* 26-9.
- Shin, S.J., Zhou, J. (2003). Transformational leadership conservation, and creativity: Evidence from Korea. *Acad. Manag. J., 46*: 703-714.
- Shuck, B., & Herd, A.H. (2012). Employee engagement and leadership: Exploring the congruence of two frameworks and implications for leadership development in HRD. *Human Resource Development Review*, 11(2), 156–181.

Volume 2 Issue 1,Jan to June 2016

Does Psychogenic Non-Epileptic Seizures Disorder (PNES) Respond to Cognitive Behaviour Therapy?: A Preliminary Research

Bajaj, M.K. *

*Assistant Professor of Clinical Psychology, Government Medical College & Hospital, Chandigarh. Sector 32 B, 160030.

Abstract

Patients who suffer from PNES often exhibit a higher incidence of symptoms such as anxiety and depression than patients with epilepsy, along with a reduced quality of life due to the effect of the seizures themselves. This study aims to examine the effectiveness of cognitive behavioral intervention in the treatment of PNES. Our primary objective is to assess the effectiveness of CBT in reducing seizure frequency. The study adopted a two-group comparison with pre and post assessment design. Sample: The sample consisted of 50 patients sub sequentially allotted to the Cognitive Behavior Therapy (n=30) and waiting control (n=20) groups. Along with the socio-demographic sheet seizure diary to record the frequency of seizure episodes, Hamilton Depression and Anxiety Rating scale (HDARS) tools were administered. The CBT group provided comprehensive cognitive behaviour therapy and the waiting control group provided only standard medical care. Conclusion: In this small clinical trial, treatment with the CBT for PNES appears to be a beneficial approach in helping patients with PNES reduce their seizure frequency, anxiety and depressive symptoms compared to standard medical care.

Key words: PNES, CBT, Anxiety, Depression.

Introduction:

Psychogenic nonepileptic seizures (PNES) are an uncomfortable topic, one which is difficult for both patients and healthcare professionals to discuss as well as treat, and yet it is estimated that PNES are diagnosed in 20 to 30% of patients seen at epilepsy centers for intractable seizures. Moreover, in the general population the prevalence rate is 2-33 per 100, 000, making PNES nearly as prevalent as multiple sclerosis or trigeminal neuralgia. Despite these startling statistics, PNES has largely remained a conversation held behind closed doors and in hushed tones throughout the medical community until now.

Epileptic seizures (ES) one of the most common neurological disorders, may be defined as a transient disturbance in brain function due to paroxysmal neuronal discharges. The non epileptic seizures refer to episodes that resemble epileptic seizures but that are not due to proximal neuronal discharges. A wide variety of medical problems can be misinterpreted as epileptic seizures. For

example syncope episodes caused by cardiac arrhythmias, vasovagal attacks or other transient cardiovascular events may be confused with epileptic events. In children, migraine, breath holding spells are also in the list. Non epileptic seizure (NES) may also have a psychological origin. As with medical disorders there are several other psychological disorders which are confused with epileptic seizures. These include panic attacks, hyperventilation attacks, and rage attacks. Most common is conversion disorder or dissociative episodes.

The term "psychogenic non epileptic seizures" (PNES) specifically refers to that subgroup of patients with NES in whom there is no physiological abnormality that explains the episodes and when there is a probable psychological reason to spells. Other synonymous terms are extent in the literature. The term "pseudoseizure"or "pseudoepilepsy" are often used.

Diagnosis of PNES is based on a history consistent with conversion disorder and confirmation of the diagnosis on prolonged video EEG (VEEG). Monitoring reveals the lack of epileptic form EEG changes during clinical events associated with alteration of consciousness or motor, sensory and/or autonomic phenomena; normal alpha rhythm (or no change in background rhythm) with or without the alteration of consciousness; and non stereotypic nature of the event. Typically, no sustained response to antiepileptic drugs (AEDs) is found. A history consistent with PNES is also used in making the diagnosis . Some patients who have possible or confirmed diagnosis of Epileptic seizures (ES) are considered to carry dual diagnosis of PNES/ES.

Treatment and management issues

Since the introduction of VEEG, epileptologist have had increased diagnostic capability, especially as regards the differentiation of ES from non epileptic seizures, which has led to many of the advances in the understanding and treatment of non epileptic seizures. A specific traumatic event, such as physical or sexual abuse, incest, divorce, death of a loved one, or other great loss or sudden change, can be identified in many patients with PNES. PNES may be more likely in people with a history of neurological/other physical disease and also can follow epilepsy surgery. It was reported that 10-37% of patients with epilepsy may also have PNES.

A Cognitive-Behavioural Model of PNES (McMackin, 2000) proposes that patients with PNES have specific belief systems regarding inhibiting expression of emotion as a result of their childhood experiences this means that they cannot deal with intense emotional experiences and develop physical symptoms in the form of seizures.

Patients who suffer from PNES often exhibit a higher incidence of symptoms such as anxiety and depression than patients with epilepsy, along with a reduced quality of life due to the effect of the seizures themselves. It is recognized, however, that conditions such as anxiety and depression often respond well to CBT. Modified from a CBT for patients with epilepsy workbook, the treatment manual has been developed over the past five years to address core issues in patients with PNES by LaFrance.

LaFrance and the researchers have outlined a clinical model for management of PNES, where a key component is to identify precursors, precipitants and perpetuating factors of the seizures. LaFrance says, "Based on the tendency of patients with PNES to somatize (to manifest mental pain as pain in one's body), they hypothesized that identifying and modifying cognitive distortions and environmental triggers for PNES would reduce PNES." The CBT to be effective in terms of reducing the frequency of PNES. He noted, "Upon completion of the CBT, 16 of the 21 participants reported a 50 percent reduction in seizure frequency, and 11 of the 17 who completed the CBT reported no seizures per week by their final CBT session." He also pointed out, "treating the seizure is not the sum total of treating the patient with a seizure disorder, so they assessed other important measures, as well." The evaluation of quality of life scores, as well as assessments of depression, anxiety, somatic symptoms and psychosocial functioning also showed statistically significant improvement from baseline to final session. With this in mind we started a preliminary study to assess the effectiveness of CBT in the treatment of PNES in our setup.

Aim:

To examine the effectiveness of cognitive behavioral therapy in the treatment of Psychogenic Non Epileptic Seizures (PNES) in comparison to standard medical care.

Objectives:

1. Assessment of the base line seizure frequency, anxiety and depressive symptoms in both the groups.
2. To study the differences between the two intervention groups.

Hypotheses:

1. There would be no difference at post intervention in both the groups on anxiety scores, depression scores and seizure frequency in persons having psychogenic non epileptic seizures.

