CHAPTER-I
INTRODUCTION

1.1. Mental Health:

In the present era of globalization, privatization and liberalization, the entire scenario of the whole world is turned into a global village but the social attitudes, value patterns, conduct, and behavior of people have been radically changed in the inverse direction. Today people live in a money worshipping society which is full of competition with values of consumerism, individualism, materialism, hedonism, sadism and masochism have significantly increased and sensitivity towards others suffering has considerably decreased. Feelings of envy and jealousy toward others are spreading in each society with impersonal relationship, alienation, non consciousness and un- mindfulness which have damaged the person himself. All kinds of insecurities – physical, mental, social etc., have engulfed the psyche of the people who are crazy for more and more materialistic possessions in order to live luxuriously and also to leave the same for generations to come. Today’s men are unnecessarily running from early morning till late at night for minting money and amassing wealth with their never ending lust. Resulting lack of emotional-social support to fellow being has created anxiety, frustration, stress, tension, maladjustment with so many personal and social problems and have disturbed health of the individual to a great extent.
According to the World Health Organization in 2004, depression is the leading cause of disability in the United States for individuals ageing 15 to 44 (Thomson, 2007). Absence from work in the U.S. due to depression is estimated to be in excess of 31 billion dollars per year (Thomson, 2007). Depression frequently co-occurs with a variety of medical illnesses. Such as heart disease, cancer and chronic pain is also associated with poorer health status and prognosis (Munce et al., 2007). Each year, roughly 30,000 Americans take their lives, while hundreds of thousands make suicide attempts (centers for disease control and prevention) In 2004, suicide was the 11th leading cause of death in the United States (center for disease control and prevention), third among individuals ageing 15-24 years (Thomson, 2007).

Despite the increasingly availability of effectual depression treatment, the level of unmet need for treatment remains high (Thomson, 2007). Reducing depression within the United States population has been an essential priority of governmental organizations over the last decade. Mental illness, disability, and suicide are ultimately the result of a combination of biology, environment, and access to and utilization of mental health treatment (Thomson, 2007). Public health policies can influence access and utilization, which subsequently may improve mental health and help to progress the negative consequences of depression and its associated disability (Thomson, 2007). Emotional mental illness has been a particular concern in the United States since the U.S. has the highest annual prevalence rates (26 percent) for mental illnesses among a
comparison of 14 developing and developed countries (Demyttenaere et al., 2004). While approximately 80 percent of all people in the United States with a mental disorder eventually receive some form of treatment, on the average persons do not access care unit nearly a decade following the development of their illness and less than one-third of people who seek help receive minimally adequate care. Health is an indispensable quality in human being. It has been described as soil from which the finest flowers grow. Health indicates psychosomatic well-being of an individual and is a broader concept which includes physical, social and mental health. People in a state of emotional, physical and social well-being fulfill life responsibilities, function effectively in daily life and are satisfied with their interpersonal relationships and in themselves. Looking at the divesting scenario of the modern society, mental health is vitally important, as our entire thought process takes place in mind, our all goals originate from our mind, and all kinds of directions are issued from mind which guide, shape, and regulate our communication, conduct, and behaviour and determine our personal and social functioning as well as adjustment. If the mind is healthy, desirable behaviour exists. It will permit the individual to lead a socially and economically productive life. Mental health is a sense of well-being, and individual experience. It determines individual’s way of living, working and leisure activities. It produces happiness, stability, and security. It is the ability of an individual to make personal and social adjustment.
Before the second-half of the twentieth century, mental health was considered as the absence of mental disease but now it has been described in its more positive connotation, not as the mere absence of mental illness. Every living being yearns for happiness and bliss and tries alike to protect from disease and distress and overcome calamities and hurdles. Health is a vulnerable asset for every individual. According to an Arabian proverb, “A man, who is healthy and has optimistic view, has everything.” In Indian culture, various epics quoted purity and divinity as the two main characteristics of mentally healthy individual. In Sri Bhagvad Gita, the nature of God is described as, “fearless, purity of mind, wider knowledge, concentration, charity, self-control, sacrifice, uprightness, vigour, forgiveness, fortitude, freedom from pride”. The “gurus” has to possess certain characteristics, which everybody should follow and “Guru” is the role-model, the qualities of “Guru” are: nonviolence, truth, freedom from anger, tranquility, aversion towards fault finding, compassion, gentleness, modesty and steadiness. All these characteristics are of a well-adjusted, well-integrated and mentally healthy individual. In Sri Bhagvad Gita, Lord Krishna emphasized on harmonious relations among individuals which leads to sound mental health and adjustment. Lord Buddha, in his book “The Dharmapada” described the enlightened individuals and the procedures to attain real happiness in life, i.e., best relationship, “nirvana” is the highest happiness, cleanse the mind, cultivate and establish thyself in good, the wise are not elated in their happiness, nor depressed when touched by sorrow. Sri Ramakrishna Paramahansa and Swami Vivekananda
emphasized on service and sacrifice, which are the essential ingredients of sound mental health. According to Atharvaveda to the human personality is considered to be one whole. But in view of ailments, it is considered to have two major aspects, physical and mental. Human personality on physical side has three components as ‘vata’, ‘pitta’, and kapha’ (A.V. XVIII/4/29.33). These three components are in every human body since birth, varying different degrees but these try to maintain equilibrium, and disequilibrium of these components gives rise to physical illness (A.V. 1/2/3). The mental side is also constituted by the three ‘gunas’ or ‘vrittis’ – ‘sattav’, ‘rajas’, and ‘tamas’ (A.V. 1/1/1 and X/8/43). These ‘gunas’ are in ‘manas’ or mental personality since birth but they try to keep a certain equilibrium which generally maintains a healthy mental state in human beings. So the total human personality at any stage, that is both on physical and mental planes is a matter of balance or imbalance of these components, viz, ‘vatta’, ‘pitta’, ‘kapha’, and ‘sattav’, ‘rajas’, and ‘tamas’. Thus, equilibrium or homeostasis in both physical and mental planes is a state of holistic health and bliss. According to Atharvaveda (Singh, 1977). The imbalance in these states of three ‘prakriti gunas’ – ‘sattva’, ‘rajas’, and ‘tamas’ – causes the unhealthy states in the beings and only the person having homeostasis in these three mental components will have sound mental health. Sushrut has taken into consideration the health of the whole personality. According to him - the person, whose ‘Atma’ (soul or psyche), senses, and ‘mana’ (mind) are in a state of well-being is mentally healthy. Some other scholars of Aurveda such as Vagbhatta (Ashtang Samgrah)
and Kashyap have also emphasized the feeling of well-being as the essential condition of mentally healthy personality. Thus, the health of an individual, according to Aurveda, is a very comprehensive term which includes his physical, mental, and spiritual well-being. This is the holistic concept of health.