Methodology:

Design: The study adopted a quasi experimental control group design with pre and post assessment comparison.

Sample: The sample consisted of 50 patients based on the exclusion and inclusion criteria given below and randomly allotted to the CBT (n=30) and waiting control (WC) (n=20) groups. The CBT group was provided comprehensive cognitive behaviour therapy for three months in once weekly format and the WC group was provided only standard medical treatment in the form of anti-anxiety and anti-depressant drugs in stable and adequate doses on monthly basis.

Inclusion Criteria:

- Age: 18-55 Years
- Gender : Any
- Video electroencephalogram (V EEG) confirmed diagnosis of PNES
- Have at least two non-epileptic seizure per month
- Able to complete self report symptom scales

Exclusion Criteria:

- Sub-average intellectual functioning
- Co- existing epileptic seizures or other neurological conditions.
- Previous history of psychological treatment
- Major psychiatric disorder i.e. schizophrenia, psychosis etc.
- Current suicidility
- Serious medical illness requiring current hospitalization

Primary Outcome Measures:

- Seizure frequency
  [Time Frame: monthly]

Secondary Outcome Measures:

- Hamilton anxiety and depression rating scales (HADRS)

Procedure:

After being diagnosed with PNES by video EEG monitoring (VEEG) and confirmed by a senior neurologist, informed consent was obtained from the participants. A total of 90 participants were screened and out of which 50 participants were fulfilling the inclusion

and exclusion criteria and gave the consent enrolled to two groups CBT (n=30) and Waiting Control (n=20) on simple random basis. Those selected in to the CBT group received once weekly sessions over 12 weeks of CBT. Those selected into the Waiting Control group received only standard medical treatment prescribed anti-anxiety and anti-depressant drugs in stable and adequate doses on monthly basis by the Neurologist. The seizure frequency, depression and anxiety symptoms were assessed at baseline, monthly basis and at treatment completion. Upon enrollment, subjects were evaluated. They have to keep a seizure diary, to evaluate their daily seizure activity. Further the subjects those did not attended the OPD were also followed by phone calls at month 4th week, 8th week, and 12th week after enrollment, to assess seizure status, medication usage, and global functioning.

Statistical analysis:

Inferential statistical methods of analysis were used. Mean, standard deviation, t-test was used to find out the differences between the groups. Data was analyzed with the help of SPSS.

Results: Results are presented in table 1-4.

Discussion: The aim of this study was to examine the effectiveness of the cognitive behavior therapy in the treatment of Psychogenic Non Epileptic Seizures (PNES) as compared to standard medical treatment. From the result table 1 it is clearly seen that

Table-1 *Baseline mean, sd and t values on seizures frequency and anxiety and depression measures in both groups*

Measures	n=30 CBT Group		n=20 WC Group		t values	Significance
	Mean	SD	Mean	SD		
Seizures frequency	.90	1.12	4.21	1.43	8.75	Highly significant
Anxiety	4.30	4.10	5.90	4.06	0.18	Not significant
Depression	4.62	2.14	7.75	4.39	0.88	Not significant

CBT group and WC groups were similar at baseline on seizure frequency, anxiety and depression measures as there were no significant difference observed on statistical analysis. So, to find out the effects of any intervention it is recommended that groups do not have any baseline differences on primary or secondary outcome measures.

Table - 2-*Post intervention mean, sd and t values on outcome measures between the groups*

Measures	n=30 CBT Group		n=20 WC Group		t values	Significance
	Mean	SD	Mean	SD		
Seizures frequency	.90	1.12	4.21	1.43	8.75	Highly significant
Anxiety	4.30	4.10	5.90	4.06	0.18	Not significant
Depression	4.62	2.14	7.75	4.39	0.88	Not significant

Table 2 showed post intervention at three months after enrolling to the study, statistically highly significant differences between the groups on primary outcome measures for seizure frequency, hence hypothesis of the study is rejected which suggests CBT is effective treatment for reducing the seizures frequency in PNES as compare to standard medical care. But no significant differences were observed on anxiety and depression measures at post intervention hence hypothesis is accepted for the anxiety and depression scores. This suggests equal effectiveness of the CBT in comparison to pharmacological intervention in reducing the anxiety and depressive symptoms in PNES. This may be because of small sample size.

Further, while analyzing it was also seen that pre to post changes were statistically significant in CBT group only this suggest greater effect size observed in the reduction of seizure frequency and anxiety , depressive symptoms (table 3). This indicates effectiveness of CBT in PNES. Whereas, in WC group there were no significant differences found from pre to post on seizure frequency and anxiety, depressive symptoms (table 4). This shows the superiority of CBT over standard medical care in the treatment of PNES.

Table 3 *Pre to post changes within the groups on measures of anxiety, depression and seizures frequency*

Measures		CBT Group n=30		t value	Significance
		Mean	SD		
Seizures frequency	Pre	5.26	2.25	9.57	Very significant
	Post	.90	1.12		
Anxiety	Pre	8.10	5.17	7.49	Very significant
	Post	4.30	4.10		
Depression	Pre	7.40	3.45	2.41	Significant
	Post	4.62	2.14		

Table 4

Pre to post changes within the groups on measures of anxiety, depression and seizures frequency

Measures		WC Group n=20		t value	Significance
		Mean	SD		
Seizures frequency	Pre	5.40	2.45	0.02	In significant
	Post	4.21	1.43		
Anxiety	Pre	7.85	5.44	0.06	In significant
	Post	5.90	4.06		
Depression	Pre	7.75	4.39	0.001	In Significant
	Post	4.55	1.87		

Further it was also noted that The dropout rate in the CBT group was very low (10%) as more than 50% patients completed 12 sessions of CBT and rest of the patients completed 8 sessions where as in waiting control group the dropout rate was high. Only 40% of the patients came for regular follow up in waiting control group. This also suggests the importance of CBT in the compliance of PNES treatment. This may be because of the kind of therapeutic intervention for example CBT which includes the psycho-education part which (includes the development of symptoms and its maintenance according to the cognitive point of view) helps the individual with PNES to develop a positive attitude towards their problem and treatment. This understanding was achieved by performing a demonstration by the therapist by differentiating symptoms of PNES and true epileptic seizures. It increases their motivation which further facilitates improvement. Whereas, in WC no such information is provided regarding the illness, they were just assured about their treatment. Overall findings are consistent with the other research findings of La Farance, 2000. They also showed overall 40-60% remission rates and 35-40% reduction in seizure frequency.