According to ‘Yoga’- Mental health is an integral part of the whole healthy personality. The outstanding features of the Indian concept of mental health are balanced physical and mental constitution, happy state of self and mind, and the holistic nature of health (Khurana & Singh, 1984; Sinha, 1990; Ram, 1998; and Dalal, 2001). Tripathi et al. (2006), stated that the Indian perceptions can make a positive contribution to the state of mental health in the modern life. Egolessness, the paradigm of ‘Sthitapragya’ and ‘Anasakti’, the paradigm of ‘Maitri’, ‘Karuna’, ‘Mudita’ and ‘Upeksha’ are the different perceptions as given by the Indian wisdom literature which complement and supplement holistic view of mental health. According to them mental health, however, is the positive capacity for living and enjoying the good life. Examination of the internal psychological states and process, i.e., ‘chittavritti’ is one of the central themes in the Indian wisdom literature. The Indian thoughts seek to understand and analyze natural inclinations, desires, passions etc., so as to consciously control them. The object of this control is to uplift and refine human personality by our coping and eliminating negative emotions and disvalues like ‘trishna’, ‘raga’, ‘dwesh’ and by replacing them with positive emotions and values like health well-being.
According to WHO Expert Committee (1959) “mental health implies the capacity in an individual to form harmonious relations with others and to participate in or contribute constructively to changes in his social and physical environment. It also implies his ability to a harmonious and balanced satisfaction of his own potentially conflicting instinctive drive, in that it reaches an integrated synthesis rather than the denial of satisfaction to certain instinctive tendencies as a means of avoiding the thwarting of others”. Mental health can be conceptualized without restricting its interpretation across cultures. WHO (2001) has recently proposed that mental health is ... “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”. World Health Organization (1946, 1986) definitions of positive mental health are still under debate but there has been a movement away from a focus solely on individual attributes such as coping skills or resilience to one which incorporates environmental and social conditions (Rutter, 1985; Health Education Authority, 1997; MacDonald & O’Hara, 1998; and Secker, 1998). So, mental health is an integral component of health through which a person realizes his or her own cognitive, affective, and relational abilities. With a balanced mental disposition, one is more effective in coping with the stresses of life, can work productively and fruitfully and is better able to make a positive contribution to his or her community (WHO, 2001).
1.2. The Humanist Concept of Mental Health

The humanistic concept has certain general premises, the first one being that man is not made for the state, for the purposes of society, but that the state and society have to serve man. The second is that man can be defined not only anatomically and physiologically, but also psychically and mentally. That in spite of differences between individuals, that in spite of differences between nations and races, man is one. Humanity is not an abstract concept, but a reality. That in as much as we are human every one of us represents humanity. We are all saints and all criminals, we are all children and we are all adults, who know that they have to die. We are all different, and yet we are all the same, and it is because of this that we can understand each other, that we can understand even the stranger. Art has many expressions and forms, and yet it is a universal language because it is the expression of universal humanity. This concept, that humanity is one and that all men share in the same basic human qualities, is the concept of humanism, is the concept of the Bible, and it is the concept of Buddha and Lao-tse, as well as it is the concept of Spinoza, Leibniz, Hegel, and Marx.

1.3. Concept of Mental Health

The concept of mental health as well as ‘mental illness’ is not a new one. Its roots are to be found in the early pre-history of man. On the basis of the primitive concept of animism’, the concept of mental illness’ grew out which based upon the ideas of animism’ (Medical writing of the Hindus) or ‘Evil spirits’ (In the medicine of Ancient Egypt). The earliest belief in this connection
was that man become mentally imbalance because ‘angry gods took his mind away’ (Kisker, 1964). This view was popular during the Homeric period, approximately three thousand years ago and a thousand years before the birth of Christ. Five hundred years later, at the time of Hippocrates, some developments were brought to understand the problem of ‘mental illness’.

Mental health is a term used to describe how well the individual is adjusted to the demand and opportunities of life. People differ in their adjustment to the problems of life; some people are able to adjust well and derive more satisfaction in socially approved manner. They are ‘normal’ or mentally healthy people.

Thus, Mental Health is the balanced development of the individual personality and emotional attitudes that enables him to live harmoniously with his fellow men. Mental Health is not exclusively a matter of the relation between persons; it is also a matter of the relation of the individual towards the community he lives in, towards the society of which the community is a part, and towards the social institutions which for a large part guides his life, determines his way of living, and the way he earns and spends his money, the way he sees happiness, stability and security.

Mental Health is a more complex concept than physical health. It is much more difficult to measure. Though we can usually recognize the extreme cases of mental ill health easily, it is difficult to categorize individuals who are normal in other ways but may have a problem in understanding another person’s view point or being
sensitive to the emotional needs of others. Such problems if they were sufficiently serious and persistent would definitely be indicative of poor mental health.

Declaration of Alma Ata on September 12, 1978, identified primary health care as a rational and practical means for developing and industrialized nations to achieve ‘Health For All by the year 2000’. It was hoped that attainment of this level of health by people will permit them to live a biologically healthy, socially enriching and economically productive life, irrespective of any national boundaries, racial prejudices, economic deprivation and political commitments”. To achieve the goal of the ‘Alma Ata Declaration’, the mental health services were to be integrated with health and social services so as to ensure the community’s well being.

The importance of mental health has been known to range from the care of the MI to the promotion of mental health. The field of mental health includes three sets of objectives. One of these has to do with mentally ill persons. For them the objective is the restoration of health. A second has to do with those people who are mentally healthy but who may become ill if they are not protected from conditions that are conducive to mental illness, which however not same for every individual. The objective for those persons is prevention. The third objective concerned with the upgrading of mental health of normal persons, quite apart from any question of disease or infirmity. This is positive mental health. It consists in the protection and development at all levels of
human society of secure, affectionate and satisfying human relationships and in the reduction of hostile tensions in persons and groups (Govindaswamy, 1970).

Therefore mental health covers an elusive and a multiplicity of meaning. As Sclmllez (1977) remarks the concept of mental health is difficult, challenging and complex. Mental health has attracted comprehensive operation in research and theoretical exposition.

1.4. Dimensions of Mental Health:

1) Close personal Relationship: Unsatisfactory scores in this component reflect a lack of the warmth and social sensitivity so necessary for healthy relationships with other people. Those who lack this warmth and sensitivity usually have few or no real friends, find difficulty working or playing harmoniously with others, and seldom have adult acquaintances in whom they can confide.

Oftentimes people learn by example. A warm, permissive, accepting manner on the part of the teacher will often “draw out” the individual who has problems with personal relationships. If, by a friendly manner, the teacher can gain the student’s confidence, help in learning to appreciate the values of satisfying relationships can be given. Most young people have positive qualities that, if cultivated, will enable them to make friends and get along well with people.

2) Interpersonal skills: The desire to gain the recognition of one’s peers is often impeded by a lack of skills in making satisfactory contacts. Some of the errors that students make which are indicative of a lack of the usual and necessary skills are; a) failure to aid other students who are in need of help, b) Failure to
evince an interest in another’s achievement or conversation, c) Minimization of actual criticism of the performance of others, d) Failure to repay courtesies or acts of kindness, and e) evidence of poor sportsmanship.

Popularity is to a considerable extent, a matter of skill in inter-personal relationships. As is the case with many skills, interpersonal skills can be taught if the learner is motivated. Most young person’s can be helped in becoming conscious of the values of these skills through group discussions. Every alert teacher can find situations where a short discussion on this subject will be beneficial.

3) Social Participation: Young people ordinarily enjoy being with others of their age group. Occasionally, however, teachers identify boys and girls who find participation with others very difficult. Examinees who give responses that place them in this situation are usually found, a) to be extremely timid, b) to shun organized group activities such as scout groups, school societies, and school parties or dances, and c) to gain social satisfactions vicariously through over indulgence in reading, watching television, and daydreaming.

Confidence in oneself and the desire to participate in social activities can be built up by practices exemplified by the a) acceptance of student as he is in a friendly, permissive manner b) Bringing a small number of shy and reserved individuals together in natural activities, c) Encouragement of participation in relatively controlled group activities in which lack of social skills will not be
obvious, and d) encouraging the shy individual to seek admittance into groups in which his known skills will be assets.