Finally, the findings are promising and has been consistent with previous research findings, in which other psychological treatments were also been compared and found to be effective than standard medical care. But there is a need to compare between different psychological treatment for the treatment of PNES in which CBT can be compared to Psychodynamic Psychotherapy, Biofeedback therapy, interpersonal psychotherapy. Since standard

medical treatment is no more effective than the CBT in the current research, but to find out the effectiveness of standard medical treatment this has to be compared with placebo control group whether these changes in anxiety and depression symptoms are because medication or these are because of time or corss sectional findings. So, well planed, double blind , randomized control group design with large sample size studies are the need of the time which also include the different psychological approaches to further strengthen the treatment approach in the particular PNES.

The main limitations of the study was, CBT intervention was not validated by an independent therapist this may have therapist bias, also the psychosocial functioning and quality of life was not assessed to further support the findings.

Conclusion: In this small clinical trial, treatment with the CBT for PNES appears to be a beneficial approach in helping patients with PNES reduce their seizure frequency, anxiety and depressive symptoms.

References:

- LaFrance, W. C. (2000) How many patients with psychogenic nonepileptic seizures also have epilepsy? *Neurology*,*58 (6)*, 990-1.
- LaFrance, W. C. & Devinsky, O. (2002) Treatment of nonepileptic seizures. *Epilepsy and Behaviour*, *3(5)*, 19-23.
- LaFrance, W.C. & Devinsky, O. (2004) The treatment of nonepileptic seizures: historical perspectives and future directions. *Epilepsia*, *45(2)*, 15-21.
- LaFrance, W.C. & Barry, JJ.(2005) Update on treatments of psychological nonepileptic seizures. *Epilepsy and Behaviour,7(3)*,364-74.
- LaFrance, W.C. , Alper, K. Babcock, D. Barry, JJ. Benbadis, S. Caplan, R. Gates, J. Jacobs, M. Kanner, A. Martin, R. Rundhaugen, L. Stewart, R. & Vert, C. (2006) for the NES Treatment Workshop participants. Nonepileptic seizures treatment workshop summary. *Epilepsy and Behaviour*, *8(3)*,451-61.
- LaFrance, W.C. Rusch, M.D. & Machan, J.T.(2008) What is "treatment as usual" for non-epileptic seizures? *Epilepsy and Behaviour*,*12(3)*, 388-94.
- LaFrance, W.C. (2008) Psychogenic non-epileptic seizures. *Current Opinion in Neurology*, *21(2)*,195-201.

Volume 2 Issue 1,Jan to June 2016

Management of Alcohol Dependence with co-morbid Psychiatric Disorder

***Gupta, T & **Gupta, C.S.**

*M.Phil, PhD Clinical Psychology, **DNB Psychiatry

Abstract

Co-morbidity of Alcohol dependence and mental disorders is very common presentation in our day today clinical practice. Co-morbid nature of illness poses a real challenge for mental health professionals in assessment and management of dual diagnosis patients. Here we present a case of 27 year old male who presented with history of alcohol dependence, sexual abuse in intoxicated state, repetitive sexual thought and guilt feelings, sadness of mood, decreased interest and interaction. The paper presents a comprehensive psychological assessment and psychotherapeutic management of the case using integrated approach to treatment that include various evidence based techniques of motivational enhancement therapy and cognitive behavior therapy. We also discussed the major challenges/barriers faced in the process and how to overcome those challenges.

Key words: Cognitive Behavior therapy, Integrated approach, Motivation enhancement therapy, co-morbidity

Introduction

Co-morbidity is defined as co-occurrence of two disorders in the same person, simultaneously or sequentially. The presence of Alcohol dependence with co-morbid psychiatric disorders is very common. The importance of co-morbidity implies in its effect on the course and prognosis of the illnesses. A high prevalence of co-morbidity of alcohol use disorder and psychiatric disorders has been consistently reported in epidemiological (Kessler et al., 1994; Wells et al., 1989; Bland., 1988; Andrews G, Slade T, Issakidis C et al., 2002) as well as clinical studies (Schuckit et al., 1997; Darke S & Ross J., 1997) from western countries. The research evidence has established the clinical relevance of co-morbidity as it is often associated with poor treatment outcome, increased risk of relapse, severe and prolonged illness course and increased burden of mental healthcare delivery system. A recent review of Indian studies on psychiatric co-morbidity in alcohol use disorder also reported mood disorders, psychotic disorders, anxiety disorders, personality disorder and sexual dysfunction as commonly associated diagnosis with alcohol use disorder (Singh & Balhara, 2016). We as mental health professionals often encounter such cases where co-morbidity makes the diagnosis as well as treatment complex. Here I am presenting a case that also became tricky as

well challenging due to the co-morbid nature of disorders.

Case Description

Mr. G is a is 27 years old male, educated up to 9th class, unmarried, belong to low SES and urban background presented with the chief complaints of alcohol abuse for past 12 years, repetitive sexual thought and guilt feelings for past 5 years, sadness of mood, decreased interest and interaction for past 3 years. He was apparently well 12 years back when he had to leave his studies due to financial constraints in the family. He started working as a salesman after discontinuing his studies to support his family. During that time, he found very little support from family and also lost his previous school friends. He would feel lonely in the evening after coming back from work so he joined a group of the boys in their neighborhood. One evening, one of his friends offered him some alcohol. He accepted that out of peer pressure and curiosity. He felt some kind of relief and relaxation from ongoing stress. Then he started consuming alcohol in company of his friends more often. Patient reported a strong desire and sense of compulsion to take the alcohol and also gradually increased in the amount of alcohol consumption to achieve the desired effect. He started consuming alcohol daily without fail. At times, he would steal money from his house for alcohol but later on he would feel guilty for the same. Many times he would think about leaving alcohol but could not resist his urge to have so. He also experienced withdrawal symptoms for alcohol like ghabrahat, palpitation, tremors, anxiety symptoms, sleep disturbances on discontinuation of alcohol or reduction in amount of alcohol.

Patient also reported repeated instances of sexual abuse from the age of 16 years by one of his friend who was older than him in age. Although these incidences had happened in the state of alcohol intoxication over which patient had no control .Still he assumed responsibility and felt guilty for the same. For past 5 years, he reported to have repetitive sexual thoughts that start after seeing other people around him. Whenever he interact with anyone, his attention would get focused on the genital area of the person which would then lead to recurrent thoughts about past experiences of his own sexual abuse. Most of the time he found himself to be preoccupied with these thoughts and feel distressed for the same. He would find these thoughts disturbing, irrational and completely unwanted. He would try to avoid

or resist these thoughts but would be unable to do so. As a result of these thoughts, he started to avoid people. He also started remaining alone at home and would scarcely engage in any meaningful conversation. He had stopped going to work. As reported by the informant that. Patient's mother expired due to renal failure 3 years back to whom he was closed to. Father reported that initial few months he was unable to accept the fact that his mother is no more. Subsequently he started feeling sadness of mood. He would not take interest in any pleasurable activity and would consume increased amount of alcohol. Family history revealed a significant history of alcohol abuse in father and depression in mother and elder brother. Mental Status Examination revealed anxious affect, preoccupation with sexual thoughts and depressive cognitions, with grade IV insight.