4) Satisfying work and Recreation: This refers to the psychological rewards that the individual obtains from time spent in school, at work, and in leisure-time activities. This component is exemplified by those a) who find school uninteresting and unprofitable, b) who have the hobbies and do not engage in recreational activities, and c) who spend a disproportionate amount of time on tasks they must perform, such as school work, chores, music lessons, etc. These latter tasks are not performed for purposes of self-satisfaction but because of the demands of others.

5) Adequate Outlook and Goals: The degree to which the individual can accept and make his own the outlooks and goals, which are accepted by society, will determine in large measure his adjustment to that society. Thus mental health includes assets and liabilities.

Assets are attitudes, beliefs, aspirations, skills and achievements which contribute to a sense of well-being and which support progress towards realizing one’s fullest potentialities. Where liabilities are threats to emotional security, which impede the attainment of needed satisfaction and objectives. The assets of mental health need to be increased while liabilities are to be minimized in order to attain positive mental health status.

According to Encyclopedic dictionary “Mental health refers to a state of mind which is characterized by emotional well-being, relative freedom from
anxiety and disabling symptoms and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life.

According to Menninger (1963) “Mental health is the adjustment of human beings to the world and to each other with maximum of effectiveness and happiness. It is the ability to maintain an even temper and alert intelligence, socially considerate behavior and happy disposition”.

Goldenson (1984) defined mental health as a state of mind characterized by emotional well being. Relative freedom from anxiety and disabling by emotional well being, relative freedom from anxiety and disabling symptoms and a capacity to establish constructive relationships and cope with the ordinary demands stresses of life. Mental health is an important aspect of one’s total health status. The basic determining factors of mental health status are happy home, an adequate school and health community. It is also influenced by the way our basic needs are satisfied specially in our childhood.

1.5. The Main Characteristics of Mental Health:

The main characteristic of mental health is adjustment. The greater the degree of successful adjustment, the greater will be the mental health of the individual. Mental health is that ability by means of which we establish our adjustment with the difficult situations of life and Mental Hygiene is that means or tool which makes this adjustment possible. This definition also helps to reveal the relation between health and mental hygiene, as well as the difference between them. Mental hygiene is the means to mental health In other words,
mental hygiene is that science which studies the laws and means of achieving mental health of maintaining it as well as doing away with mental ill-health. Mental health is the end and mental hygiene the means. Mental health refers to that condition of an individual which results from the normal organization and functioning of this mind. A mentally healthy person is mentally at ease.

A healthy individual is not only, physically healthy but is also mentally healthy. It includes a sound, efficient mind and controlled emotions. It means that both body and mind are working efficiently and harmoniously. Man is an integrated psychosomatic limit, whose behaviour is determined by both physical and mental factors. Mental health is a basic factor that contributes to maintenance of physical, health as well as social effectiveness. It is normal state of well being. In the words of Johns and Webster, “It is a positive but relative quality of life. It is condition which is characteristic of the average person who meets the demands of life on the basis of his own capacities and limitations”. It is a positive, active quality of the individual’s daily living. It means the ability to face and accept the realities of life.

2.1. Self-Confidence:

Meaning of Self Confidence:

Generally speaking- Self confidence is a feeling or belief in your powers and abilities. The dictionary meaning of self confidence is having confidence in one’s own ability. Two main things contribute to self confidence: self efficacy and self esteem. A child gains a sense of self efficacy when that child sees
himself mastering skills and achieving goals that matter in those skill areas. This is the confidence that, if a child learn and work hard in a particular area, will succeed and it’s this type of confidence that leads people to accept difficult challenges and persist in the face of setbacks.

This overlaps with the idea of self esteem, which is a more general sense that a person can cope up with what is going on in their lives, and that they have right to be happy. Partly, this comes from a feeling that the people around us, agreed with us, which may or may not be able to control. However, it also comes from the sense that a person is behaving virtuously, that they are competent at what we do, and that we can compete successfully when they put their minds to it. Some people believe that self confidence can be built with affirmations and positive thinking. Self confidence is the oil that smoothly turns the wheels of the relationship between an individual and their capability- that is, their natural talents, skills and potential.

Self-confidence introduction By Ellen Prue Having poor self-confidence or low self-esteem can make many things really difficult. Conversely, when you have self confidence that is solid and reliable, most things become easy and fun as well. Good self-confidence allows you to achieve the real goals in your life whether they are to do with work, relationships or just being comfortable with yourself. Without self-confidence it’s difficult to fulfill your potential in any area. If you’re giving a presentation and you’re constantly worrying about how you’re coming across, that’s a waste of brain power! How much more compelling,
exciting or persuasive would you be if all of your attention was focused
powerfully on the job in hand? If you’re talking to someone you’d like to get to
know better, how will you come across if you’re always thinking ‘Am I saying
the right thing?’, ‘Do they like me?’. If you’re going out socially, you need to be
able to enjoy it, that’s what socializing is about. People need other people, but
without self-confidence, you miss out on the joy that good relationships bring.
Think about it now. When are you at your most relaxed, happy, funny, or chatty?
It probably is when you’re with people you’re most comfortable with. Maybe old
friends or family. Now, what if you could feel that good meeting new people, in a
meeting at work or doing public speaking? What if you could really feel ‘I am
what I am, take it or leave it!’? How would things be if you could go into any
situation with curiosity and a sense of fun, with the thought ‘Whatever happens
here, I’ll be fine’? What will it mean to you to be 100% confident? Not arrogant,
not loud and annoying, just easily, calmly confident about who you are and what
you can do. It’s essential for your motivation that you do this. Think a little about
it now. What will those old difficult situations be like once you are self-confident?
How will you feel with that person that currently causes you problems?

The three biggest myths of self confidence these are the most common
things we hear with regards to having confidence:

- “You have to be born with it.” Not true, self-confidence is a set of skills that
can be learned, just like learning to drive or play a game.
“If you’ve had your confidence destroyed, it’s gone for good.” Wrong. It may take a greater leap of faith to start building it back up, but once you’re there you’ll be much harder than you were before and less likely to have your confidence shaken again.

“I’ll know I’m confident when I can be sure I’ll succeed at something new”. How can you know you’ll succeed when you’ve never done something before? Confidence is much more about tolerating uncertainty: being cool with not knowing what is going to happen.

1. **Modeling self-confidence** - One of the quickest and most effective ways to understand how someone else goes about things is to ‘model’ them. This means copying their outward appearance and so getting an idea of how they feel on the inside. This is so effective that some sports clinics have failing athletes do this - they show them video of their winning days including races, interviews, news footage and have them copy what they were doing at the time. And think of the apprentice system that still survives in some occupations. The apprentice would ‘pick up’ how to do things from the master just by being around him or her. When you really apply yourself to this you’ll find the difference astounding.

Think of one person who you consider to be self-confident in a situation where you would like to be (see your answers to exercise 1). Write down their name. Do this for every situation in which you would like more self-confidence. Once you have a ‘confidence model’ for every situation, write down what it is that lets you know that that person is confident - make it specific. For example,
rather than, “the way he looks”, write “his face is relaxed and smiling a little”.

Cover all aspects of the person:

- Facial expression
- Posture
- voice tonality (loud, soft, deep...)
- gestures
- the way they dress
- how they interact with others
- how others react to them
- anything else you notice about them

And if you can’t remember enough details for a really good description, study them and watch them. Important: When describing the person, it is vital to be as specific as possible. It’s no good writing that their posture is confident-looking. It’s confidence you’re learning to make here, so you need to know its ingredients.

2. Building unconscious patterns of self-confidence:

This exercise builds up an unconscious pattern for confidence. One of the biggest problems with self-confidence is that people spend their time trying to be less uncomfortable in a situation, or less nervous. Getting away from something is hard, and there’s no guarantee you’ll end up where you want to be. Just like a route map, the exercise lets your mind know where you want to go. Without a clear idea of your destination, you could end up anywhere.
Now, for the first confidence model on your list from exercise two, (if there’s more than one), read carefully through what you wrote about them until you begin to build up a strong idea of them. Then, as long as you’re somewhere you won’t be disturbed for 5 minutes, close your eyes and imagine being with that person in the sort of situation where you admire their confidence. The more relaxed you are, the better this works. Focus on the way their voice sounds, the way they look, how other people interact with them, the way they stand or sit, their facial expressions, gestures and so on… Once you’ve got a good imagination of that person in your mind, then imagine merging with them, or drifting into them. Imagine what it’s like to be that person, seeing how others react to you, how they look at you, how they talk to you, how it feels to be that person. Some people find this very easy; others take longer to become good at it. However, it is worth the effort - successful people are naturally good at this type of imaginative exercise it’s an essential ingredient for success.

Although this may seem very simple, it is startlingly effective. If you can ride a bike, you may remember a time when it was very hard to do. Then all of a sudden, it became easy. After that, even if you haven’t ridden a bike for years, you can hop back on one and off you go! This is how this exercise works. By imaginative rehearsal, you teach your mind to perform the skill unconsciously. So, just like with riding a bike, confidence becomes effortless. Some people worry that if they’re copying someone else, they’re not being themselves. Well guess how confident people got that way? They learnt it somewhere! Usually
this is by copying other people unconsciously while growing up, be it their parents or peers. This is partially how we form our personalities - by ‘trying things on’ and keeping the things we like. One last tip for keeping your confidence is to surround yourself with optimistic, positive people and ideas. You can’t expect to be at your best if people around you are always bringing you down. This doesn’t mean I advocate dumping your less upbeat friends of course, just to be aware of the effect that others can have on you. Read over what you have written in your course notes so far, just to get you in the swing of things. Do this now before reading further, paying particular attention to your answers to the questions in exercise one.

3. Self-confident fantasy:

Now you read over your notes from the previous exercises, get yourself comfortable and ready to do this exercise. Exercise four Imagine you have been granted three wishes. One of your wishes is to have the self-confidence you want. You go to bed tonight and during the night miraculously your wish is granted. When you wake up in the morning, you have all the confidence you need. What is life like? Close your eyes and really begin to explore this fantasy. Imagine going to bed, doing your night time routine, switching off the lights, getting comfortable in bed and that lovely feeling as you begin to drift off… This is a fantastic way to use your imagination. (After all, you probably use it to scare yourself enough - imagining things going wrong; why not use it to help yourself for a change?).
In your fantasy, answer the following questions:

- How do you feel when you get up in the morning?
- What do you look like in those situations that used to be a problem?
- How do you sound?
- What is your facial expression like?
- What do others notice about you that is different?
- How do you think about those things that used to be a problem?
- What do you do during your day that you didn’t before?
- Work at doing this exercise.

The more detail you include the better. This could be the most important 15 minutes you have ever spent. Afterwards, write in your notes the things you noticed about the newly confident you. This will be very useful for future exercises. Also, as I’ve already said, you must know where.

2.2. Leadership and Self-confidence

Self-confidence is the fundamental basis from which leadership grows. Trying to teach leadership without first building confidence is like building a house on a foundation of sand. It may have a nice coat of paint, but it is ultimately shaky at best. While the leadership community has focused on passion, communication, and empowerment, they’ve ignored this most basic element and in the process they have planted these other components of leadership in a bed of quicksand. Self-confidence indicates whether you are self-assured in your
judgments, decisions, ideas, and capabilities. Self-confidence influences individual goals, efforts, and frustration tolerance. Without strong self-confidence, leaders are less likely to influence followers or take on difficult tasks. Before most people can exert leadership, they need to develop an appropriate amount of self-confidence. Self-confidence is necessary for leadership because it helps assure group members that things are under control. A leader who is too self-confident, however, may not admit to errors, listen to criticism, or ask for advice. Also, you may appear insecure if you are too self-confident. Self-confidence is also important because it contributes to self efficacy.

2.3. Emotional Maturity and Self-confidence:

“My philosophy is that not only are you responsible for your life, but doing the best at this moment puts you in the best place for the next moment.” — Oprah Winfrey. The above statement stands true when the situations are handled confidently and with the state of emotional maturity at the right time. Since many years, the perceived dispute about the relationship between cognitive aspects and emotions, one can arrive at a conclusion based on theory and practice that cognitive components have upper hand in managing and directing emotions. Further, in turn, emotions do influence several aspects of one’s behaviour. Emotions are great motivating forces throughout the span of human life; affecting aspirations, actions and thoughts of an individual. Apart from emotions, self-confidence is also considered as one of the motivators and regulators of behaviour in a individual’s everyday life (Bandura, 1986). Self-
confidence is a positive attitude of oneself towards one’s self-concept. In general terms, “self confidence refers to an individual’s perceived ability to act effectively in a situation to overcome obstacles and to get things go all right” (Basavanna, 1975). A study by Mehta and Kaur (1996) found that self-confident girls (rural, urban and total sample) were found to be more adjusted in total and in all areas like emotional, social, educational, home and health. The literature is reviewed to indicate the dearth of information about impact of emotional maturity on particularly stress and self-confidence among adolescents.

Definition of Self Confidence:

In the words of Basavanna (1975), “In general terms, self confidence refers to an individual’s perceived ability to act effectively in a situation to overcome obstacles and to get things go all right.”

In the words of Bandura (1986), “Self confidence considered as one of the motivators and regulators of behaviour in an individual’s everyday life.”

In the words of Sieler (1998), “Self confidence is an individual’s characteristics (a self construct) which enable a person to have a positive or realistic view of situations that they are in”.

2.4. Characteristics of a self confident person:

(1) Self Belief

Self confident people simply believe that they can succeed and do what they set out to do. They are able to define goals for themselves and to take steps
to obtain them. Their self belief allows them to rise to any challenge. Believing in our own self is a powerful force, motivating and empowering.

(2) Assertiveness:

All the self confident people have the courage to be assertive enough to stand up for themselves and their beliefs. Even if their opinion is considered unpopular. Self confident people will stand up for what they believe in. Being assertive is not about being aggressive.

(3) Optimism:

Self confident people have a view of their future. They can recognize that even bad situations will eventually right themselves and that difficulties can be overcome with sensible plans. They have the ability to see the light at the end of the tunnel and plan their journey toward it. Optimism allows self confident people to believe that they will be fine, no matter how bad the current situation.

(4) Yourself:

Self confident people have realistic self images. They can look at themselves and find things they like. They don’t focus on the negative, instead realizing the things and they do well. However, they also recognize aspects of themselves on which they have to improve and through improving these things, they thus become stronger and more confident.

(5) Taking responsibility:

Self confident people have the courage to take responsibility for their own actions. When they make a mistake, they own up to and admit they are wrong.
They have the ability to learn from their mistakes and make changes needed to avoid the same mistakes in the future. That in turn increases their self-confidence.