Method

Single case study design was used to assess the patient. The patient was assessed comprehensively using following tools.

Assessment

A detailed Psycho-diagnostic assessment was carried out and findings are shown in table 1

Table 1: Psychological Assessment, Rationale and findings

TEST ADMINISTERED	RATIONALE	FINDINGS
Sack Sentence Completion Test (SSCT)	To know the conflict areas	Severe conflict in family (father) area sex area (heterosexual relationships) and self area (fears and guilt feelings)
Draw a person Test (DAPT)	To know the psychopathology and self concept.	Feelings of inadequacy, lack of confidence, aggression, depressive conditions, rejection and need for affection, sexual conflict, obsession, anxiety, impulsivity, lack of ambition and passivity.
Beck Depression Inventory (BDI-II)	To assess the severity of depression.	Scores- 34, Severe level of depression.
Y-BOCS	To assess the severity and type obsessive and compulsive symptoms	Scores on obsession-21 (Moderate severity)
Rorschach Inkblot Test	To assess the personality structure	Limited kind of perception And stereotyped view of

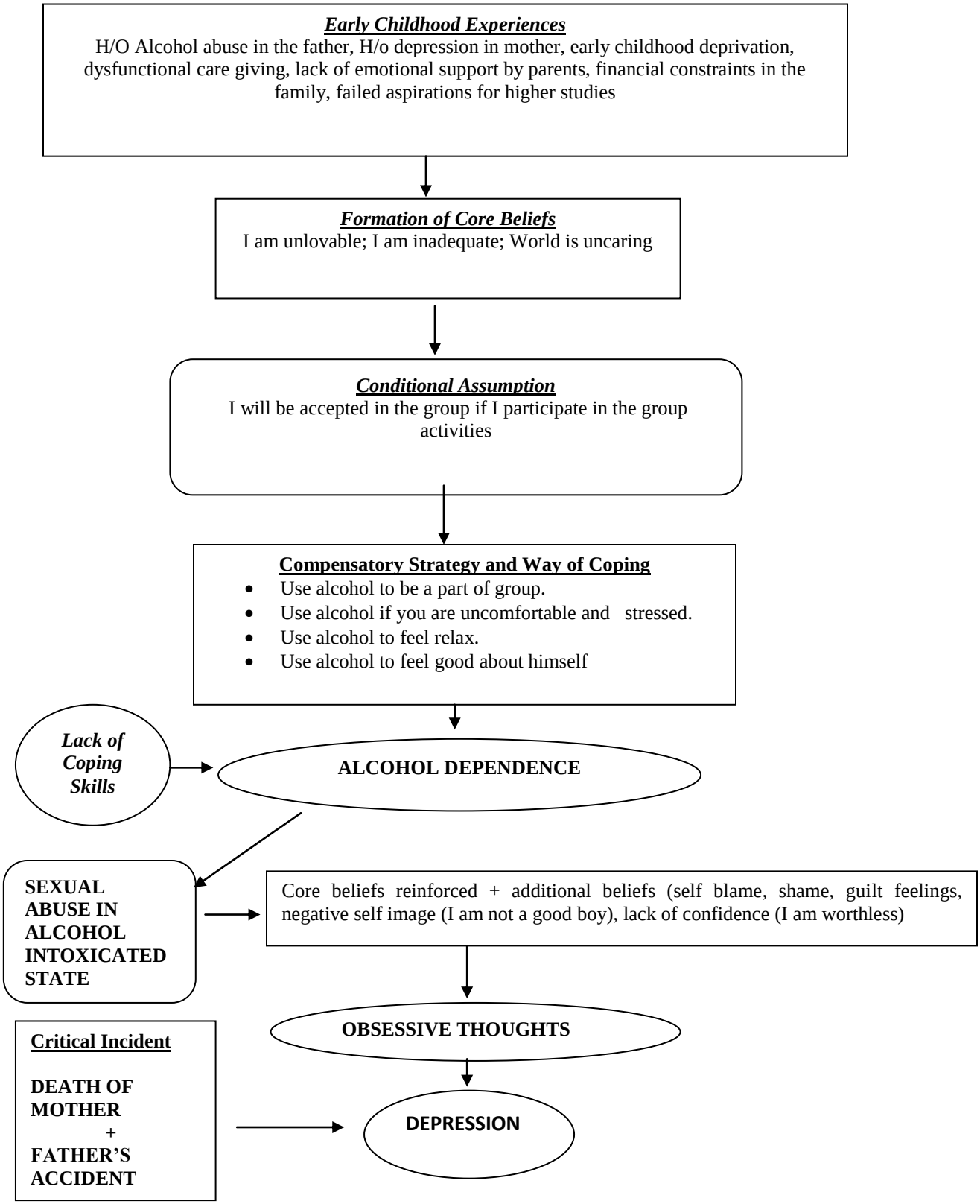
	and organization.	the world. Preoccupation with minute details. Difficulties in dealing effectively with other people and impaired interpersonal relations. Emotional deprivation, feelings of helplessness and lack of voluntary control in dealing with powerful instinctual urges.

PSYCHOLOGICAL FORMULATION

As we can see from the diagrammatic representation below that some childhood experiences like alcoholism in father, depression in mother caused early childhood deprivation, dysfunctional care giving, lack of emotional support by parents, financial constraints in the family and failed aspirations for higher studies. These experiences had contributed to the formation of core beliefs i.e I am unlovable, I am inadequate, world is uncaring. To counter that core beliefs patient developed a conditional assumption i.e. I will be accepted in the group if I participate in group activities. Lack of coping skills to deal with those core beliefs and ongoing stressors in the family led patient to use alcohol as a compensatory strategy or way of coping due to easy availability of alcohol with the development of some beliefs related to alcohol i.e use alcohol to be a part of the group, Use alcohol if you are uncomfortable and stressed., Use alcohol to feel relax, Use alcohol to feel good about himself. This later became an addiction and thus led to alcohol dependence. This alcohol dependence became a major contributing factor of sexual abuse done to the patent which further reinforced the existing core beliefs with additional beliefs related to self blame, shame, guilt, negative self image and lack of confidence and led to the formation of obsessive thoughts. In continuation with his obsessive thoughts, a critical incident in the form of mother's death and father's accident led to depression.