Any individual’s success or failure depends not upon his/her abilities, but upon his perception about himself. In other words while doing any work how he perceives himself “Whether I do work, whether the given problem is simple or complex, may I attain success or not” all such perceptible factors determine the output. Strictly speaking any kind of failure or success will be determined by the self-confidence. Self-confidence is an attribute of perceived self, it is not apart from the self or it is not independent from the self. Self-confidence refers to an individual’s perceived ability to act effectively in a situation to overcome obstacles and to attain successes.

More often the very choice of an individual’s type of education soon after the compulsion of secondary education depends upon the level of self-confidence, which he has. To take decision on his/her own, about any matters-educational, vocational etc, is possible only for those individuals whose confidence to high in this context it is important to measure the self confidence of students in general and to study its effects on student academic performance particularly on their academic achievement. In general terms, self confidence refers to an individual perceived ability to act effectively in a situation to overcome obstacles and to get things go all right.

Different researchers have measured self-confidence as a construct, variously in the past. Klein and Schoenfeld (1941) measured it by asking the
subjects to state the degree of confidence they felt in the accuracy of their performance after they had taken some psychological tests. Immediately thereafter each subject was asked to rate his performance on the task just finished on a three paint rating scale and these rating were used to infer self-confidence.

3.1. Depression

Depression is one of the most common psychological problems affecting nearly everyone either personally or through a family member. Depression can interfere with normal functioning and frequently causes problems with work, social and family adjustment. Serious depression can destroy the family life and the life of the depressed person. The term depression is used in many different ways: to describe transient states of low mood experienced by all people at some time in their life through to severe psychiatric disorders. Depression is understood to be a condition that generally comes and goes that is more likely at certain stages of the life cycle and with some types driven by genetic, biological factors and other types being more a response to major life events.

The clinical diagnosis of depression is made on the basis of the existence of a collection of signs and symptoms also called a syndrome. Currently, the most widely used classification systems for depressive disorders are the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and International Classification of Diseases (ICD-10) which has replaced by ICD-9. The DSM-IV system underpins much clinical practice and is both a dimensional
and categorical are the sub typing of DSM-IV system. It allows a continuum of severity but also includes three major depression sub types:

1. Mild, moderate or severe major depression without psychotic symptoms.

2. Severe major depression with psychotic symptoms and

3. Melancholia. The ICD-10 system forms the basis of much research and international comparisons. It subdivides depression along a severity continuum into: a. Mild. b. Moderate and c. Severe with or without psychotic features. Depressive symptoms can be measured in the community and in research populations by a number of self-report inventories and checklists. Depression is nearly twice as common in women as in men. Many women (particularly in this cohort of older adults) may have experienced postpartum or “empty nest” depression that was not recognized or treated. Because of the stigma associated with mental illness in this cohort, the depression may have been labeled as having a “nervous breakdown” or “bed sick” after some traumatic life experience. As a result, there may be no record of depression in the medical or psychiatric history [Rogerio, 2007].

**Common Behavioral Challenges:**

The depressed persons may easily become so apathetic, lethargic and uncaring about personal hygiene, eating, activity etc., that the patients require an increased amount of staff time to execute their daily chores [Stice, 2001]. Many depressed elderly are mistaken for persons with dementia because of their concentration is so impaired that it seems their memory has failed. The person
may become psychotic, hearing voices or believing things that aren’t real leading staff to think them as schizophrenic [Migliore, 1994]. Agitated depression with increased irritability, brooding, pacing, and worry can create many problems for the staff and other residents. The person may become either verbally or physically threatening.

3.2 Types of Depression

**Major Depression:** Major depression is a serious illness that affects a person’s family personal relationships, work or school life, sleeping eating habits and general health. Its impact on functioning and well-being has been equated to that of chronic medical conditions such as diabetes. These observable changes occur nearly every day over at least a two week period of time and represent a change from the person’s previous level of functioning. A Major Depressive Disorder (MDD) is characterized by episodes of more persistent and pervasive disturbances in mood and accompanying features. It is formally diagnosed by the presence of at least five out of the nine symptoms including depressed mood and loss of interest. Over time, the person may also withdraw from social contact and show impairment in performing usual social roles. MDD is generally categorized into bipolar and unipolar subtypes. A distinction is made based on the different courses of the disorders and indicating different approaches to treatment [John, 2006].

**Minor Depression:** It is also called as “subclinical” or “subsyndromal” depression because it does not meet the full criteria for major depression. For
example, the person has 4 of 5 symptoms. Like major depression, minor depression is associated with disability, reduced quality of life and responds well to the same treatments that are used with major depression. 1. Dysthymic Disorder: It is a chronic but less severe form of depression that includes depressed mood and at least two additional symptoms that persist for at least two years. People with dysthymia may also develop major depression. 2. Bipolar Disorder: Bipolar disorder is characterized by episodes of depression which may alternate with mania, which is indicated by elevated mood or irritability and other symptoms. Bipolar disorder requires different treatments from major depression; professional diagnosis and treatment is essential. 1.2.5

Unipolar disorders: Unipolar disorders represents a larger residual group of disorders where an individual experiences depressive episodes only. 1.2.5.1 Melancholic or endogenous depression: It is associated with specific clinical features, particularly disturbance of psychomotor function. Although melancholic depression is rare in the community, it is an important condition in specialist treatment settings as it responds best to chemo physical treatments such as antidepressant drugs and electroconvulsive therapy, and 1.2.5.2 Residual: It is a quite heterogeneous group of disorders, including ‘reactive depression’, ‘adjustment disorder with depressed mood’ and depressions secondary to and personality style [Goldberg, 1988]. It also includes DSM-IV disorders such as dysthymia and cyclothymia. Both of the latter are characterized by either fewer depressive symptoms or less severe expression of
depressive symptoms than the MDDs, but the symptoms are persistent, lasting two or more years.

3.3. Post-Natal Depression

It describes the expression of depression associated with childbirth and post-partum mood disorder. These include brief episodes of depressed mood, MDD and post-partum psychosis in which psychotic symptoms are also present.

1.2.7 Adjustment Disorder with Depressed Mood: It has signs and symptoms of depression that occur in response to a significant psychosocial stressor but do not meet the full criteria for major depression. Symptoms occur within 3 months of the stressor and subside within six months after the stressor or its consequences have resolved.

1.2.8 Bereavement: It is signs and symptoms of depression that occur following the loss of a loved one. It is considered as bereavement unless the patients “persist for more than two months or include marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms or psychomotor retardation.”

Affective disorders or mood disorders are terms that can be used to describe all those disorders that are characterized by mood disturbance. Disturbances can be in the direction of elevated expansive emotional state or in the opposite direction, i.e., in a depressed emotional state. Seasonal affective disorder is a subtype of mood disorder where there is a seasonal pattern of mood variation. There is a regular pattern of onset and remission of depressive symptoms and episodes, which usually have onset in autumn / winter and remission in spring / summer. The
symptoms of seasonal affective disorder are a typical of depression, often comprising hypersomnia, carbohydrate craving as well as increased appetite and weight gain [David, 1989].

3.4. Causes of Depression

*Stress and Loss Associated with Ageing:* Physical illness or disability decreased sensory capacities, changes in social status and responsibilities to others. It decreased self esteem due to role loss or change, loss of friends and family, relocation, loss of financial resources, social isolation and diminished capacity to adapt to change. 1.3.2 Biological Depression: Comes “out of nowhere”, tends to be more severe than the “reactive” type and person more likely to have other episodes earlier in life

*Physical Illness:* Physical illness can directly cause the symptoms of depression, physical illness can cause a reaction of depression by causing chronic pain, or fear of pain, disability, loss of function, loss of self esteem, increased dependence, fear of death, depressed elderly may present with physical complaints and medications can cause the symptoms of depression. The environment in which physical illnesses are treated may contribute to isolation, sensory deprivation and enforced dependency.