Volume 2 Issue 1,Jan to June 2016

Figure: 1 Psychological formulation



Therapeutic Process

An integrated approach was used by accommodating different techniques from motivation enhancement therapy (MET), supportive therapy and cognitive behavior therapy

Objectives of therapy:

Short term objectives:

- To ensure complete abstinence and symptom resolution.

***Long term objectives*:**

- Maintenance and relapse prevention with coping skills training

Initial phase

Initial phase of the treatment was focused upon the establishing rapport and connect empathically with the patient, explore more about his condition, goal setting and discussing about the psychological formulation of his illness.

Psycho-education and Goal Setting: Psycho-education session was focused on discussion about nature of illness and psychological formulation. Motivation assessment was carried out using readiness to change questionnaire. He was encouraged to ventilate his feelings and emotions about his experiences. Mutual goals' setting was done for therapy

Motivational interviewing & Activity Scheduling

Motivating enhancement therapy (MET) initiated by giving the feedback about the motivation assessment results that revealed contemplation stage of motivation. Patient was motivated by informing that you are at better motivation level as compare to other people. Therapist emphasized on client's responsibility for change and capability for change lie within the client.

Activity scheduling is a behavioral technique of CBT to manage passivity of depression. Patient was asked to engage himself in to some productive activities along with increased participation in ward activities with other patients.

Building phase of Motivation

Cost and Benefit analysis

Therapist encouraged the active involvement of the client in the identification of the problems caused by alcohol in the cost benefit analysis and tried to elicit the self motivational statement from the client by raising the client's awareness of the negative consequences of his drinking. In this

analysis, patient gave only one positive aspect of his drinking that he would feel nice after having a drink where as he reported many negative aspects of drinking. Therapist tried to prepare him to enter into frank discussion of change in order to reduce perceived discrepancy and regain emotional equilibrium.

Distraction techniques was taught to the patient after explaining the rationale by saying that it would help him reduce his preoccupation with sexual thoughts as well as distress associated with them. In distraction technique client is asked to count 20-1 backward counting whenever he would have the thoughts or he can engage himself in some activities like reading newspaper and watching TV. Therapist encouraged the patient to participate in the group meeting in the ward.

Decision matrix was reviewed by asking the patient to describe the benefits of change, disadvantages of continuing the use of alcohol. By using decision matrix, therapist assisted the patient to see accurately the consequences of drinking and to begin devaluing the perceived positive aspects of alcohol. Therapist's tried to shift the balance in favor of change. Therapist enhanced the self efficacy of the client by appreciating the client for his motivation.

Middle phase of the therapy:

Thought switching*:* A variant of thought stopping i.e thought- switching procedure was used. In which client was trained to dismiss the unwanted thought and substitute another thought in its place.

Ventilation, a technique of supportive therapy was used to address the issue of sexual abuse. The therapist encouraged the patient to ***ventilate*** his feelings and emotions related to those past experiences. The main focus of these sessions was addressing the client's feelings of guilt, and responsibility for the abuse and his beliefs related to that abuse by empathizing with the client.

Cognitive Restructuring was used to deal with the patient's beliefs about his own self and others. Therapist asked the patient to monitor his negative thoughts. Identified negative automatic thoughts were challenged by the therapist using verbal challenging and provided alternative views. Most of these thoughts were related to patient's feelings of inadequacy and low confidence in his ability to deal with the problems.

Positive self talk and Coping self talk was introduced to enhance the patient's self

efficacy and self esteem. It also helped the patient in dealing with the thoughts and feelings related to patient's inadequacy. Therapist prepared the flash cards of positive affirmations and asked the patient to verbalize it as home work assignment.

In the second phase of ***MET: strengthening the commitment*** to change. Therapist involved the father in the treatment process. Therapist asked the father to give his feedback about negative effects of drinking on the patient's life. At the same time, therapist asked the father to employ the support to the patient by commenting favorably on the positive steps taken by the patient to make a change in drinking. Therapist also tried to elicit the self motivational statement from father to facilitate the process of change in patient's behavior and to strengthening his commitment to change.

Terminal phase of therapy: focused on long term objectives of the treatment

Maintenance and Relapse Prevention

Assessment of High Risk Situation: Assessment of high risk situations was done. It involved the identification of events that typically precede the use of alcohol and the identification of the consequences which may reinforce or maintain that use. During the interview patient was asked to describe the all situations specific to them that had been frequently associated with heavy drinking, with strong urges to drink, or with difficulty resisting urges in the past. Patient reported financial stressors, family problems and peer pressure as the three high risk situations for lapse or relapse. After identification of high risk situation, therapist tried to enhance the coping skills of the patient.

Assertiveness training and Drink Refusal skills were used with the aim of enhancing the client's interpersonal effectiveness in social situations and would make him competent enough to handle the future high risk situations. Modeling and role plays were done in the session by creating the situation in the session to enhance the assertiveness of the patient. Session was also held on the management of craving using ***Stimulus control technique*** in which patient was asked to avoid those stimulus which provoke the drinking behavior.

Development of the Social Support Network of the client by increasing the patient's interaction within the family and to have a group of sober friends where he can share his feelings and to whom he can ask for help when needed. Patient was also

encouraged to be a member of a group which would help him in maintaining sobriety and to widen his social support network.

PHASE-3 MET

In phase -3 of the MET, therapist reviewed the progress and tried to enhance the motivation and commitment of the patient. Therapist educated the patient about relapse and lapse and how to handle it. Therapist expressed her confidence on patient's ability to deal with these situations in the future and tried to motivate him to take the responsibility. Therapist tried to prepare the patient for termination by increasing the time duration in between the session and giving all the responsibility on the client. It was done by appreciating his efforts and active involvement in the treatment.

Follow up and Outcome:

A total of 14 sessions were held with the patient. Eleven sessions were held during his inpatient stay and three sessions as follow up. He had significant improvement as he was maintaining abstinence for past 3 months after being discharged from the hospital. Improvement in sadness of mood and obsessive thoughts was also reported which was assessed during the post therapy assessment by using BDI-II and Y-BOCS. On BDI-II, patient obtained the score of 10, indicate minimal depression. On Y-BOCS, the scores on obsession come down to 10. A significant improvement was also observed in socio-occupational functioning of the patient as he started going to work and have got few sober friends. Booster sessions were planned for maintenance and relapse prevention.