3.5. Physical Illnesses that is Associated with Depression

Metabolic Disturbances: Acid-base disturbance, azotemia, uremia, dehydration, hypo and hypocalcaemia, hypo and hyperglycemia, hypo and hyperglycemia, hypo and hypernatremia and hypoxia. 1.4.2 Endocrine:

3.6. Signs and Symptoms of Depression:

Disturbed Mood: Sadness, discouragement, crying, anxiety, panic attacks, brooding, irritability and the patients feel sad, blue, depressed moods. 1.5.2. Disturbed Perception: Loss of ability to experience pleasure, withdrawal from usual activities often related to fatigue, loss of concentration, or inability to feel pleasure, feelings of worthlessness, unreasonable fears, which are often associated with anxiety, excessive worry, feelings of guilt, including self-reproach for minor failings, delusions, and hallucinations. 1.5.3 Behavioral Changes: Increased or decreased body movements: (e.g., psychomotor agitation or retardation); pacing,
wringing hands, pulling or rubbing hair, body, or clothing. Sleep disturbance: difficult to get sleep, staying asleep or especially waking up early. Changes in appetite: usually loss of appetite but sometimes increased appetite; weight loss, but occasionally weight gain; fatigue, decreased energy.

Preoccupation with physical health imagining as suffering from cancer or some other serious illness when the patients don’t have; Difficulty in concentrating, thinking or making decisions: slowed speech, slowed responses with pauses before answering, decreased amounts of speech, low or monotonous tones of voice; thoughts of death or suicide or suicide attempts; constipation and unusually fast heartbeat. 1.5.4 Study Indication Groups, Major depressive disorder, other depressive disorders, other psychiatric disorders, behavioral disorders and other disorders. 1.5.5 Other Depressive Disorders: Bipolar disorder, premenstrual dysphoric disorder, posts natal depression, seasonal affective disorder, typical depression, bipolar disorder, and dysthymia. 1.5.6 Other Psychiatric Disorders: Adjustment disorder, anxiety disorders, alzheimer’s disease, bulimia, generalized anxiety disorder, generalized social phobia, negative symptoms of schizophrenia, neurasthenia, non-depressed Obsessive Compulsive Disorder (OCD), pain disorder, panic disorder, post-traumatic stress disorder and social anxiety disorder.

4.1. Anxiety:

Anxiety plays an important role in sports and games. Anxiety is considered as an important phenomenon in motor performance. Anxiety especially the state
type plays a significant role in the motor performance of individuals. Adjustment of these natural properties may have to be done with some care. Either type may be amenable to high level sports performance with certain constraints. Trait Anxiety is predisposition to perceive certain situations as threatening and to respond to these situations with varying levels of state anxiety. In Spielberger’s (1977) words- Anxiety states are characterized by subjective, consciously perceived feelings of apprehension and tension, accompanied by or associated with activation or arousal of the automatic nervous system.

Anxiety is an emotion that predates the evolution of man. Children, adolescents and adults experience anxiety in different forms. While this is visible in some, it can be inferred in others from their physiological and psychological responses. Anxiety also varies in frequency and intensity in different persons, even in response to the same stimulus (Trivedi & Guptha, 2010). It is a generalized state of apprehension or foreboding. There is much to be anxious about. Our health, social relationships, examinations, careers and conditions of the environment are but a few sources of possible concerns. It is normal and even adaptive to be somewhat anxious about these aspects of life.

Anxiety serves us when it prompts us to seek regular medical checkups or motivates us to study for tests. Anxiety is an appropriate response to threats, but it can be abnormal when its level is out of proportion to a threat. In extreme forms anxiety can impair our daily functioning. History and definition nearly a century ago, Sigmund Freud (1895) coined the term anxiety neurosis, which he believed
resulted from dammed-up libido: a physiological increase in sexual tension leads to a corresponding increase in libido, the mental representation of physiological event. The normal outlet of such tension in Freud’s view is sexual intercourse but 2 sexual practices such as abstinence and coitus interrupts prevent tension release and produce neuroses. The conditions of heightened anxiety related to libidinal blockage include neurasthenia, hypochondriasis, and anxiety neuroses, all of which were regarded by Freud as having a biological basis. The word anxiety has as its root angst, German for fear.

According to Hallam (1992) anxiety is a word used in every day conversation and refers to a complex relationship between a person and his situation. Anxiety is often a diffuse, unpleasant and uncomfortable feeling of apprehension, accompanied by one or more bodily sensations that characteristically recur in the same manner in the person. It is an alerting signal that warns an individual of imminent danger and enables him to take measures to deal with it. Anxiety and fear may exist simultaneously or follow each other. Anxiety or fear-arousing stimulus may be internal or external, immediate or future, definite or vague, and conflictual or non-conflictual in nature. One can, however, differentiate anxiety from fear, in that in fear no conflict is involved and the threat is known. A symptom of anxiety involves a variety of symptoms such as fear, distractibility, muscle tension, and restlessness.

The following are the main symptoms of anxiety (DSM-IV-TR; APA, 2000). Mood symptoms: Mood symptoms in anxiety disorders consist primarily
of anxiety, tension, panic and apprehension. In 3 individual suffering from anxiety experiences a feeling of impending doom and disaster. Secondary mood symptoms caused by anxiety may include depression and irritability. Cognitive symptoms: Cognitive symptoms in anxiety disorders revolve around the doom and disaster scenarios anticipated by the individual. Because the individual’s attention is focused on potential disasters, the individual ignores the real problems at hand and is therefore inattentive and distractible. As a consequence, the individual often does not work or study effectively, which can increase his or her anxiety. Physical symptoms: The physical symptoms of anxiety can be divided into two groups. The first group consists of the immediate symptoms, including sweating, dry mouth, shallow breathing, rapid pulse, increased blood pressure, throbbing sensations in the head, and feelings of muscular tension. These symptoms reflect a high level of arousal of the autonomic nervous system. Other immediate symptoms include hyperventilation, light headedness, headache, tingling of the extremities, heart palpitations, chest pain, and breathlessness. If the anxiety is prolonged, the second group of symptoms may set in. These delayed symptoms include chronic headaches, muscular weakness, gastrointestinal distress and cardiovascular disorders, including high blood pressure and heart attack. These symptoms reflect the breakdown of the physiological systems caused by prolonged arousal. Motor symptoms: Because of the high level of arousal, anxious individuals often exhibit restlessness, fidgeting, pointless motor activity such as toe tapping and exaggerated startle responses to sudden noise.
Normal versus abnormal anxiety in many instances anxiety is a normal, adaptive and positive response that motivates us and increases our productive efforts. There are three factors to consider when making a distinction between normal and abnormal anxiety (DSM-IV-TR; APA, 2000). 1. Level of the anxiety: In many situations some level of anxiety is appropriate, but if the anxiety goes above that level, it can be considered abnormal. 2. Justification for the anxiety: Anxiety for which there is not a realistic justification is considered abnormal. 3. Consequences of the anxiety: Anxiety that leads to negative consequences can be considered abnormal. In DSM IV anxiety is considered a symptom if it interferes significantly with the person’s normal routine, occupational/academic functioning or social activities or relationships or there is a marked distress about having the anxiety symptoms. 5 Types of anxiety disorders The DSM IV-TR recognizes the following specific types of anxiety disorders: phobic disorders, such as specific phobia, social phobia and agoraphobia; panic disorder with agoraphobia and without agoraphobia, generalized anxiety disorder, obsessive compulsive disorder, and acute and posttraumatic stress disorder. Prevalence of anxiety disorders Anxiety disorders are one of the most prevalent of all psychiatric disorders in the general population. Simple phobia is the most common anxiety disorder, with up to 49 percent of people reporting an unreasonably strong fear and 25 percent of those people meeting the criteria for simple phobia. Social anxiety disorder is the next most common disorder of anxiety with roughly 13 percent of people reporting symptoms that meet the DSM criteria. Post traumatic
stress disorder which is often unrecognized, afflicts approximately 7.8 percent of the overall population and 12 percent of women, in whom it is significantly more common. In victims of war trauma, post traumatic stress disorder prevalence reaches 20 percent. Surprisingly, disorders that are more commonly recognized have lower lifetime prevalence rates, generalized anxiety disorder and panic disorder, have lifetime prevalence rates of roughly 5 percent and 3.5 percent, respectively. Of the panic sufferers, up to 40 percent also meet the criteria for agoraphobia. Another often under diagnosed disorder, obsessive compulsive disorders is found in 2.5 percent of the population (Kessler, Demier, & Frank, 2005). The female to male ratio for any lifetime anxiety disorder is 3:2. Most anxiety disorders begin in childhood, adolescence, and early adulthood. Separation anxiety is an anxiety disorder of childhood that often includes anxiety related to going to school. This disorder may be a precursor for adult anxiety disorders. Panic disorder demonstrates a bimodal age of onset in the age groups of 15-24 years and 45-54 years. The age of onset for obsessive compulsive disorder appears to be the mid 20s to early 30s. Most social phobias begin before the age of 20 years (median age at illness onset is 16 years.) Agoraphobia usually begins in late adolescence to early adulthood (median age at illness onset is 29 years.) In general, specific phobia appears earlier than social phobia or agoraphobia. The age of onset depends on the particular phobia. Most simple (specific) phobias develop during childhood (median age at illness onset is 15 years) and eventually
disappear. Those that persist into adulthood rarely go away without treatment (Kessler, Demier, & Frank, 2005).

4.2. Generalized anxiety disorder

A) Excessive anxiety about a number of events or activities, occurring more days than not for at least six months.

B) The person finds it difficult to control the worry.
   
   a) The anxiety and worry are associated with at least three of the following six symptoms (with at least some symptoms present for more days than not for the past six months): a) Restlessness or feeling keyed up or on edge. b) Being easily fatigued. c) Difficulty concentrating or mind going blank. d) Irritability. e) Muscle tension. f) Sleep disturbance.

C) The focus of the anxiety and worry is not confined to features of an Axis I disorder, being embarrassed in public (as in social phobia), being contaminated (as in obsessive-compulsive disorder), being away from home or close relatives (as in separation anxiety disorder), gaining weight (as in anorexia nervosa), having multiple physical complaints (as in somatization disorder), or having a serious illness (as in hypochondriasis), and the anxiety and worry do not occur exclusively during posttraumatic stress disorder.

D) The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social or occupational functioning.
E) The disturbance does not occur exclusively during a mood disorder, a psychotic disorder, pervasive developmental disorder, substance use, or general medical condition.

1) Specific phobia:

A) Persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation.

B) Exposure provokes immediate anxiety, which can take the form of a situationally predisposed panic attack.

C) Patients recognize that the fear is excessive or unreasonable.

D) Patients avoid the phobic situation or else endure it with intense anxiety or distress.

E) The distress in the feared situation interferes significantly with the person’s normal routine, occupational functioning, or social activities or relationships.

F) In persons younger than 18 years, the duration is at least six months.

G) The fear is not better accounted for by another mental disorder.

2) Social phobia:

A) A marked or persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others and feels he or she will act in an embarrassing manner.

B) Exposure to the feared social situation provokes anxiety, which can take the form of a panic attack.

C) The person recognizes that the fear is excessive or unreasonable.
D) The feared social or performance situations are avoided or are endured with distress.

E) The avoidance, anxious anticipation, or distress in the feared situation interferes significantly with the person’s normal routine, occupational functioning, or social activities or relationships.

F) The condition is not better accounted for by another mental disorder, substance use, or general medical condition.

G) If a general medical condition or another mental disorder is present, the fear is unrelated to it.

H) The phobia may be considered generalized if fears include most social situations.

3. **Agoraphobia:**

A) Fear of being in places or situations from which escape might be difficult (or embarrassing) or in which help might not be available in the event of having unexpected panic-like symptoms.

B) The situations are typically avoided or require the presence of a companion.

C) The condition is not better accounted for by another mental disorder.

4. **Panic attack:**

A panic attack is a period of intense fear or discomfort, developing abruptly and peaking within 10 minutes, and requiring at least four of the following:
1. Chest pain or discomfort
2. Chills or hot flushes
3. Derealization (feelings of unreality) or depersonalization (being detached from oneself)
4. Fear of losing control
5. Feeling dizzy, unsteady, lightheaded, or faint
6. Feeling of choking
7. Nausea or abdominal distress
8. Palpitations or tachycardia
9. Parenthesis
10. Sensations of shortness of breath or smothering
11. Sense of impending doom
12. Sweating
13. Trembling or shaking

5. Panic disorder:

1. Recurrent unexpected panic attacks. At least one of the attacks has been followed by at least one month of one or more of the following: a) Persistent concern about having additional panic attacks b) Worry about the implications of the attack or its consequences c) A significant change in behavior related to the attacks B. Presence or absence of agoraphobia. C. The panic attacks are not due to the direct physiologic effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism). D. The panic
attacks are not better accounted for by another mental disorder. Obsessive-compulsive disorder A. either obsessions or compulsions: Obsessions as defined by 1, 2, 3, and 4. 1) Recurrent and persistent thoughts, impulses or images that are experienced as intrusive and inappropriate, causing anxiety or distress. 2) The thoughts, impulses or images are not simply excessive worries about real-life problems. 3) The person attempts to ignore or suppress such thoughts, impulses, or images or to neutralize them with some other thought or action. 4) The person recognizes that the obsessional thoughts, impulses or images are a product of his or her own mind. Compulsions as defined by 1 and 2, 1) Repetitive behaviors or mental acts that the person feels driven to perform in response to an obsession or according to rules that must be applied rigidly. 2) The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation. B. These behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent, or they are clearly excessive. C. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. D. The obsessions or compulsions cause marked distress, take up more than one hour a day, or significantly interfere with the person’s normal routine, occupation or usual social activities. E. If another Axis I disorder, substance use, or general medical condition is present, the content of the obsessions or compulsions is not restricted to it. 13 Posttraumatic stress disorder A. The person has been exposed to a traumatic
event in which both of the following were present: 1) the person experienced, witnessed or was confronted with an event that involved actual or threatened death or serious injury or a threat to the physical integrity of others. 2) The person’s response involved intense fear, helplessness, or horror. B. The traumatic event is persistently re-experienced in at least one of the following ways: 1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. 2) Recurrent distressing dreams of the event. 3) Acting or feeling as if the traumatic event was recurring, including a sense of reliving the experience, illusions, hallucinations, and flashback episodes. 4) Intense psychological distress at exposure to cues that symbolize an aspect of the traumatic event. 5) Physiologic reactivity on exposure to cues that symbolize or resemble an aspect of the traumatic event.