Discussion

A number of different treatment approaches exist. The most common model of treatment for individuals suffering both alcohol use disorders and mental illness is sequential treatment. Commonly, the addiction is treated first, and once abstinence is achieved then the psychiatric symptoms are addressed. Alternatively, parallel treatment, in which a patient receives treatment for both addiction and mental illness simultaneously. Another evidence based approach to treat co-morbidity is integrated approach that has shown its effectiveness for managing substance use disorder co-morbid with anxiety or depression in a recent randomized control trial (Wüsthoff; Waal & Gråwe., 2014). Integrated approach was first developed in United States in 1989 (Minkoff

K., 1989) and with a purpose to offer a combine treatment to patients with substance use disorder with co-morbid mental disorder by the same therapist. This approach is comprehensive approach that use various evidence based techniques and focus on rehabilitation as well as harm reduction in such patients.

We also used integrated approach to manage the patient described above and the reason behind treating alcohol problem and psychiatric illness at the same time was its impact on the treatment outcome. Psychiatric symptoms affect a person's level of motivation to remain abstinent. At the same time as per our short term objectives of symptom resolution, we focused on the current issues of distress first and at the same time dealing with the alcohol dependence. A total of 14 sessions were held with the patient. Eleven sessions were held during his inpatient stay and three sessions were held in OPD follow up as booster sessions. The major obstacle in treating substance use lies in its nature of relapse and so here comes the role of regular booster sessions with the patient. As we all know that the ward stay is a very safe period for the patient to remain abstinent but the major test of maintenance of abstinence happens after going back to the same community of friends and same environment with same ongoing stressors. So it becomes important for the therapist to be in touch with patient's wellbeing and continue with booster session to enhance his coping skills to deal with high risk situations. Generally after getting discharged from the hospital, the patient would come for follow up to the treating doctor/psychiatrist for medication to manage withdrawal/craving however they lost follow up with therapist as they do not feel a need of the psychotherapeutic intervention or they do not want to be involved in to the therapy due to its time consuming nature. So to overcome this barrier we planned brief booster session with patient and encouraged him to be in therapy follow up by involving the treating psychiatrist to make sure that the patient would take booster session first and then get the medicine follow up and also encouraged family to share their concerns with the therapist and motivate patient to be in follow up.

The major challenges of treatment are being caused by the co-morbidity of alcohol dependence with depression, anxiety however to overcome this challenge we used symptom focused approach and target the most distressing part (guilt, shame of sexual

abuse) of illness first. Being a female therapist pause another challenge in rapport building with the patient. The major reason for improvement lies in patient's own level of motivation, continuous support from father and his self efficacious beliefs in his own ability. To conclude, integrated treatment approach is a need of hour for managing patients with co-morbidity.

REFERENCES

Andrews, G., Slade, T. I. M., & Issakidis, C. (2002). Deconstructing current comorbidity: data from the Australian National Survey of Mental Health and Well-being. *The British Journal of Psychiatry*, *181(4)*, 306-314.

Darke, S., & Ross, J. (1997). Polydrug dependence and psychiatric comorbidity among heroin injectors. *Drug and Alcohol Dependence*, *48(2)*, 135-141.

Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., ... & Kendler, K. S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey. *Archives of general psychiatry*, *51(1)*, 8-19.

Minkoff, K. (1989). An integrated treatment model for dual diagnosis of psychosis and addiction. *Psychiatric Services*, *40(10)*, 1031-1036.

Schuckit, M. A., Tipp, J. E., Bergman, M., Reich, W., Hesselbrock, V. M., & Smith, T. L. (1997). Comparison of induced and independent major depressive disorders in 2,945 alcoholics. *American Journal of Psychiatry*, *154(7)*, 948-957.

Singh, S., & Balhara, Y. P. S. (2016). A review of Indian research on co-occurring psychiatric disorders and alcohol use disorders. *Indian journal of psychological medicine*, *38(1)*, 10.

Wells, J. E., Bushnell, J. A., Hornblow, A. R., Joyce, P. R., & Oakley-Browne, M. A. (1989). Christchurch Psychiatric Epidemiology Study, Part I: Methodology and lifetime prevalence for specific psychiatric disorders. *Australian and New Zealand Journal of Psychiatry*, *23(3)*, 315-326.

Wüsthoff, L. E., Waal, H., & Gråwe, R. W. (2014). The effectiveness of integrated treatment in patients with substance use disorders co-occurring with anxiety and/or depression-a group randomized trial. *BMC psychiatry*, *14(1)*, 1-6.

Volume 2 Issue 1,Jan to June 2016

Suicidal Ideation Among Adolescents

Budhiraja R(M.A)* & Singh, V(Ph.D)**

*M.A Student of AIBHAS, Amity University, 2013.

** Corresponding Author, Dr. Vijander Singh Ex. Assistant Professor, AIBHAS, Amity University.

Abstract

Suicide is the third leading cause of death among people between ages of 10 to 24 years, with about 4400 lives lost each year. Prevalence of suicidal ideation is usually found to at an alarming rate among adolescents. Vijaykumar, 2007, suggested that failure in examination, anticipated punishment, physical illness, potentially self-injurious action with a non-fatal outcome and impending loss love are the major risk factors. Adolescent suicide is generally categorized as someone below age 21, deliberately ends their own life. The majority of suicides (37.8%) in India are by those below the age of 30 years. The fact that 71% of suicides in India are by persons below the age of 44 years imposes a huge social, emotional and economic burden on our society.

Key Words: Suicidal Ideation, prevalence, failure in examination.

Suicide is prevalent across continents under different stressful situations. It may be considered as an extension of symptoms of sever depression. Suicide is characterized and defined by an irrational desire to die. This irrational thought is regarded as a permanent solution to the worries of the individual rather than facing the difficulties and discomfort raised while facing the real-life failures and inability to cope. It is regarded as a complex behavior as a result of uncertainties in dealing with stress factors and underlining causes. It is considered as second most common cause of death among teenagers and among top ten causes at middle ages. Possible cause of suicide among adolescent are Family history of mental disorders or substance abuse disorder, physical or sexual abuse, over expectation by parents and self as well, unachievable goals, family violence and highly competitive environment.

Brabent, Habert et al (2013) explored the clinical profiles of 77 female teenagers survivors of sexual abuse and examined the association of abuse-related and personal

variables with suicidal ideations. Analyses revealed that 64% of the percipients experienced suicidal ideation. Finds from classification and regression analysis indicated that depression, PTSD, and hopelessness discriminated profile of suicidal and non-suicidal survivors. They suggested that suicidal ideation is not the sole variable to be discussed and explored but depression, hopelessness and post-traumatic stress symptoms are also related to suicidal ideation in survivors.