6. Etiology of anxiety disorders:

There are no clear-cut answers as to why some people develop an anxiety disorder, although research suggests that a number of factors may be involved. Like most mental health problems, anxiety disorders appear to be caused by a combination of biological factors, psychological factors and challenging life experiences, including: x stressful or traumatic life events x a family history of anxiety disorders x alcohol, medications or illicit substances x other medical or psychiatric problems Biological factors The biological causes of anxiety disorders include problems with brain chemistry and brain activity, genetics and medical, psychiatric and substance use issues. 17 Regulation of brain chemistry
Research has revealed a link between anxiety and problems with the regulation of various neurotransmitters, the brain’s chemical messengers that transmit signals between brain cells. Three major neurotransmitters are involved in anxiety, serotonin, nor epinephrine and gamma-amino-butyric acid (GABA) (Lydiard, 2003). Serotonin plays a role in the regulation of mood, aggression, impulses, sleep, appetite, body temperature and pain. A number of medications used to treat anxiety disorders raise the level of serotonin available to transmit messages. Nor epinephrine is involved in the fight or flight responses and in the regulation of sleep, mood and blood pressure. Acute stress increases the neither release of nor epinephrine. In people with anxiety disorders, especially those with panic disorder, the system controlling the release of nor epinephrine appears to be poorly regulated. Some medications help to stabilize the amount of nor epinephrine available to transmit messages. Gamma-amino-butyric acid plays a role in helping to induce relaxation and sleep, and in preventing over excitation. Medications known as benzodiazepines enhance the activity of GABA producing a calming effect. 18 Genetic factors Research confirms that genetic factors play a role in the development of anxiety disorders. People are more likely to have an anxiety disorder if they have a relative who also has an anxiety disorder. The incidence is highest in families of people with panic disorder, where almost half have at least one relative who also has the disorder (Hettema, 2005). Substance use Substance use may induce anxiety symptoms, either while the person is intoxicated or when the person is in withdrawal. The
substances most often associated with generalized anxiety or panic symptoms are stimulants, including caffeine, illicit drugs such as cocaine, and prescription drugs such as methylphenidate (Hoehn-Sark, 2004). Medical conditions A range of medical conditions can cause anxiety symptoms and result in anxiety disorders (Hettema, 2005). For example, both panic and generalized anxiety symptoms can result from medical conditions, especially those of the glands, heart, lungs or brain. Most often, treatment of the medical condition reduces symptoms of anxiety.

7. Psychodynamic:

From the psychodynamic perspective, anxiety is a danger signal that threatening impulses of a sexual or aggressive nature are nearing the level of awareness. To fend off these threatening impulses, the ego tries to divert the tide by mobilizing its defense mechanisms (Freud, 1959). For example, with phobias, the defense mechanisms of projection and displacement come into play. A phobic reaction is believed to involve the projection of the person’s own threatening impulses onto the phobic object.

In generalized anxiety disorder, unconscious conflicts remain hidden but anxiety leaks to the level of awareness. The person is unable to account for the anxiety because its source remains shrouded in the unconscious. In panic disorder, unacceptable sexual or aggressive impulses approach the boundaries of consciousness and the ego strives desperately to repress them, generating high levels of conflict that bring on a fully fledged panic attack. Panic dissipates
when the impulse has been safely repressed. Obsessions are believed to represent the leakage of unconscious impulses into consciousness, and compulsions are acts that help keep these impulses repressed. Obsessive thoughts about contamination by dirt or germs may represent the threatened emergence of unconscious infantile wishes to soil oneself and play with feces. The compulsions help keep such wishes at bay or partly repressed (Freud, 1959). The psychodynamic model remains largely speculative, in large part because of the difficulty of arranging scientific tests to determine the existence of the unconscious impulses and conflicts believed to lie at the root of these disorders.

8. Psychological and Physical Activity:

The physical activity includes positive changes in self perception, improvement of self confidence and awareness and positive changes in mood. Even a moderate physical exercise has an impeccable effect on one’s self esteem, self-image and mood. The competitive nature and involvement of group activity in sports have a boosting effect on the self-perception and spirit of the individuals and heighten their self-esteem and confidence levels and mental readiness to face the challenge in life. Physical activity acts as a safety value for the individuals to reduce their stress and tension, which they experience in their routine life. Physical activity helps to divert and release their emotions and physical tensions, thereby, averting psychosomatic disorders. It is for this reason that Sutherland and Copper (1990) regarded physical activity as a “development of defense mechanism”. By acting as a mental diversion outlet for stress
tensions, Physical activity saves the individual from emotional disturbances, thereby, promoting his/her Psychological well-being.

- **Competitive and Anxiety: Competitive Trait**

  Anxiety is a situation specific modification of the more general trait construct competitive. A trait is defined as a tendency to perceive competitive situations as threatening and to respond to these situations with A-state the operationalization of the competitive A trait construct is important in understanding behaviour in sports particularly in understanding which competitive situations are perceived as threatening and how persons respond to threat. The Sports Competition Anxiety Test (SCAT), discussed and developed to assess Competitive A-Trait and construction of SCAT was based on four significant, the article developments in the field of personality.

  1) The adoption of an interactional theory of personality that predicts behaviour better than do trait or situational paradigms.

  2) The development of situation specific A-trait instruments that have superior -predictive power compared to general A-trait scales.

  3) The treat-state theory of anxiety, which distinguishes between A-trait and A-state.

  4) The development of a conceptual model for the study of competitions as social process.
Spielberger’s (1966) conceptual distinction between A-trait and A-state is fundamental to his theory of Anxiety. Spielberger’s (1972) trait -state theory of anxiety is based on the following assumptions:

1. Stimuli that are either external or internal to the person and that are perceived as threatening evoke A-state reactions. High levels of A-state are experienced as unpleasant through sensory and cognitive feedback - mechanism.

2. The greater the amount of threat perceived the more intense A-state reaction.

3. The longer the person perceived threat, the more enduring the A-state reaction.

4. Compared with persons, low in A-trait, persons high on A-Trait will perceive more situations as threatening, respond with more intense A-state reactions, or both. Evidence indicates that situations involving potential failure or threats to self-esteem are more potent sources of threat than are potentially, physically harmful situations. It is primarily through past experience, that some persons acquire high or low A-trait.

5. Elevated levels of A-state have stimulus and drive properties that may be manifested directly in behaviour or that may serve to initiate psychological defense that have been effective in reducing A-state in the past.

6. Stressful situations frequently encountered, may cause an individual to develop specific psychological defense mechanisms that are designed to reduce or minimize state.
From this theory, it is clear that the focus of future research must be on the stimuli or antecedent conditions that evoke A-state, on the cognitive process that interpret these stimuli as threatening and on the behaviours that are manifested in response too, the perceived threat.

- **Influence of Anxiety on the Game Participation:**

  According to Cratty (1980) the anxiety transitions under conditions are marked by low, moderate and high level of anxiety.

  1. Low levels of anxiety are marked by a failure of the individual to exclude irrelevant stimuli in the situations.

  2. Moderate levels of anxiety seem to work best that is the individual who evidences moderate concern for the performance threat, in a situation in able to exclude irrelevant stimuli and it can attend and react to important stimuli in situations.

  3. Under high levels of anxiety, the individual begins to narrow attention too much and also displays attention in flexibility.

  There are numerous other situations and feelings that are likely to trigger anxiety in athletes. In some athletes (and teams) too many success proves anxiety producing. They may hold back from doing their best in order to avoid the social consequences and responsibilities that success may being (Silva, 1982).