Brauch, Decker, et al (2011) examined adolescent participation in self-asphyxial risk taking behaviour and its relationship with other adolescent risk behaviours, including non-suicidal self-injury. Researchers proposed that participation in SAB and NSSI would be associated with suicidal behaviours, disordered eating and substance abuse. Using a large community-based sample, results revealed preliminary associations between self-asphyxial risk taking behaviour and non-suicidal self-injury reported more concurrent risk behaviours. Results indicate that greater awareness is important.

Methods

Objectives: 1. To assess suicidal ideation among adolescent. 2.To assess role of Psychological factors in suicidal ideation among adolescents.

Hypothesis : The study was an exploratory in nature, so it was hypothesis free.

Sample: A sample of 39 adolescent aged 13-18 were taken using purposive sampling. The sample of the study was collected from same geographical area i.e. Delhi and NCR.

Inclusion Criterion: Only adolescent aged 13-18 years were included.

Exclusion Criterion: Adolescent below 13 years and above 18 years were excluded and adolescent with premorbid psychiatric and medical ailment were excluded.

Measures: To understand the problem and objectives, a twofold approach, comprising of quantitative as well as qualitative analysis was adopted.

The participants were assessed following tools:

1. Consent form 2. Demographic data sheet 3. Suicidal ideation questionnaire ABOUT MY LIFE by William M. Reynolds was used.

Scoring: Scoring was done by placing the scoring key over the SIQ form HS questionnaire so that the black dots exactly overlie the black dots on the questionnaire. Items 2,3,4,7,8 and 9 were identified as critical items. The SIQ have high reliability (.97) and validity (.94).

Statistical Analysis: data was analysed using SPSS(Statistical Package for Social Sciences) 11.5. The most suitable method of analysis were descriptive statistics and correlational analysis.

Results and Discussion:

Table 1. shows us the socio-demographic details of the respondents. Here we can see that 38 individuals ,97.4% of the total no. of respondents belong to age group 16-18 years ,and 1 of them belongs to the age group of 13-15 years ,which is 2.6% of the total sample.26 of them are males, comprising a percentage of 66.67%, 13 of them are females comprising a percentage of 33.3%.While 14 of the total sample,35.9% are studying in

Table 1. Demography

	Frequency (%)
Age:	
13-15 years	1(2.6)
16-18 years	38(97.4)
Gender:	
Male	26(66.67)
Female	13(33.3)
Grade:	
10	14(35.9)
11	25(64.1)
Educational Qualification:	
Secondary	9(23.1)
Senior secondary	30(76.9)
Substance use:	
Yes	0(0)
No	39(100)
Living with family	
Yes	39(100)
No	0(0)
previous self-harming attempts:	
yes	8(20.5)
no	31(79.5)

grade 10, 25 of them belong to grade 11 which is 64.1% of the total. Also all of them are senior- secondary school qualified, show no substance use and are living with parents. 8 of them has attempted self-harming behaviours which 20.5% of the total sample and 31,which is 79.5% of the total sample, have shown no previous self-harming attempts.

From Table 2, it is evident that in item 2,i.e "I thought about killing myself' the highest frequency i.e. 19,48.7% of the total percentage is shown by the response "I never had this thought" and the lowest frequency is of the response "couple of times a week" i.e. 2, 5.1% of the total. item 3 i.e."I thought about how I would kill myself" again shows highest frequency of the response I never had this thought" i.e. 20(51.3%)and the lowest frequency is of the response "couple of times a month" i.e. 1, 2.6% of the total percentage. in item 4 i.e. ",I thought about when I would kill myself" the highest frequency i.e. 20,51.3% of the total percentage is shown by the response "I never had this thought" and the lowest

Table 2

Item/Response	I never had this thought (%)	I had this thought before but not in the past month (%)	About once a month (%)	Couple of times a month (%)	About once a week (%)	Couple of times a week (%)	Almost everyday (%)
ITEM 2	19(48.7)	13(33.3)	0(0)	0(0)	0(0)	2(5.1)	5(12.8)
ITEM 3	20(51.3)	11(28.2)	0(0)	1(2.6)	2(5.1)	0(0)	5(12.8)
ITEM 4	20(51.3)	14(35.9)	0(0)	0(0)	0(0)	0(0)	5(12.8)
ITEM 7	29(74.4)	2(5.1)	0(0)	1(2.6)	2(5.1)	0(0)	5(12.8)
ITEM 8	28(71.8)	4(10.3)	1(2.6)	0(0)	1(2.6)	1(2.6)	5(12.8)
ITEM 9	30(76.9)	2(5.1)	1(2.6)	0(0)	1(2.6)	0(0)	5(12.8)
ITEM 13	16(41)	3(7.7)	9(23.1)	5(12.8)	4(10.3)	2(5.1)	0(0)
ITEM 18	20(51.3)	10(25.6)	0(0)	1(2.6)	6(15.4)	0(0)	2(5.1)

frequency is of the response "almost everyday" i.e. 5, 12.8% of the total .

Table 2 also shows that, Item 7 i.e "I thought about what to write in a suicide note" reflects the highest frequency i.e. 29,74.4% of the total percentage is shown by the response "I never had this thought" and the lowest frequency is of the response "couple of times a month" i.e. 1,2.6% of the total representative sample. Item 8 i.e. "I thought about writing a will" shows the highest frequency of the response I never had this thought" i.e. 28,71.8% of the total and the lowest frequency is of the responses "about once in a week" and "couple of times a week" i.e. 1, 2.6% of the total percentage. Item 9 i.e." I thought about telling people I planned to kill myself" shows the highest frequency of the response I never had this thought" i.e.30,76.9% of the total and the lowest frequency is of the responses "about once in a month" and "about once in a week" i.e. 1, 2.6% of the total percentage Item 13 i.e. "I thought about how easy it would be to end it all" shows the highest frequency of the response I never had this thought" i.e. 16,41 % of the total and the lowest frequency is of the response "couple of times a week a week" i.e. 2, 5.1% of the total percentage Item 18 i.e. "I thought if I had a chance, I would kill myself" also shows the shows highest frequency of the response I never had this thought" i.e. 20,51.3%and the lowest frequency is of the response "couple of times a month" i.e. 1, 2.6% of the total percentage

The analytic aspects covered in Table 2. Shows that maximum respondents have answered to all of the above critical items with the response "I never had this thought" and the least frequent response in the critical items is "almost everyday". Hence , this indicates that greater no. of respondents do not reflect suicidal ideation and thoughts. But ,a few of the respondents have

responded with options “almost everyday” and “couple of times a week”. By interpretation with the suicidal ideation questionnaire manual, such individuals are classified critical and reflect suicidal ideation. the details and causes of such thoughts and suicidal ideation are probed by the methods of clinical case history taking.

Similar to present study, researchers were done by Reinherz, 2006, Halfon, Labelle, Cohen (2013) , examined psychosocial risks for adolescent suicidal ideation and attempts, as well as the link between earlier suicidal behaviour and later functioning. Early gender-specific risks for suicidal ideation included preschool behaviours that are counter to typical gender norms, such as aggressive behaviour in females and dependence in males. Suicidal ideation at age 15 and suicide attempts were both associated with deficits in later adolescence (at age 18) in behavioural and social-emotional functioning. It was concluded that suicidal ideation at age 15 was a marker of distress with long-term implications for later functioning.

References

Brabant, M. E., Hebert, M., & Chagnon, F. Identification of sexually abused female adolescents at risk for suicidal ideations: a classification and regression tree analysis. *J Child Sex Abus*, 22(2), 153-172.

Brausch, A. M., Decker, K. M., and Hadley, A. G. (2011). Risk of suicidal ideation in adolescents with both self-asphyxial risk-taking behavior and non-suicidal self-injury. *Suicide Life Threat Behav, 41(4)*, 424-434.

Mayer P, Ziaian T. (2002). Suicide, gender and age variations in India. Are women in Indian society protected from suicide? *Crisis, 23*: 98-103.

Halfon, N, Labelle, R., Cohen, D., Guile, J. M., and Breton, J. J. (2013) Juvenile bipolar disorder and suicidality: a review of the last 10 years of literature. *Eur. Child Adolesc. Psychiatry, 22(3)*: 139-151.

Vijaykumar, L. (2007). Suicide and its prevention: The urgent need in India. *Indian Journal of Psychiatry, 49 (2),* 81-84.

Reinherz, H. Z., Tanner, J. L., Berger, S. R., Beardslee, W. R., and Fitzmaurice, G. M.(2006). Adolescent suicidal ideation as predictive of psychopathology, suicidal behavior, and compromised functioning at age 30. *Am J Psychiatry.163(7):*1226-32.

Volume 2 Issue 1,Jan to June 2016

Instruction to Author

These articles should clearly describe new and carefully confirmed results and experimental procedure which should be given in required details for others to verify the work.

The manuscript should be prepared in English using "MS Word". "Times New Roman" font should be used. The font size should be of 12pt but main subheadings may be of 14pt. All research articles should have the following sections: Title page, Abstract, Key words, Introduction, Materials and methods, Results, Discussion, Conclusion, Acknowledgement (if any) and References.

Title: The title should then followed by the author name and the institution name and address by indicating suitable superscripts. Title page should contain title of the paper in bold face, title case, names of the authors in normal face, upper case (font size 12) followed by the address(es) in normal face lower case. An asterisk (*) must be placed after the corresponding authors name as superscript whose email id, fax, telephone number can be given. Corresponding author has the responsibility to ensure that all co-authors are aware and approve the contents of the submitted manuscript.

Abstract: This section should detail the problems, experimental approach, major findings and conclusion in one paragraph and should appear on the second page. Avoid abbreviation, diagram and references in the abstract. It should be single - spaced and should not exceed 150-200 words for full papers.

Keywords: Author(s) must give about 4-6 key words which can identify the most important subjects covered by the paper. They must be placed at the end of the abstract.

Introduction: The manuscript should include a brief introduction stating the purpose of the investigation and relating the manuscript to similar previous research. Only information essential to the arguments should be presented.

Materials and Methods: This section must contain specific details about the materials studied, instruments used, specialized chemicals source and related experimental details which allows other research worker to reproduce the results. Obtain permission for all fully borrowed, adapted, and modified tables and provide a credit line in the footnote. Results and Discussions The results should be concisely presented. Results and discussion may be separate or combined based on the author's requirement. Tables and figures should be designed to maximize the comprehension of the experimental data. The interpreted results should be explained clearly in discussions and should relate them to the existing knowledge in the field as clearly as possible. Tables, Graphs and figures (Illustrations) should be inserted in to the main text at respective place they should appear when published and should have appropriate numbers and titles with an explanatory heading. Labels of the table, graph and figures MUST be in the text form and should not form part of the image. Colour photographs and illustrations (line drawings, halftones, photos, photomicrographs etc) must be clean originals or digital files would be charged that may be intimated along with the acceptance letter. Those photographs must be clear and sharp. Digital files are recommended for highest quality reproduction.

Acknowledgement (if any): This section can be kept at the end of the manuscript before reference section. This section can be used to acknowledge the help of those who do not qualify for authorship or to acknowledge funding, donated resources or significant contribution to the research.

References: Use APA Style referencing.

Manuscript can be submitted by mail. Mail is upsjournal@gmail.com

Unique Institute of Behavioral Sciences (UIBS)
(Under the aegis of Unique Psychological Society)

Training Programs Schedule

S.NO.	Training
1.	**School Counseling**
2.	**Sexuality Education**
3.	**Relationship Counseling**
4.	**LD & ADHD**
5.	**Autism Spectrum Disorders**
6.	**Forensic Psychology**
7.	**Psychological Assessment and Testing**
8.	**Cognitive Behavior Therapy**
9.	**Career Counseling**
10.	**Basic Counseling Skills**
11.	**Research Methods Statistics**
12.	**Life Skills**
13.	**Alcohol & Drug De-addiction**

FOR DETAILS CONTACT US AT

uniquepsychological@gmail.com call at **011-6565-3070**

Visit
www.uibsdel.org

International Journal of Contemporary Issues in Behavioural Sciences

Subscription Form

Name:

Date of Birth: **Sex:** **Nationality:**

Address:

Email address:

Phone number **Mobile Number**

Organization Name & Address:

Subscription Fee: Tick right in the desired column and put x in all other column. All the charges are inclusive of postage.

	Annual	3 Years	5 Year
Individual	1700.00	4900.00	8000.00
Institutional	2200.00	6200.00	9400.00

Details of Subscription fee:

Bank

Name:.....Branch:.....City:.....

Draft

number:.....Date:.....Amount:.....

I _____certify that the information on this subscription form is complete and correct. I understand and declare that all information furnished and true to the best to my knowledge and belief.

SIGNATURE PLACE DATE

Directions: *Subscription form can be send along with Subscription fee by post or by hand to the address* ***Unique***

Unique Psychological Society
101 Bharat Nagar, New Friends Colony
New Delhi 110025
011-65653070
uniquepsychological@gmail.com
www.unipsy.in